

Care Quality Commission

Inspection Evidence Table

OHP-Craven Arms Medical Practice (1-4200602792)

Inspection date: 5 February 2019

Date of data download: 29 January 2019

Overall rating: add overall rating here

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.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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:	
Policies were centrally produced by OHP and maintained on GP team net however practices were	

Safeguarding	Y/N/Partial
<p>expected to make these practice specific. The central team also reviewed and updated policies. Practices could also use their own policies as part of the OHP autonomy model. We found that staff had access to practice specific safeguarding policies and procedures.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment took place at practice level although staff were centrally employed. The provider supported the practices in relation to recruitment for example advertising on the OHP website and newsletters. The central team produced standardised job descriptions for the practices.</p> <p>We saw evidence of health clearance reports for staff from the Occupational Health department including details relating to staff immunisation status.</p>	

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: 20/06/2017	Y
There was a record of equipment calibration. Date of last calibration: 22/08/2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 27/06/2018	Y
There was a log of fire drills. Date of last drill: 24/01/2019	Y
There was a record of fire alarm checks. Date of last check: 1/02/2019	Y
There was a record of fire training for staff. Date of last training: 29/01/2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 23/01/2019	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they undertook visual checks of their electrical equipment daily and if any issues were identified they would replace.</p> <p>A copy of the fire procedure was on display in every room. A record was kept of weekly fire alarm checks undertaken using different activation points. Staff had undertaken fire training but one staff member had not completed fire training since 2015. Following the inspection, the practice had sent evidence to show that the staff member had completed the fire training on the 12/02/2019.</p> <p>The practice had fire marshals, who had undertaken training relevant to this role on 14/02/2018.</p> <p>The practice was required to submit to the provider organisation details of maintenance of equipment checks (including cleaning/PAT and calibration checks) in addition to evidence of fire drills undertaken in the last 12 months as part of their self-declaration.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 01/02/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 01/02/2019	Y
<p>Explanation of any answers and additional evidence:</p> <p>An external company had completed a legionella risk report on the 3/5/2018. Monthly water temperature checks had been completed, water outlet checks were last completed in January 2019 and sample analysis check undertaken in December 2018.</p> <p>The practice was required to complete health and safety risk assessments, including legionella, and accessibility of the premises in line with the Equality Act. These were part of the core quality markers submitted to the provider by the practice as part of their self-declaration.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met. Although we found the premises to be clean and tidy the practice could not demonstrate that it had effective systems in place for monitoring standards of cleanliness and hygiene.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit: see below	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: The practice had a designated infection control lead. Policies and procedures were available for staff to access. The practice undertook basic monthly checks on equipment such as the stethoscopes and blood pressure monitoring machines. A cleaning assessment tool was used monthly to check equipment such as the medicines fridges, cupboards and trolleys. The practice shared a copy of their cleaning audit on the day of the inspection. However, no in-depth infection prevention and control (IPC) audit had been completed since the last inspection. This was discussed with the practice manager, who immediately obtained a more in-depth IPC audit documentation and undertook to act on our findings. Following the inspection, the practice had sent us a completed Infection Control Audit as evidence that they had acted on our findings. Blue (medicines), yellow (sharps) and purple (cytotoxic) topped bins were available, which were regularly collected by a recognised waste disposal company.	

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	Y

unwell patient and had been given guidance on identifying such patients.	
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. There were currently 35 members of staff who had signed up to working in this 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. There had been four GP recruited through this scheme. • International recruitment 	

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Explanation of any answers and additional evidence: 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. Compliance with legislation was part of the core quality markers self-declaration from the practices. As part of the core quality markers submitted to the provider, practices were required to state the date of the oldest electronic data transfer letter to add to the patient records and the oldest documents work flowed but not yet actioned. During the inspection we found patient information was being managed in a timely way.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, the management of patient group directions needed improving.

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>	0.97	0.94	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>	7.4%	7.9%	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).	No
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.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and	Y

Medicines management	Y/N/Partial
written procedures for the safe ordering, receipt, storage, administration, balance checks 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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Partial
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 data-bbox="57 871 807 907">Explanation of any answers and additional evidence:</p> <p data-bbox="57 940 1536 1048">Blank prescriptions were kept securely within a locked cupboard in the dispensary. The serial numbers of the prescriptions were recorded upon receipt. A record of the serial numbers of the blank prescriptions was also kept when distributed around the surgery.</p> <p data-bbox="57 1104 1536 1283">We looked at 23 Patient Group Directions (PGDs). Of these 23, we found that nine were out of date. There were 20 PGDs where one of the registered nurses had not signed as read and understood. There were also gaps in the authorising manager signatures, with seven of the 23 not having been signed by an authorising manager. Following the inspection, the practice sent evidence to show that they had acted on our findings.</p> <p data-bbox="57 1339 1536 1518">The emergency medicines that were stocked were kept secure and their expiry dates were checked every month. We checked the emergency medicines. On the day of the inspection, not all recommended emergency medicines were held at the practice including Voltarol and Glucogen. We brought this to the attention of the practice, who immediately put in a request for these medicines to be delivered the next day.</p> <p data-bbox="57 1574 1536 1792">The temperature of the dispensary fridge and the fridge used to store vaccines was monitored daily. The maximum and minimum temperatures of the fridges were measured and recorded. Records showed the contents of the fridge were being stored correctly. The plug to the vaccine fridge could be reached. There was a warning sticker on the plug not to remove it but there was nothing protecting the switch, which could be accidentally switched off. Following the inspection, the practice wrote to us to say they had fitted a plug cover to the wall to minimise the risk of the vaccine fridge being switched off.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Y
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Y
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Y
Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Y
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Y
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Y
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	NA
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Y
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Y
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Y
<p>Explanation of any answers and other comments on dispensary services:</p> <p>The surgery had a separate and clearly defined area for the dispensing of medicines. The dispensary itself was very small but clean, well-lit and organised. Tablets were kept separate from liquids, which in turn were kept from external medicines and inhalers. To try and reduce picking errors the strength of tablets was organised so that the lowest strength was to the left and the highest strength was to the right.</p> <p>Standard operating procedures (SOPs) were available that covered all processes in the dispensary. These were reviewed annually by the Dispensary Manager. The surgery participated in the Dispensary Services Quality Scheme.</p> <p>Repeat prescriptions awaiting collection were checked every month and if they have not been collected the patient was contacted. A record of the none collection was made on the EMIS system.</p>	

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:	7
Number of events that required action:	7
Explanation of any answers and additional evidence: Significant events were openly discussed at weekly clinical meetings or whole practice meetings depending on the relevance of the significant event. Events were coded in order of severity.	

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

Event	Specific action taken
A two week wait proforma was completed for a patient but no further action was taken. No task was sent to the reception team to inform them to complete the proforma and send.	The process for acting on two week wait referrals was reviewed and clinicians were reminded to complete all tasks and not leave a referral half completed.
Data security breach. Incorrect patient information was selected and given to a patient.	The procedure for giving information to patients was reviewed. It was agreed that staff would ask each patient when they requested information to confirm their name, date of birth and address which would be double checked when they handed over any paperwork to the patient.

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 shared with practices through GP Team Net and the practice was required to access	

the alerts and give a response to the provider of any relevant actions taken and assurances that they had acted on them.

The practice manager had responsibility for disseminating the alerts to the necessary clinician. We saw evidence that alerts had been actioned. The scanning of medicines on to the EMIS system meant that if any recalled medicines had gone out to patients then the surgery could contact those patients and ask them to return the recalled medicines. The surgery would replace with a non-affected batch.

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: Staff could access best practice guidance and safety alerts through a computerised system (GP Team Net). Updates in best practice guidance were discussed during clinical meetings. GPs shared experiences and discussed cases together during the week.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	0.61	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. A register of frail and vulnerable patients was maintained and updated monthly. The practice worked closely with the district nursing team, and met weekly to discuss housebound patients. The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age.
- Patients had access to an elderly care co-ordinator based at the practice who was part of the weekly meetings with GPs and district nurses. They signposted patients to various support groups in the community to help for example reduce loneliness and isolation.

People with long-term conditions

Population group rating: Good

Findings

- A register was held of patients with long term conditions. Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.
- For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. Monthly meetings were held with practice nurses, district nurses and palliative care nurses to discuss patients on the cancer and palliative care register.
- 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 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.
- Every prescription was manually checked and signed by a doctor and so patients would have their records checked at the same time a prescription was issued to ensure they were up to date with blood checks, blood pressure and eye screening for example.

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)	88.0%	81.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	18.6% (44)	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)	76.4%	76.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	19.1% (45)	9.9%	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>	87.4%	80.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	15.7% (37)	13.2%	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>	79.8%	75.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	6.9%	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>	93.3%	90.9%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.2% (2)	12.1%	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)	86.1%	82.4%	82.6%	No statistical variation
Exception rate (number of exceptions).	5.7% (38)	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)	95.6%	88.4%	90.0%	No statistical variation
Exception rate (number of exceptions).	6.3% (6)	7.0%	6.7%	N/A

Any additional evidence or comments

The practice had a GP lead for diabetes. The exception reporting for two of the three diabetes indicators was higher than the CCG. The practice told us that they only exception reported patients if on maximum therapy or after three letters were sent and failed attendances. Reception staff were tasked to chase referrals for annual reviews.

Families, children and young people

Population group rating: Good

Findings

- Childhood immunisation uptake rates were above the World Health Organisation (WHO) targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception.

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)	53	54	98.1%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	36	38	94.7%	Met 90% minimum (no variation)
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)	36	38	94.7%	Met 90% minimum (no variation)
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)	36	38	94.7%	Met 90% minimum (no variation)

Any additional evidence or comments

Meeting 90% target for the quarter for child immunisations was part of the core quality markers submitted to the provider by practices as part of a self-declaration.

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.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG	England	England
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		average	average	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) (PHE)	71.1%	76.6%	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)	78.1%	78.3%	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)	64.1%	61.7%	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)	72.2%	73.0%	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)	36.0%	49.7%	51.9%	No statistical variation

Any additional evidence or comments

The practice's uptake for cervical screening was 71%, although in line with the national average, it was below the 80% coverage target for the national screening programme.

Discussions were underway within the practice to see how they could encourage greater cervical screening uptake among younger patients. Both nurses and a GP were trained in how to carry out cervical screening allowing for female sample takers to be available. Women were actively encouraged to attend their screening.

The practice's uptake for breast and bowel cancer screening was in line with the local average and above the national average.

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.

- 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 and referred them onto the Shropshire substance misuse Team.
- The practice reviewed patients with a learning disability and offered health checks.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- 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.
- Staff had received dementia training and the practice manager had completed dementia friends training.

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)	64.3%	92.5%	89.5%	Variation (negative)
Exception rate (number of exceptions).	3.4% (1)	12.0%	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)	79.3%	90.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	0 (0)	10.1%	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)	74.3%	85.0%	83.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (5)	5.9%	6.6%	N/A

Any additional evidence or comments

Last year's QOF achievement for comprehensive care plans and recording of alcohol consumption for patients with mental health needs was below the CCG and national average. The practice was aware of this and told us they felt it related to insufficient number of GP appointments to carry out these checks. Since then, there had been an increase in GP appointments. This had resulted in an increase in performance in this area. Information shared with us on the day of the inspection showed that up to the day of the inspection, 84% of patients had a comprehensive care plan in place and 93% of patients had information about their alcohol consumption recorded.

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)	548.7	549.4	537.5
Overall QOF exception reporting (all domains)	5.2%	5.2%	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

<p>The practice had carried out a range of audits to include one cycle and two cycle audits in areas such as dermatology, rheumatoid arthritis and chronic kidney disease. Audits we reviewed demonstrated quality improvement. For example, a completed audit of the in-house dermatology clinic demonstrated a reduction in dermatology referrals to secondary care as patients could be seen and treated at the practice.</p> <p>The completion of two full cycle clinical audits annually was part of the core quality markers submitted to the provider by practices as part of a self-declaration.</p>
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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.	NA
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:	

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.	Y

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> <p>Practice staff were aware of the benefits of social prescribing and, with the support of the community care coordinator, had links to community groups and support networks. The practice ran an in-house Help2Quit programme to support patients who wished to stop smoking. The practice instigated a compassionate communities project utilising selected volunteers to befriend elderly patients offering some important companionship for elderly patients who were often alone and isolated socially and geographically.</p> <p>Patients were signposted to the good neighbours' scheme run locally which facilitates transport for elderly patients to allow them to keep surgery appointments, hospital outpatient appointments or social appointments such as lunchtime clubs.</p>	

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%	95.0%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (3)	0.7%	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
Explanation of any answers and additional evidence: Clinical staff demonstrated an understanding of best practice guidance in obtaining consent and were aware of Gillick competences and Fraser guidelines when providing care and treatment to children. We saw written consent had been obtained prior to a patient receiving minor surgery.	

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards	
Total comments cards received.	20
Number of CQC comments received which were positive about the service.	18
Number of comments cards received which were mixed about the service.	1
Number of CQC comments received which were negative about the service.	1

Source	Feedback
OHP Policies	The provider had an equality and diversity statement in place.
Comments cards	All except one patient commented positively on the service they received. Patients described staff as very good, caring professional and respectful. Patients also told us that staff did their best to support them.

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
3957	227	115	50.7%	2.91%

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)	98.5%	92.2%	89.0%	Variation (positive)
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)	100.0%	91.7%	87.4%	Significant Variation (positive)
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)	100.0%	97.0%	95.6%	Variation (positive)
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)	95.8%	88.5%	83.8%	No statistical variation

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

Any additional evidence
The practice had reviewed the results from the National GP survey published in August 2018, but as the responses were positive, decided not to carry out a repeat in-house survey. Monthly friends and family tests were reviewed.

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
Patients were asked to inform reception staff or the practice manager should they have any communication difficulties.	

Source	Feedback
CQC comment cards	Patients commented that they felt staff were patient and understanding. Patients told us that staff listened to their concerns and problems and did their best to support them.

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)	100.0%	95.8%	93.5%	Variation (positive)

	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
Translation services were available as the practice had identified patients who required this service. The self-check-in service was available in ten different languages.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 77 patients as carers. This represented 2% of the practice population.
How the practice supported carers.	The practice had a community care co-ordinator, who assisted patients in obtaining support they needed.
How the practice supported recently bereaved patients.	A register of patients at the end of life was maintained. Patients received a call or a visit from a GP as needed, and were signposted to external bereavement services as required. Patients also had access to bereavement leaflets in the waiting area.

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
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.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence:	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am – 1pm and 2pm-6pm
Tuesday	8.30am – 1pm and 2pm-6pm
Wednesday	8.30am – 1pm and 2pm-5pm (until 6pm on the 2 nd and 4 th Wednesday of the month)
Thursday	8.30am – 1pm and 2pm-6pm
Friday	9.30am – 1pm and 2pm-6pm
Appointments available: (to include GP and nurse appointments)	
Monday	9am -12.30pm and 2.30pm – 5.30pm
Tuesday	9am-12.30pm and 2pm-5.30pm
Wednesday	9am -12.30pm and 2pm-5.30pm
Thursday	9am -12.30pm and 2pm-5.30pm
Friday	9am -12.30pm and 2pm-5.30pm
	The practice had become part of a network of practices in South Shropshire, working together to offer patients an extended access service. Extended hours appointments were offered via this network in the evenings between 6.30pm and 8pm and on Saturday morning 8.30am and 12.30pm whether at their own practice or at a nearby practice in the local area.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3957	227	115	50.7%	2.91%

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)	98.6%	95.6%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived including a residential home.
- 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 kept a list of frail patients and reviewed it regularly. Patients had access to a community care co-ordinator who could signpost them to local services for support.
- The practice offered a dispensing service.

People with long-term conditions

Population group rating: Good

Findings

- The practice held a register of patients with long term conditions.
- Regular clinics were held to review patients with long term conditions.
- 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.
- A phlebotomy service was offered four mornings each week within the practice.

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.
- A weekly midwife led clinic was offered at the surgery for expectant mothers.
- Six-week check appointments and post-natal checks were performed in house.
- Family planning clinics and contraceptive services including implant insertion and removal, intrauterine devices, and pill checks were provided in house.
- Influenza vaccination for target children's population and pregnant mothers were provided via the practice nurses.

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 offered a wide range of appointment options for all patients to be seen, including telephone consultations which could be booked in advance or on the day.
- Extended hours appointments were offered via a network of practices in South Shropshire. Appointments were available in the evenings between 6.30pm and 8pm and on Saturday morning 8.30am and 12.30pm at a nearby practice in the local area.
- Appointments could be booked on-line or through contacting the practice.

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.
- 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, for example through offering longer appointments.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly. A care co-ordinator assisted patients of any age in need of help, support and advice by offering a signposting service. This included advice regarding care, transport, benefits, financial support, local support groups, housing and social isolation.

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 range of appointment options were offered. Patients were able to pre-book their appointments up to a week in advance either by calling the practice or on-line. Urgent slots were available in the morning and the afternoon for the same day. We were told that no patients were turned away should they have an urgent medical need.	

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)	98.6%	N/A	70.3%	Significant Variation (positive)
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)	92.4%	76.0%	68.6%	Variation (positive)
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)	74.3%	71.3%	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)	92.4%	79.2%	74.4%	Variation (positive)

Source	Feedback
CQC Comment Cards	Six out of the 20 comment cards received made references to appointments. Patients told us they were always able to get an appointment and that they were fitted in promptly.

	Most patients told us that they didn't have to wait long to be seen however there were two comments where patients told us that the appointment waiting time could be improved.
NHS Choices	One person left a comment on NHS choices which indicated that they were always able to get an appointment.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	0
Number of complaints we examined.	NA
Number of complaints we examined that were satisfactorily handled in a timely way.	NA
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	NA

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	NA
Explanation of any answers and additional evidence: The practice leaflet made references to the complaints and compliments procedure. Complaints would be managed by the Practice Manager. During the inspection, a copy of the complaints leaflet was requested but the staff were unable to produce one. Following the inspection, the practice wrote to us and told us that comments and complaints leaflet had been completed and put around the practice and was part of the welcome pack given to new patients.	

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider organisation (OHP) added OHP – Craven Arms to their registration in August 2017. The OHP partnership model was 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 took on a more strategic role. The OHP Board was made up of nine elected GP partners, the Operations Director and Finance Director. Board elections were 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.</p> <p>There was a small central OHP team that supported the practices to achieve future sustainability and resilience. They did 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).</p> <p>OHP were aware of challenges faced by GP practices and had for example undertaken work to develop longer term workforce solutions. They recognised locality differences and had focussed General Practice Forward View money to help practices identify new and innovative ways to address local challenges. This had involved working with affiliated non-OHP practices within the same localities.</p> <p>At OHP-Craven Arms, we found that the practice was pro-active in responding to the changes in primary care. They had taken up opportunities for more collaborative working with other OHP practices and were part of the Shropshire Medical Group Hub.</p>	

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	Y

external partners.	
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> <p>There was a collective vision among OHP member practices which was to provide: 'A strong and sustainable GP partnership that influences change in health and social care for the benefit of our patients, partners and practices, whilst providing leadership, standards, and support to ensure all we do clinically or operationally is of the highest quality.'</p> <p>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.</p> <p>The practice shared the collective vision of OHP and strived to offer the highest possible quality of accessible care to their patient population. Staff told us that they strived to do the best for their patients and provide help whatever the patients' needs were. A copy of the practice's mission statement was available in every room within the practice.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>There was an expectation that practices who wished to join OHP shared the same goals.</p> <p>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.</p> <p>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.</p> <p>At provider level we saw that there was a strong emphasis on the safety and well-being of staff. One of the provider's 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.</p> <p>Staff told us that there was an open, non-judgmental and no blame culture at the practice and felt able to raise concerns.</p>	

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

Source	Feedback
Interviews with staff	Staff commented that the practice offered a supportive and welcoming environment. Staff commented that the management team was approachable and felt they aimed to offer the best possible service.

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> <p>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.</p> <p>The provider communicated with the practices through the sharing of minutes from board meetings and regular weekly newsletters which were made available through GP team net.</p> <p>The practice had a clear organisational structure and staff had allocated lead roles and responsibilities. For example, there were identified lead staff for areas such as infection control, diabetes, dermatology and safeguarding. Staff demonstrated a good understanding of their roles and responsibilities. A range of meetings were held within the practice to discuss best practice and to share learning. Meetings were recorded and shared.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <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 practices had a business continuity plan which was saved on GP team net and could be accessed remotely. The plan was last reviewed in December 2018 and included important telephone numbers that may be required in an emergency or unexpected event.</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.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	

GP Team Net (clinical and governance system) had been rolled out across OHP member practices and provided the main forum for sharing management information. This enabled both the practice and central team to manage and monitor information such as those relating to incidents, complaints, safety alerts and staffing.

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

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

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>Patient involvement: The practice reviewed its national GP survey and the friends and family test (FFT) results. The practice had not carried out an internal patient survey in the last 12 months as the national survey results were very positive. Patient Participation Group (PPG) feedback was used to support the development of new services. The practice had considered ways of increasing the membership of the PPG to fully represent the patient population. This had included considering a virtual PPG group. Suggestions put forward by patients were acted upon where possible.</p> <p>Staff involvement: 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. Regular in-house meetings took place, which involved the whole team.</p> <p>Stakeholder involvement: 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.</p>	

Feedback from Patient Participation Group.

Feedback
We spoke with the Chairperson of the PPG. The PPG met about three to four times per year. Its current membership was around six active members. Meetings were recorded and minutes were available for patients to read in a folder in reception. There was also a PPG designated notice board in the waiting areas for patients to read information relating to the work of the PPG. The practice manager attended these meetings and sent in a practice manager report, updating the group on practice related matters. We were told that patients were satisfied with the service they received in the practice. The service was described as responsive and we were told the practice performed well.

Continuous improvement and innovation

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

	Y/N/Partial
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There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence:</p> <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.. • 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. <p>OHP – Carven Arms is a teaching practice in association with Keele University and had won two awards for their teaching work.</p> <p>The practice worked in collaboration with other practices in the area to provide improved extended hours access and for shared learning.</p> <p>The practice had put forward a suggestion to the CCG for reviews/appraisal of practice managers to be undertaken by OHP practice manager peers in association with the GPs. The aim was to better improve the quality of the reviews. The CCG had agreed funding to carry out this idea.</p>	

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.