

Care Quality Commission

Inspection Evidence Table

Dudley Wood Surgery (1-7315549388)

Inspection date: 19 November 2020

Date of data download: 04 November 2020

Overall rating: Good

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2019/20.

At our previous inspection in January 2020, we rated the practice as Inadequate due to a significant number of areas of non-compliance with the Health & Social Care Act 2008 Regulations. The practice was placed in special measures and a notice of decision was issued.

At this inspection, we found the practice had made significant improvements in all areas of previous non-compliance to such an extent that we have rated the practice as Good overall. We have continued to rate the working age people (including those recently retired and students) population group as Requires Improvement due to below local and national averages in cancer screening uptake performance.

Safe

Rating: Good

At our previous inspection in January 2020, we rated the practice as Inadequate for providing safe services because of the lack of effective systems & processes relating to safeguarding, infection prevention and control, staff recruitment, health and safety risk assessments and patient notes summarisations.

At this inspection, we have rated the practice Good for providing safe services because significant improvements had been made in all areas of previous non-compliance.

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	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • The practice did not have appropriate processes in place to support safeguarding. • Staff had not received appropriate levels of safeguarding training relevant to their roles. • There was a backlog of summarising patient notes and the practice was unable to provide assurance that there was no safeguarding information held in these notes. • DBS checks, risk assessments and updated training had not been undertaken for staff who chaperoned. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • The practice had policies and processes to support staff in safeguarding. There were registers which were regularly reviewed to keep patients safe. • Staff were trained to the appropriate safeguarding level for their roles and were able to access updated policies and procedures. • DBS checks had been undertaken for all staff working at the practice. 	

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 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
Explanation of any answers and additional evidence:	
At our previous inspection in January 2020, we found:	
<ul style="list-style-type: none"> • There were gaps in the practice system for staff employment and recruitment records. • Not all recruitment checks were completed in accordance with regulations. • The locum pack held by the practice at the time of the inspection contained policies and procedures that were all out of date • There was no documentation to show that an effective employee immunisation programme was in place for any staff. 	
At this inspection, we found:	
<ul style="list-style-type: none"> • Policies and procedures were now in place to support the recruitment and induction of staff. We saw evidence in staff recruitment files which included interview schedules, job descriptions and induction schedules in accordance with the regulations. • There was an up to date locum pack which contained updated policies and procedures. • There was an effective employee immunisation programme for staff carried out in line with public health. This had been completed for staff, however there had been delays in obtaining results for some staff due to COVID-19. 	

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: August 2020	Y
There was a record of equipment calibration. Date of last calibration: 17 August 2020	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: 10 November 2020	Y
There was a log of fire drills. Date of last drill: 7 July 2020	Y
There was a record of fire alarm checks. Date of last check: 16 November 2020	Y
There was a record of fire training for staff. Date of last training: 23 March 2020	Y

There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 23 April 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<p>At our previous inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • Fire safety risk assessment had not been carried out since April 2017 and therefore there was no evidence of actions taken to mitigate any risks. • There was no evidence that fire drills and fire alarm checks had been completed for staff working in the practice. • There was no lone working policy or risk assessment in place to mitigate risks to staff who worked alone in the practice. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • We saw evidence of an up to date fire risk assessment. Actions identified had been completed. For example, lowering the fire extinguishers, making no smoking signs more visible and the removal of rubbish to the back area of the car park. <p>There were two appointed fire safety marshals and evidence of fire drills and fire testing being carried out. Fire extinguishers and notices were visible throughout the practice.</p> <ul style="list-style-type: none"> • The practice had completed assessments in place for the Control of Substances Hazardous to Health (COSHH). • Face to face fire safety training was due to take place for all staff in April 2020, however this was cancelled due to COVID-19. The practice sent us evidence to demonstrate that all staff had completed on-line fire safety training instead. • A lone working policy had been reviewed and risk assessment completed for staff who worked alone. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 23 April 2020	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 23 April 2020	Y
Explanation of any answers and additional evidence:	
At our previous inspection in January 2020, we found:	

- There was no documentation of an effective operational system to manage, regularly assess and monitor risk and safety.
- The practice had a health and safety policy which was updated in May 2019, however information contained within it required updating.
- The practice policies for premises, security and health and safety policies and assessments were out of date.
- Carpets were missing from areas in the practice and were to be replaced. We found potential hazards relating to health and safety for example, external areas of the building contained rubble and discarded material which could pose a risk to patients accessing the rear car park.

At this inspection, we found:

- At the time of this inspection there was a health and safety lead in the practice and all health and safety policies were up to date. Health and safety risk assessments had been carried out and appropriate action had been taken. For example, staff risk assessments which included updating display screen equipment and providing staff with replacement chairs.
- As part of our inspection we also saw evidence of the system for the control of substance hazardous to health (COSHH) and legionella testing implemented since our last inspection.
- The practice policies for premises, security and health safety policies had now been updated and action had been taken to decorate the premises and remove rubble and discarded material to external areas of the building.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 18 August 2020	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
At the inspection in January 2020, we found:	

- The practice had an infection control lead and policy in place, however this individual was unaware that this was their responsibility. No infection control audit had taken place and not all staff had received up to date infection prevention and control training
- Three months before our January 2020 inspection the practice had been flooded and although areas of carpets had been removed to the lower ground floor there were areas inside and outside of the building that required attention.
- The practice policy for dealing with spillage for bodily fluids and the sharps injury policy was out of date.

At this inspection, we found:

- There was a lead nurse for infection prevention and control (IPC). An IPC policy had been updated and the practice had undertaken two IPC audits in the past 12 months. The audit in April 2020 had achieved an overall score of 84%. As a result, the practice completed an action plan to address the areas which included replacement patient chairs, new bins and toilet brushes, removing rust marks and replacing wall mounted alcohol gel. Most areas had been completed from the audit and at the time of our inspection the practice had revisited outstanding areas for action.
- Areas of decoration had been completed in the practice for example, the replacement of new carpets and decoration. A boiler had been relocated to another area of the practice.
- The policy for dealing with spillage for bodily fluids and the sharps injury policy was in date.

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
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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

When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
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Explanation of any answers and additional evidence:

At the inspection in January 2020, we found:

- There were significant issues with staffing levels in the practice and no effective system to manage the workload when staff were absent.
- There was no evidence of an effective induction system for newly appointed staff. In addition to this the practice were unable to assure us that clinical staff were being supervised or had the necessary competencies to carry out their role. Staff training records were incomplete.
- There was no available sepsis policy in the practice. Reception staff had not received training in the 'red flag' symptoms of sepsis, however, there were posters in the reception area with this information for staff to refer to.

At this inspection we found:

- The practice had employed additional clinical and non-clinical staff in the practice. There were processes in place to mitigate risk and rota's to support the delivery of the service.
- We saw evidence of a newly implemented comprehensive induction processes for new staff. This included protected time for training and clinical oversight where applicable. There were systems in place and oversight for staff training records which was kept under review by the practice manager. Clinical staff had protected time each week for supervision, oversight and continued professional development.
- Staff we spoke with demonstrated that they understood how to prioritise patients who reported signs and symptoms of sepsis. All staff had completed sepsis training relevant to their role since our last inspection. We also saw information on display throughout the practice to guide staff on how to manage patients presenting with sepsis symptoms.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
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

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) (NHS Business Service Authority - NHSBSA)	0.95	0.88	0.85	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). (01/07/2019 to 30/06/2020) (NHSBSA)	3.9%	5.5%	8.6%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets	4.93	5.18	5.35	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2020 to 30/06/2020) (NHSBSA)				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2020 to 30/06/2020) (NHSBSA)	1.36	1.57	1.92	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.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

Medicines management	Y/N/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>Explanation of any answers and additional evidence:</p> <p>At the inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • The practice could not evidence that there was any clinical supervision or oversight for any clinical staff. There was a lack of systems, and procedures, for supervision or peer review of clinician's work. • The practice had a system in place for the monitoring of blank prescriptions however this needed embedding further to reduce the risk of prescriptions going missing and in line with their current prescription policy. • The system for monitoring fridge temperatures needed to be reviewed, as we found an incident with the fridge temperature which was outside of the recommended temperature range. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • There was clinical oversight and supervision in place for staff. Clinical staff were given time each week with the principal GP to review clinical competencies and oversight. • The practice participated in the clinical commissioning group (CCG) incentive scheme. Data provided by the practice showed that their prescribing indicators were in line with local and national averages. • Systems to monitor patients prescribed high risk medicines that required regular monitoring were in place. We saw that patients received appropriate monitoring. • The practice's pharmacists supported the clinical team with the management of patients' medicines, including regular reviews and audits to ensure appropriate prescribing. The practice maintained a review of antimicrobial stewardship through clinical audit, sharing, learning and reflection at clinical meetings. • The practice used a medicines optimisation tool to monitor and review patients on high risk medicines. Audits were an integral part of the management of medicines and the practice carried out a range of audits to monitor the appropriate management of medicines. For example, fentanyl (opioid) audit and antibiotic audit. • Blank prescriptions were kept securely in a locked cupboard. The practice had a policy and system in place to monitor this safely. We saw evidence this was being adhered to during our inspection. • The system for monitoring fridge temperatures had been reviewed, this included updating the cold chain policy. We found that fridge temperatures were being routinely checked and recorded. • There was a system in place for emergency medicines and these were routinely checked by a nurse. We saw evidence of the appropriate policy in place which included the monitoring of medicines held on-site and for the doctor's bag. 	

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:	9
Number of events that required action:	9
Explanation of any answers and additional evidence:	
<p>At the January 2020 inspection, we found:</p> <ul style="list-style-type: none"> The practice had an up to date incident reporting policy, however the process for monitoring significant events was lacking. Staff were comfortable in raising concerns and these events were recorded on the appropriate forms however, there was no comprehensive, chronological record of significant events and there was limited evidence that learning was taken from these. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> Staff understood their duty to raise concerns and report incidents and near misses. There were systems in place for reviewing and investigating when things went wrong. The practice learned and shared lessons to improve safety. However, this still needed to be embedded further to ensure all significant events and associated learning were documented in relevant meeting minutes. 	

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

Event	Specific action taken
A two week cancer wait referral for a patient was not actioned until three days after the initial request.	The practice took immediate action and the patient was still seen within two weeks. The practice did not have a secretary in place at the time so staffing was reviewed to include training staff for dual roles to mitigate future risk. New guidance was reviewed and implemented for all staff.
There was a six day delay in issuing a MED3 (sick certificate) for a patient. This was actioned after the patient contacted the practice to request this further.	The practice apologised to the patient for the delay and issued the MED3 certificate immediately. GPs were reminded to review tasks regularly. This was discussed and reviewed at a practice meeting.

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
<p>Explanation of any answers and additional evidence:</p> <p>At the January 2020 inspection, we found:</p> <ul style="list-style-type: none"> Although there was a process in place to review and action safety alerts, there was no evidence of these discussions through minutes we saw evidence that alerts were being monitored and actioned appropriately. <p>At this inspection we found:</p> <ul style="list-style-type: none"> There was a system and process in place to review and action safety alerts. These were sent to the practice manager and a generic email inbox. This was sent to the GP for review and cascaded to the relevant clinicians for actioning. Copies of alerts were added to a spreadsheet and discussed and minuted in meetings. 	

Effective

Rating: Good

At our previous inspection in January 2020, we rated the practice as Inadequate for providing effective services because of the lack of effective staffing, appraisals, clinical supervision, oversight and quality improvement activity.

At this inspection, we have rated the practice Good for providing effective services and good for all of the population groups, with the exception of working age people (including those recently retired and students) which we rated as requires improvement because significant improvements had been made in all areas of previous non-compliance.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2019 to 30/06/2020) <small>(NHSBSA)</small>	0.50	0.75	0.70	No statistical variation

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicine reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review prior and during COVID-19 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered appropriate medicines such as statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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	84.0%	75.0%	76.6%	No statistical variation

in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)				
Exception rate (number of exceptions).	4.9% (8)	6.3%	12.3%	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 (01/04/2019 to 31/03/2020) (QOF)	98.1%	87.2%	89.4%	Tending towards variation (positive)
Exception rate (number of exceptions).	6.9% (4)	5.0%	12.7%	N/A

Indicator	Practice	CCG average	England average	England comparison
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 (01/04/2019 to 31/03/2020) (QOF)	90.9%	92.2%	91.8%	No statistical variation
Exception rate (number of exceptions).	6.8% (4)	3.1%	4.9%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice has not met the minimum 90% target for two out of five childhood immunisation uptake indicators, however it had put an action plan in place and were working to address this.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- 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 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus,	29	31	93.5%	Met 90% minimum

Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	26	28	92.9%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	26	28	92.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	25	28	89.3%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	26	29	89.7%	Below 90% minimum

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

Any additional evidence or comments

The practice's performance for uptake of childhood immunisations was below the World Health Organisation (WHO) target of 90% for two indicators. The practice had experienced recruitment difficulties for over 12 months which had left the nursing provisions unstable at the practice. In addition, there had been clinical coding issues that had not been carried out appropriately. A newly appointed nurse was in post during our inspection and an action plan had been implemented to improve the uptake of childhood immunisations. There was a recall system in place and text message reminders as well as the follow up of non-attenders. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care and would liaise with health visitors when necessary. We saw evidence that immunisation outcomes had increased since our last inspection.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

- Patients could book, cancel and have online appointments during the pandemic 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). (Snapshot date: 30/06/2020) (Public Health England)	72.0%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	72.1%	70.4%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	48.8%	52.8%	58.0%	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 (01/04/2019 to 31/03/2020) (QoF)	100.0%	67.2%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	55.6%	51.8%	53.8%	No statistical variation

Any additional evidence or comments

The practice's uptake for cervical screening was below the 80% target rate; the practice were aware of their low cancer indicator rates and were working to address this with a newly appointed nurse through an action plan.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. This continued to take place during COVID-19.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

- The practice demonstrated that they had a system to identify people who were vulnerable.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	81.3%	10.4%	85.4%	No statistical variation
Exception rate (number of exceptions).	5.9% (1)	13.2%	16.6%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	100.0%	31.6%	81.4%	Variation (positive)
Exception rate (number of exceptions).	10.0% (1)	12.4%	8.0%	N/A

Any additional evidence or comments

- Although data is available on the practice nationally through the quality outcomes framework, Dudley CCG have their own quality outcomes for health framework (DQOFH) that is different from the national quality outcomes framework (QOF) and therefore comparisons of DQOFH with national averages were not available.

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)	501.32	Not Available	533.9
Overall QOF score (as a percentage of maximum)	89.7%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	5.2%	Not Available	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

The practice had carried out an audit to review its cervical screening rates as these were below the 80% national target set by Public Health England. The practice initiated this audit due to concerns that COVID-19 could impact further on their outcomes and identifying previous coding issue. The audit found that for women aged 25-49 they were 9% below target and for women aged 50-64 they were 4% below target. An action plan was put in place to address improvement. This included writing letters to those with no contact numbers, a data cleansing exercise and a review of their recall system in order to continue to offer this during COVID-19. The audit would be repeated in six months' time.

The practice had carried out two cycle audits for the number of patients who were being prescribed methotrexate to ensure patients were being monitored in line with evidence-based practice. The practice acted to run searches, identify patients and take the appropriate action to ensure they were compliant. The practice found that the overall audits carried out had seen improvements in the monitoring of this. This audit remains ongoing and monthly searches were being carried out to support this process.

Any additional evidence or comments

- The practice had access to a clinical commissioning group (CCG) pharmacist who carried out regular searches, reviews and audits for medicines management; this included high risk medicines and antibiotic prescribing.

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
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:	
<p>At the January inspection, we found:</p> <ul style="list-style-type: none"> We found evidence that some clinical staff were completing reviews which were outside of their sphere of competence. We found there was not an appropriate tailored induction in place for nursing staff including health care assistants to enable them to access information at the point of need. There was no induction record for recently employed staff. The practice could not demonstrate acceptable levels of competence for new nursing staff who carried out their roles unsupervised. We reviewed the documentation for the practice's statutory and required training e-learning system. There was no system to provide oversight of the practice's training requirements and completion or a process to take appropriate action when training was not completed. We found gaps in the training record provided. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> There were meetings in place each week with clinical staff for oversight and supervision; this included reviews of patient consultations as part of best practice. 	

- Appraisals for existing staff and probation reviews for newly appointed staff had been completed. Induction processes were in place and included protected time to complete required training.
- The practice used an electronic training platform to provide most training courses. We saw that the training was up to date for all staff and this was kept under review by the practice manager. In addition, staff were encouraged to complete training to enhance their clinical competencies as part of continued professional development (CPD).

Coordinating care and treatment

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

Indicator
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.
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.
Patients received consistent, coordinated, person-centred care when they moved between services.
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice held monthly multi-disciplinary meetings to review complex patients and identify those in need of additional support. This included end of life care and palliative patients.

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	96.1%	92.3%	94.5%	No statistical variation
Exception rate (number of exceptions).	0.4% (3)	0.5%	0.8%	N/A

Consent to care and treatment

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

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

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

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

Source	Feedback
NHS Choices	Feedback on NHS choices reported that staff were kind, caring and listened to patients.
Patient Survey Results	Results from the national patient survey result for July 2020 reported that 91% of patient were involved as much as they wanted to be in decisions about their care and treatment during their last general practice appointment and 95% of patients find the receptionists at this GP practice helpful.

National GP Survey results

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 (01/01/2020 to 31/03/2020)	80.3%	89.8%	88.5%	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 (01/01/2020 to 31/03/2020)	78.0%	87.6%	87.0%	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 (01/01/2020 to 31/03/2020)	93.3%	95.8%	95.3%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	72.2%	81.3%	81.8%	No statistical variation

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

Any additional evidence
<ul style="list-style-type: none"> The practice continued to review results from the national GP patient survey and continued to obtain feedback from patients who attended this service, however this had been limited due to COVID-19.

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

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 (01/01/2020 to 31/03/2020)	91.0%	93.9%	93.0%	No statistical variation

	Y/N/Partial

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 90 patients who were also carers which represented 3% of the practice's list size. This had increased by 1% since our last inspection in January 2020.
How the practice supported carers (including young carers).	The practice had a carers lead and carers literature was available in the reception area. All carers were eligible for a flu vaccination.
How the practice supported recently bereaved patients.	Literature and information was available for patients on bereavement services available locally. Reception staff told us that the GP would arrange to see or telephone patients who were bereaved to offer support. A bereavement guide and protocol was available to assist staff and the practice signposted patients to a bereavement officer if required.

Privacy and dignity

The practice respected patients' privacy and dignity.

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

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Due to COVID-19 the delivery of the service had been amended. The front door of the building was kept locked and face to face appointments were triaged by a clinician over the telephone before a patient attended the practice. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	7am – 8.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	7am – 8pm (medicine reviews) 8am – 11.30am and 3pm – 8.30pm
Tuesday	8am – 11.30am and 3pm – 6.30pm
Wednesday	8am – 11.30am and 3pm – 6.30pm
Thursday	8am – 11.30am and 3pm – 6.30pm
Friday	8am – 11.30am and 3pm – 6.30pm
<ul style="list-style-type: none"> Appointments at 7am on Monday's were prebookable appointments for medicine reviews only. 	

National GP Survey results

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 (01/01/2020 to 31/03/2020)	96.2%	94.9%	94.2%	No statistical variation

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> 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 prior to and throughout COVID-19. The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings
<ul style="list-style-type: none"> Patients with multiple conditions had their needs reviewed in one appointment. The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues. Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings
<ul style="list-style-type: none"> Additional appointments were available until 8pm on a Monday for school age children so that they did not need to miss school. This continued to be in place during COVID-19. 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. The midwife held weekly clinics at the practice.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8pm on a Monday. Pre-bookable appointments were also available to patients between 7am and 8am on a Monday for medicine reviews. This continued to be in place during COVID-19.

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 such as homeless people and travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The practice hosted a weekly counsellor for patients requiring extra support.

Timely access to the service

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

	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"> The practice had a home visiting protocol in place. All requests for home visits were triaged by a GP and if deemed appropriate a home visit was carried out. 	

National GP Survey results

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 (01/01/2020 to 31/03/2020)	76.7%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	70.0%	62.1%	65.5%	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 (01/01/2020 to 31/03/2020)	59.0%	63.1%	63.0%	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 (01/01/2020 to 31/03/2020)	65.5%	70.0%	72.7%	No statistical variation

Source	Feedback
NHS UK Website	There were mixed reviews on NHS Choices prior to and during COVID-19 about access to appointments. Some patients reported easy access obtaining an

	appointment, whilst others had experienced a delay in getting an appointment.
Patient survey results	Patient survey results in July 2020 told us that 77% of patients find it easy to get through to this GP practice by phone, which was higher than the CCG average of 63% and national average of 63%. These results were prior to COVID-19.

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.	4
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
<p>During our inspection in January 2020, we found:</p> <ul style="list-style-type: none"> The practice had received some verbal complaints but they had not been recorded. There was no evidence that complaints from a variety of sources such as NHS choices or a suggestion box were reviewed and documented to drive improvement. <p>During this inspection, we found:</p> <ul style="list-style-type: none"> There were systems in place to review and capture verbal and formal complaints which were reviewed in practice meetings. The practice used information from a variety of sources to review and respond to complaints. For example, verbal, formal and NHS Choices complaints which were captured, documented, reviewed and discussed as a practice to continuously drive improvement in the quality of care. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient complained to the practice via email that a receptionist was rude whilst making an appointment.	Patient was offered an apology and the complaint was investigated further with the individual staff member who completed customer service training. No further action was taken.

The practice had not registered a patient correctly on their system and they could not be seen for an appointment until this was completed.	Patient was offered an apology and was registered at the practice immediately. The practice completed an audit for all registration checks. This was discussed with the staff member and further training needs were identified.
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Well-led

Rating: Good

At our previous inspection in January 2020, we rated the practice as Inadequate for providing well-led services because there was a lack of systems and processes to manage governance, risks issues and performance, clinical oversight and limited evidence of learning and continuous quality improvement.

At this inspection, we have rated the practice Good for providing well-led services because significant improvements had been made in all areas of previous non-compliance.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
At the inspection in January 2020, we found:	
<ul style="list-style-type: none">• Concerns that the practice leadership team had failed to take action to address areas of leadership and governance which impacted on safety and staff morale.• We found the practice was reactive rather than proactive and some actions had been undertaken immediately following the inspection. For example, a process regarding the summarising of patient records.• There was a lack of focus on clinical leadership and governance systems. There was limited audit activity and no peer reviews to ensure all were working to an appropriate standard.• The practice had not formally assessed the challenges to offering good quality care and there was no realistic strategy or contingency planning in place to identify how this would be measured.	
At this inspection, we found:	
<ul style="list-style-type: none">• There was a committed leadership team who understood the challenges to quality and sustainability and had identified the actions necessary to address these challenges. The leadership team were committed in involving all staff to shape and improve the service.• There was evidence of effective planning to address areas of concerns through action planning with progress against delivery.• The practice could evidence that they had regular management meetings to review the current challenges they faced regarding the quality and sustainability of the practice. They had experienced challenges in recruiting staff and were regularly reviewing their staffing levels to ensure that areas of performance were being addressed. This included mitigating risk and	

recruiting a female GP to expand the clinical team further to meet the needs of the practice population.

- The practice was a member of a primary care network (PCN) and the leadership team were aware of the changing landscape of primary care.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

At the inspection in January 2020, we found:

- The practice had a mission statement in place that reflected “We aim to provide high-quality, patient centred care that is safe, effective, caring, responsive and well-led in a clean and welcoming environment”. There were areas of clinical and governance systems and processes that could not assure us about patient safety.
- The practice had a business plan however, they could not demonstrate they had a realistic strategy in place to address challenges they had identified and concerns we found on inspection.
- The practice had recently formed a Primary Care Network (PCN), however there was a limited engagement with these meetings due to limited resources internally.

At this inspection, we found:

- The practice had a mission statement in place: “To deliver high quality and effective health care to all of our patients, tailored and responsive to the needs of the local population. We aim to treat our patients with dignity and respect”.
- The practice held regular meetings and kept their strategy under review to ensure progress was being achieved. All staff had been involved in developing the practice’s mission statement and the work needed to make improvements in the practice.
- The practice was engaging with their Primary Care Network (PCN) and were engaged in the needs of the locality.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in January 2020, we found:</p> <ul style="list-style-type: none"> The practice could not demonstrate who had oversight of all systems and processes to ensure effective care and to drive quality improvement. For example, effective staffing, supervision and appraisal, clinical audit and an overall lack of oversight to ensure safe and effective care. There were no staff meetings taking place with practice staff and no up to date record of appraisals. Staff were working extra hours to manage the current workload and this was impacting on staff morale and wellbeing. Whilst members of staff told us they felt supported by the practice leadership team; the practice did not effectively identify and mitigate fire safety or health and safety risks within the practice. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> There were clear systems and processes in place to ensure effective care and drive quality improvement. The practice had clear policies and procedures accessible to all staff, for example, whistleblowing and health and safety. Staff felt they were well supported in their roles and were able to share any concerns with the leadership team. Staff felt that there was an open-door policy and staff were approachable and worked together to achieve the best possible outcomes for their patients. 	

- The practice manager was very accessible and there was an open-door policy in place. The practice had been committed in improving the culture and held regular meetings with staff to ensure there was a good flow of communication. Staff were able to raise concerns in confidence or in staff forums and were encouraged to do so.
- There was a focus on staff wellbeing with regular dialogue and communication on changes during COVID-19. In addition, all staff had undertaken a personalised risk assessments and had access to external services for wellbeing support during COVID-19.

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

Source	Feedback
Staff interviews	<ul style="list-style-type: none"> • Staff told us they felt well supported in their roles. We were told there was a supportive culture with an open-door policy. • Staff felt able to raise concerns and felt the management team were very approachable and considerate.

Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<p>At the inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • Leaders were unable to address areas of responsibility such as governance and the overall management of the practice due a number of incidents occurring in the practice. These priorities had led to lack of governance structures and systems that had led to a number of failings. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • Structures, processes and systems to support good governance and management were established, clearly set out, understood and effective. Appropriate policies, procedures and activities to ensure safety were established and monitored to ensure effectiveness. • Governance arrangements were proactively reviewed and reflected best practice, for example, clinical oversight, supervision and continued professional development (CPD). • Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. There were systems and processes in place for the shredding of confidential waste. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<p>At the inspection in January 2020, we found:</p> <ul style="list-style-type: none"> • The practice did not have effective systems in place to ensure quality of care. There was limited quality improvement activity outside of medicines audits. • There was a lack of clinical supervision of clinical staff, including a lack of active supervision of a nurse and health care assistant (HCA) working at the practice. • A limited number of policies had been updated, however assessments such as health and safety of the premises and fire risk assessments were out of date. The practice did not have appropriate infection control measures in place. The practice did not maintain a record of staff immunisation and vaccination history. There was a lack of training for safeguarding level three and chaperoning. • There was a business continuity plan however practice information contained in it was out of date and needed urgent review. • The practice could not demonstrate they had considered the impact on quality and sustainability when service developments or changes had occurred. For example, the impact on childhood immunisations and cervical screening when they were without a practice nurse. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> • There were systems in place to manage and mitigate risk. The practice had employed an external consultancy service to embed new systems. They had implemented a new governance assessment framework and there were clear processes to ensure this was kept under review; this included a review of health and safety, premises and external building issues. • Clinical supervision and oversight by the principal GP was in place for nurses and HCA's as part of best practice. • A business continuity plan had been reviewed and updated. 	

- The practice was aware that there were areas of their performance for their quality outcomes that required improvements and were working through an action plan to improve their performance for immunisations and cervical screening. In addition, there was a range of clinical and non-clinical audit activity to improve quality and performance.
- Required training for staff was managed via an electronic monitoring system and there were processes in place for monitoring and review through supervision and appraisal processes.

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:

At the inspection in January 2020, we found:

- Records we checked showed that clinical information was accurate and reliable. However, organisational risk had not been managed.
- Medical alerts and guidance updates were reviewed in clinical meetings however the practice did not require clinicians to participate in peer reviews to ensure they were working to an appropriate standard.
- The practice could not demonstrate that when performance was below national targets, this information was used to hold staff and management to account.
- The practice could not demonstrate there were effective arrangements for identifying, managing and mitigating risks. For example, health and safety and the infection control risk.

At this inspection, we found:

- Organisational risks had been managed appropriately, this included succession planning and mitigating risks. The practice had systems in place to effectively manage their overall governance and staffing issues in the practice.
- Clinical oversight was in place to ensure staff were working at the appropriate standard. This was reviewed by the leadership team and through supervision and appraisal processes.
- Action plans had been produced to address areas below national targets. This was currently under review to address areas for cervical screening and child immunisations.
- Health and safety and infection control measures had been reviewed and assessed appropriately.

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the time of our inspection there was no active patient participation group (PPG). Efforts had been initiated to contact some patients who had expressed an interest, however this had not been prioritised due to COVID-19. 	

Continuous improvement and innovation

There were 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>At the inspection in January 2020, we found:</p> <ul style="list-style-type: none"> Due to the significantly reduced staffing levels at the time of the inspection, there was limited focus on learning and continuous improvement. The practice completed medicines audits that had resulted in improvement in prescribing practices however, it was unclear how these results were shared with all clinical staff. There was limited improvement activity outside of medicines audits. The practice told us the learning from significant events was discussed during meetings. However, the practice did not provide evidence of meetings where the three significant events we reviewed had been discussed. <p>At this inspection, we found:</p> <ul style="list-style-type: none"> Staff training and development was being reviewed in practice meetings and during supervision and appraisal processes. We found evidence of clinical and non-clinical audit activity that was used to drive continuous improvement in the practice. The practice had reviewed their significant events processes and this was being reviewed with staff during practice meetings. 	

- The practice was part of a primary care network (PCN) with other local GP practices working together to improve services for patients.
- At the time of our inspection the practice were in the process of applying to be a designated site for food bank vouchers for vulnerable patients.

Examples of continuous learning and improvement

- As part of their continued professional development the practice manager had commenced a leadership programme.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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