Care Quality Commission

Inspection Evidence Table

St Werburgh Medical Practice (1-4551112454)

Inspection date: 5 and 6 November 2019

Date of data download: 28 October 2019

Overall rating: Inadequate

We rated the practice as Inadequate overall because:

- The practice's systems, processes and practices did not always help to keep patients safe and safeguarded from abuse.
- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice had not made enough improvements to the arrangements for medicines management to help keep patients safe.
- Care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- Quality improvement activity was insufficient.
- Two members of staff had not received a regular appraisal.
- Clinical supervision for relevant staff was limited.
- Since our last inspection in November 2018, results of the national GP patient survey related to patients' experience of services provided at St Werburgh Medical Practice had deteriorated for two indicators.
- The practice did not always have enough staff to deliver services to meet patients' needs.
- People were not always able to access care and treatment from the practice within an acceptable timescale for their needs.
- Since our last inspection in November 2018, results of the national GP patient survey relating to patient access to services at St Werburgh Medical Practice had deteriorated for four indicators.
- Leadership was complex and did not always function as intended by the provider.
- Improvements to governance arrangements were insufficient.
- Improvements to their processes for managing risks, issues and performance were insufficient.
- The practice had not acted sufficiently on the feedback they had received from the public.
- Systems and processes for learning and continuous improvement were not yet sufficiently effective.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Inadequate

We rated the practice as Inadequate for providing safe services because:

- The practice's systems, processes and practices did not always help to keep patients safe and safeguarded from abuse.
- Risks to patients, staff and visitors were not always assessed, monitored or managed in an effective manner.
- Staff did not always have the information they needed to deliver safe care and treatment.
- The practice had not made enough improvements to the arrangements for medicines management to help keep patients safe.

Safety systems and processes

The practice's systems, practices and processes did not always help to keep people safe.

Safeguarding	
There was a lead member of staff for safeguarding processes and procedures.	Yes
Policies and other documents covering adult and child safeguarding were accessible to all staff. They clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.	Yes
GPs and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs) and knew how to identify and report concerns.	Yes
The practice worked in partnership with other agencies to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Information about patients at risk was shared with other agencies in a timely way.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
Notices in the practice advised patients that chaperones were available if required.	Yes

Additional evidence or comments

The practice's safeguarding lead worked one day per week at St Werburgh Medical Practice and one day per week at the Stoke Village Hall branch surgery. Staff told us that this member of staff was contactable by email and telephone on the days they did not work at the service. This member of staff had access to the practice's computer system via a laptop at home if staff contacted them with any safeguarding concerns when they were not at work. However, staff told us that most safeguarding concerns were able to wait until the safeguarding lead was next at work.

Recruitment systems	
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England guidance and if relevant to role.	Yes
There were systems to help ensure the registration of clinical staff was checked and regularly monitored.	Yes

Safety Records	
There were up to date fire risk assessments that incorporated an action plan to address issues identified.	Partial
The practice had a fire evacuation plan.	Yes
Records showed fire extinguishers were maintained in working order.	Yes
Records showed that the practice carried out fire drills.	Partial
Records showed that the fire alarm system was tested regularly.	Yes
The practice had designated fire marshals.	Yes
Staff were up to date with fire safety training.	Yes
All electrical equipment was checked to help ensure it was safe to use.	Yes
All clinical equipment was checked and where necessary calibrated to help ensure it was working properly.	Yes

Additional evidence or comments

There was a fire risk assessment dated 31 October 2019 for the St Werburgh Medical Practice. However, staff told us that a fire risk assessment of the Stoke Village Hall branch surgery had not been carried out.

The fire risk assessment for the St Werburgh Medical Practice incorporated an action plan, with dates by which the actions were to be completed, to address issues identified.

During our inspection visit we saw that there was a high threshold at the rear fire escape at the Stoke Village Hall branch surgery that could hamper egress in the event of an emergency.

Records showed that fire drills were carried out regularly at St Werburgh Medical Practice. However, fire drills were not being carried out regularly at the Stoke Village Hall branch surgery. Records showed that the last fire drill at this branch surgery was 19 June 2017.

Infection prevention and control	
We observed the premises to be clean and all areas accessible to patients were tidy.	Partial
There was a lead member of staff for infection prevention and control who liaised with the local infection prevention teams to keep up to date with best practice.	Yes
There was an up to date infection prevention and control policy.	Yes
There were up to date infection prevention and control audits that incorporated an action plan to address issues identified.	Partial

Relevant staff were up to date with infection prevention and control training.	Yes
The arrangements for managing waste kept people safe.	Yes

Additional evidence or comments

Records showed that the following infection prevention and control audits had been carried out at St Werburgh Medical Practice: environmental cleanliness checklist / audit tool for general practice; hand hygiene audit; aseptic technique competency audit; decontamination of equipment audit tool for general practice.

Records also showed that the following infection prevention and control audits had been carried out at Stoke Village Hall branch surgery: environmental cleanliness checklist / audit tool for general practice; decontamination of equipment audit tool for general practice.

The practice's infection prevention and control policy contained an audit tool for staff to use: appendix three – Infection control audit for general practices. However, there were no records to show that this had been completed for either St Werburgh Medical Practice or the Stoke Village Hall branch surgery. This audit tool contained questions that were not contained in any of the audits that had been carried out at either practice site. For example, a handwash basin is available in all clinical and toilet areas; floors are impervious and sealed; lighting is adequate to allow good visibility; there is adequate ventilation; there is room for a dressing trolley; questions regarding the availability of protective clothing such as fluid repellent face masks.

During our visit to the Stoke Village Hall branch surgery we saw that the corner of one of the walls in the nurse's room was not intact and was rusty. This meant that cleaning would not always be effective. We also saw that there were signs of penetrating damp to the ceiling of this room as well as to the back wall of the cupboard used to store emergency equipment and emergency medicines. This meant that there was a risk of cross contamination in this room that staff told us was used to carry out invasive procedures. For example, intramuscular injections. These issues had not been identified by any infection prevention and control audit activities.

There were records of the cleaning that was carried out at St Werburgh Medical Practice. However, there were no such records for the Stoke Village Hall branch surgery.

Risks to patients, staff and visitors

Risks to patients, staff and visitors were not always assessed, monitored or managed in an effective manner.

The provider had systems to monitor and review staffing levels and skill mix.	Yes
There was an effective approach to managing staff absences and busy periods.	No
Staff knew how to respond to emergency situations.	Yes
All staff were up to date with basic life support training.	Partial
Emergency equipment and emergency medicines were available in the practice including medical oxygen and an automated external defibrillator (AED).	Yes
Records showed that emergency equipment and emergency medicines were checked regularly.	Yes

Emergency equipment and emergency medicines that we checked were within their expiry date.	Yes
There was up to date written guidance for staff to follow in the event of major incidents that contained emergency contact telephone numbers.	Partial
There was written guidance for staff to follow to help them identify and manage patients with severe infections. For example, sepsis.	Yes
Staff were up to date with training in how to identify and manage patients with severe infections. For example, sepsis.	Yes
The practice had systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Yes
There were a variety of health and safety risk assessments that incorporated action plans to address issues identified.	Partial
There was an up to date health and safety policy available with a poster in the practice which identified local health and safety representatives.	Yes
There were up to date legionella risk assessments and an action plan to address issues identified.	Partial

Additional evidence or comments

Staff told us the practice used a capacity planning matrix to calculate the number of appointments required per 1,000 patients. On the day of our inspection of St Werburgh Medical Practice, the capacity planning matrix showed that: 24 additional hours of additional GP time; 118 hours of additional advanced nurse practitioner time; and 81 hours of additional practice nurse time were necessary to meet the number of appointments required per 1,000 patients. Therefore, the practice was not employing enough clinical staff to meet the number of appointments required per 1,000 patients calculated by their own capacity planning matrix.

Staff told us that patients were not always directed to the correct member of staff in the first instance. For example, there were occasions when requests for repeat prescriptions for antibiotics were directed in the first instance to the locum clinical pharmacist instead of an advanced nurse practitioner or GP. Staff told us that if patients were directed to them in the first instance and their needs were outside of their protocols, they would re-direct patients to the relevant clinician. Staff told us this sometimes resulted in delays to patient care and treatment.

We looked at the training records of four members of staff and saw that one (non-clinical) was not up to date with basic life support training.

There was written guidance for staff to follow in the event of a major incident. For example, the business continuity plan. The guidance contained details of the Dulwich Medical Centre (DMC) Incident Management Team (IMT) who were to be contacted in the event of any business continuity issue occurring. For example, telephone failure or power loss. However, the written guidance did not contain contact details for any of the IMT. The written guidance also gave the names of the IMT, one of whom no longer worked for the organisation. The guidance was therefore not up to date.

There was an up to date health and safety risk assessment for St Werburgh Medical practice that incorporated action plans to address issues identified. However, staff told us that a health and safety risk assessment had not been carried out for the Stoke Village Hall branch surgery.

There was an up to date legionella risk assessment for St Werburgh Medical Practice that incorporated action plans to address issues identified. Records demonstrated that water samples had been sent for

testing and results showed that colonisation by legionella had not been detected. The practice also carried out regular flushing of little used water outlets as well as monitoring of the temperature of water from hot and cold outlets on a regular basis.

Staff told us that a legionella risk assessment had not been carried out for the Stoke Village Hall branch surgery. There were no records to demonstrate that water samples had been sent for testing, that regular flushing of little used water outlets was taking place or that the temperature of water from hot and cold outlets was being monitored for the Stoke Village Hall branch surgery.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment.

Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Yes
The care records we saw demonstrated that information needed to deliver safe care and treatment was made available to relevant staff in an accessible way.	Partial
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented.	Yes
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Yes
The practice demonstrated that when patients used multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes

Additional evidence or comments

The records of patients who were prescribed high-risk medicines did not always contain up to date blood test results to help guide staff before repeat prescriptions were issued.

Appropriate and safe use of medicines

The arrangements for managing medicines did not always help to keep patients safe.

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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	1.01	0.81	0.87	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
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). (01/07/2018 to 30/06/2019) (NHSBSA)	14.0%	10.4%	8.6%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	6.98	5.99	5.63	Variation (negative)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	3.76	2.39	2.08	Tending towards variation (negative)

The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
Blank prescription forms and pads were securely stored and there were systems to monitor their use.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with Public Health England guidance to ensure they remained safe and effective in use.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions).	Yes
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.	Yes
Up to date local prescribing guidelines were in use.	Yes

Additional evidence or comments

Performance for two antibiotic prescribing indicators was higher than local and national averages. Performance for one of these had not improved since our last inspection in November 2018. For example, 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) was 13.6% in June 2018. This had deteriorated slightly and was 14% at June 2019.

The practice's clinical lead GP worked one day per week at St Werburgh Medical Practice and one day per week at the Stoke Village Hall branch surgery. They were aware of the practice's performance indicators for prescribing and told us that locum GPs were being repeatedly advised of correct prescribing guidance for antibiotics and analgesia to help reduce prescription of these medicines

Indicator	Practice	CCG average	England average	England comparison

where possible. However, there were no records to confirm this.

At our previous inspection on 20 November 2018 we looked at the records of five patients who were prescribed high-risk medicines and saw that blood test results were not recorded as being received and reviewed by a clinician prior to further prescriptions being issued for four of these patients.

At this inspection on 5 November 2019 we looked at the records of four patients who were prescribed high-risk medicines and found that up to date blood test results were not recorded before repeat prescriptions were issued.

At our previous inspection on 20 November 2018 records showed that the temperature of one designated medicines refrigerator at St Werburgh Medical Practice had been recorded as being outside of the recommended limits, of between two and eight degrees centigrade, on three occasions so far in 2018. There was written guidance for staff to follow when the temperature of any of the designated medicines refrigerators went outside of the recommended limits. However, staff had not recorded the action they took on the occasions when the temperature of the designated medicines refrigerators had been recorded as being outside of acceptable limits.

At this inspection on 5 November 2019 records showed that on 9 August 2019, 4 September 2019, 2 October 2019 and 4 October 2019 the temperature of the designated medicine refrigerator at St Werburgh Medical Practice went outside of the acceptable temperature limits of between two and eight degrees centigrade. There was written guidance for staff to follow when the temperature of designated medicine refrigerators was recorded as being outside of acceptable limits. For example, the policy and procedures for maintaining the vaccine cold chain. However, there were no records to demonstrate that staff had taken the correct action on any of these occasions to help establish if medicines stored in the designated refrigerator were safe to use.

At this inspection on 6 November 2019 records showed that on 19 August 2019 the temperature of the designated medicine refrigerator at the Stoke Village Hall branch surgery went outside of the acceptable temperature limits of between two and eight degrees centigrade. There was written guidance for staff to follow when the temperature of designated medicine refrigerators was recorded as being outside of acceptable limits. For example, the policy and procedures for maintaining the vaccine cold chain. However, there were no records to demonstrate that staff had taken the correct action on this occasions to help establish if medicines stored in the designated refrigerator were safe to use.

Lesson learned and improvements made
The practice learned and made improvements when things went wrong.

Significant events	
There was up to date written guidance available for staff to follow to help them identify, report and manage any significant events.	Yes
Staff told us they would inform the practice manager of any incidents and there was a recording form available that supported the recording of notifiable incidents under the duty of candour.	Yes
Number of recorded significant events in the last 12 months.	16
Records showed that the practice had carried out a thorough analysis of reported significant events.	Yes

There was evidence of learning and dissemination of information from significant events	Partial

Additional evidence or comments

Although there was evidence of learning and dissemination of information from significant events that had been reported, the findings from our inspection on 20 November 2018 had not been reported as a significant event and there was no evidence of learning from it. For example, at our previous inspection on 20 November 2018 we looked at the records of five patients who were prescribed high-risk medicines and saw that blood test results were not recorded as being received and reviewed by a clinician prior to further prescriptions being issued for four of these patients. At this inspection on 5 November 2019 we looked at the records of four patients who were prescribed high-risk medicines and found that up to date blood test results were not recorded before repeat prescriptions were issued.

Safety Alerts	
The practice had systems for notifiable safety incidents.	Yes
The practice's systems for notifiable safety incidents ensured this information was shared with staff	Yes
Staff were aware of how to deal with notifiable safety incidents.	Yes
The practice acted on and learned from national patient safety alerts.	Yes
The practice kept records of action taken (or if no action was necessary) in response to receipt of all national patient safety alerts.	Yes

Effective

Rating: Inadequate

We rated the practice as Inadequate for providing effective services because:

- Care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.
- Quality improvement activity was insufficient.
- One member of non-clinical staff was not up to date with essential training.
- Clinical supervision for relevant staff was limited.
- Two members of staff had not received an appraisal within the last 12 months.

Effective needs assessment, care and treatment

Patients' needs were assessed. However, care and treatment were not always delivered in line with current legislation, standards and evidence-based guidance.

The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Partial
Staff had access to guidance from NICE and used this information to deliver care and treatment that met patients' needs.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes

Additional evidence or comments

The practice's systems and processes to keep clinicians up to date with current evidence-based practice were not always effective.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) (NHSBSA)	2.63	0.86	0.75	Significant Variation (negative)

Additional evidence or comments

Performance for hypnotics prescribing was significantly higher than local and national averages. There had been little improvement to this since our last inspection in November 2018. The average daily quantity of hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescription Unit (STAR PU) was 2.90 in June 2018. This was 2.63 in June 2019.

The practice's clinical lead GP worked one day per week at St Werburgh Medical Practice and one day per week at the Stoke Village Hall branch surgery. They were aware of the practice's performance indicators for prescribing and told us that locum GPs were being repeatedly advised of correct prescribing guidance for hypnotics to help reduce prescription of these medicines where possible.

Monitoring care and treatment			

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. However, performance for some indicators for patients with long-term conditions had deteriorated since our last inspection in November 2018. Improvements to exception rates for some patient population groups were insufficient.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	505.1	No Data	539.2
Overall QOF score (as a percentage of maximum)	90.4%	No Data	96.4%
Overall QOF exception reporting (all domains)	8.7%	No Data	No Data

Older people

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

The practice offered proactive, personalised care to meet the needs of the older people in its population.

The practice followed up on older patients discharged from hospital and ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions

Population group rating: Inadequate

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

Patients with long-term conditions were offered a structured annual review to check their health and medicine 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.

Specific staff had lead roles in chronic disease management. For example, nursing staff were leads in the care of patients with asthma and diabetes.

Patients at risk of hospital admission were identified as a priority.

Performance for asthma, COPD and atrial fibrillation indicators was in line with local and national averages.

Since our inspection in November 2018 performance for one diabetes indicator as well as the hypertension indicator had deteriorated and was now significantly below local and national averages:

- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 68.4% in March 2018. This had deteriorated to 64.7% in March 2019.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90 mm/Hg or less was 81.2% in March 2018. This had deteriorated to 65.3% in March 2019.

Performance for two diabetes indicators was tending towards variation negative when compared with local and national averages. Both indicators had been in line with local and national averages at the time of our last inspection in November 2018.

At the time of our last inspection in November 2018 the exception rate for one diabetes indicator, as well as indicators for asthma and COPD, were higher than local and national averages. Current published results indicated improvements, significantly so in some cases, to the practice's exception rate for these indicators. However, these remained higher than local and national averages. For example:

- The exception rate for patients with diabetes on the register whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 18.8% in March 2018. This had improved slightly to 17.6% in March 2019 but was still higher than local and national averages.
- The exception rate for patients with asthma on the register who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions, NICE 2011 menu ID: NM23 was 49.8% in March 2018. This had improved to 19.3% in March 2019 but was still higher than local and national averages.
- The exception rate for patient with COPD who had 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 was 29.3% in March 2018. This had improved to 18.1% in March 2019 but was still higher than local and national averages.

Staff told us that their practice nurse who specialised in the care of patients with diabetes had left the practice in August 2019 and had not yet been replaced. However, one of the GPs had received training in the care of patients with diabetes to help improve performance.

Staff also told us that a new system had been recently introduced that called patients with long-term conditions in for relevant health and medicine reviews according to the birth month of the patient. They planned to monitor the impact of these changes on performance.

During our inspection we saw that there was a ramp to the front entrance of St Werburgh Medical Practice to facilitate access for patients with mobility issues. The door at the front entrance did not open automatically. However, there was a doorbell placed at a suitable height for people who required assistance to open the door to call for help from staff.

During our inspection we saw that there was a ramp to the front entrance of the Stoke Village Hall branch surgery to facilitate access for patients with mobility issues. However, the door at the front entrance did not open automatically and people who required assistance to open the door relied on attracting attention of staff for help when necessary. There was no doorbell or other means by which they could do so.

Staff told us that the practice had not carried out a disability access risk assessment for St Werburgh Medical Practice or the Stoke Village Hall branch surgery.

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 (01/04/2018 to 31/03/2019) (QOF)	68.2%	78.4%	79.3%	Tending towards variation (negative)
Exception rate (number of exceptions).	12.0% (77)	13.5%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	67.0%	75.2%	78.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	12.8% (82)	10.2%	9.4%	N/A
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 (01/04/2018 to 31/03/2019) (QOF)	64.7%	77.7%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	17.6% (113)	13.5%	12.7%	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 (01/04/2018 to 31/03/2019) (QOF)	68.7%	72.1%	75.9%	No statistical variation
Exception rate (number of exceptions).	19.3% (134)	10.8%	7.4%	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 (01/04/2018 to 31/03/2019) (QOF)	82.5%	84.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	18.1% (34)	12.7%	11.2%	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 (01/04/2018 to 31/03/2019) (QOF)	65.3%	80.6%	83.0%	Significant Variation (negative)
Exception rate (number of exceptions).	2.4% (33)	4.8%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	85.8%	90.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (2)	5.1%	5.9%	N/A

Families, children and young people

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. Childhood immunisation uptake rates were carried out in line with the national childhood vaccination programme. NHS England published results showed that uptake rates for the vaccines given met the target percentage of 90% or above in all four indicators. 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, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	129	136	94.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	147	160	91.9%	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) (01/04/2018 to 31/03/2019) (NHS England)	147	160	91.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	146	160	91.3%	Met 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

Working age people (including those recently retired and students)

Population group rating: **Inadequate**

Findings

The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

The practice's uptake for cervical screening in 2017 / 2018 was below the 80% coverage target for the national screening programme. Unverified data showed that the practice achievement rate for eligible patients who had attended for cervical screening had increased by 9% to 84% in 2018 / 2019.

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

Since our last inspection in November 2018 performance for one cancer indicator had deteriorated:

- The percentage of patients with cancer, diagnosed within the preceding 15 months, who had a patient review recorded as occurring within six months of the date of diagnosis was 43.8% at the time of our inspection in November 2018. This had deteriorated to 36.8% at the time of this inspection and was below local and national averages. Unverified data showed that the practice achievement rate for this group of patients had increased by 13% to 50% in 2018 / 2019. However, this was still below local and national averages.

The number of new cancer cases treated which resulted from a two week wait referral was above local and national averages.

The practice was proactive in offering online services, as well as a full range of health promotion and screening that reflected the needs for this age group.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	74.6%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	67.7%	71.7%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	53.7%	55.4%	57.3%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	36.8%	74.1%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	63.2%	50.9%	51.9%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. The practice held registers of patients living in vulnerable circumstances including homeless people and those with a learning disability to help ensure they received the care they needed. The practice regularly worked with other health care professionals in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff we spoke with were aware of responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. 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.

People experiencing poor mental health (including people with dementia)

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing effective services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. Performance for hypnotics prescribing was significantly higher than local and national averages. There had been little improvement to this since our last inspection in November 2018. The average daily quantity of hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescription Unit (STAR PU) was 2.90 in June 2018. This was 2.63 in June 2019. Performance for mental health related indicators was in line with local and national averages. Performance for the dementia related indicator was in line with local and national averages. At the time of our last inspection in November 2018 the exception rate for all three mental health related indicators was above local and national averages, significantly so in two of the indicators. Current published results indicated some improvements to the practice's exception rate for these indicators. However, improvements were insufficient, and results were still above local and national averages, significantly so in two indicators: • The exception rate for patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive agreed care plan documented in the record in the preceding 12 months was 51.1% in March 2018. This had improved slightly to 30.9% in March 2019 but still remained significantly above local and national averages. • The exception rate for patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption had been recorded in the preceding 12 months was 46.8% in March 2018. This had improved slightly to 43.6% in March 2019 but still remained significantly above local and national averages. • The exception rate for patients diagnosed with dementia whose care plan had been reviewed in a face to face review in the preceding 12 months was 19.4% in March 2018. This had improved slightly to 13% in March 2019 but was still above local and national averages. Staff told us that the practice had plans to recruit a community psychiatric nurse to support improvements to performance for all mental health related indicators. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	86.8%	85.8%	89.4%	No statistical variation
Exception rate (number of exceptions).	30.9% (17)	15.8%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	87.1%	87.7%	90.2%	No statistical variation
Exception rate (number of exceptions).	43.6% (24)	13.5%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	90.0%	85.2%	83.6%	No statistical variation
Exception rate (number of exceptions).	13.0% (3)	6.8%	6.7%	N/A

Effective staffing

Staff did not always have the skills, knowledge and experience to carry out their roles.

The practice had an induction programme for all newly appointed staff.	Yes
The learning and development needs of staff were assessed.	Partial
All staff were up to date with essential training.	Yes
Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.	Yes
All staff had relevant access to appraisals, one to one, coaching and mentoring, clinical supervision and revalidation.	Partial
Clinical staff were supported to meet the requirements of professional revalidation.	Yes
There was a clear approach for supporting and managing staff when their performance was poor or variable.	Yes

Additional evidence or comments

Management support from Dulwich Medical Centre (DMA) level staff to local management staff was limited to weekly teleconference meetings between practice managers from DMC locations and monthly meetings at DMC's head office building. Practice managers from DMC's locations had recently been paired up to offer a 'buddy' system of support. However, there were no records to demonstrate local management staff had received formal training for their role at the practice.

At our inspection on 20 November 2018 we looked at the personnel records of four members of staff. These records showed that one member of non-clinical staff had not received a regular appraisal.

At this inspection on 5 November 2019 we looked at the personnel records of four members of staff. Two staff (one clinical and one non-clinical) had not receive a regular appraisal. After our inspection the practice wrote to us and told us that they were unable to find records of the last appraisal for the clinical member of staff. They also stated that the appraisal for this member of staff was now scheduled for 12 and 14 November 2019.

Clinical supervision for all relevant staff was limited as the practice did not have a permanent clinical lead GP. The acting clinical lead GP only worked at St Werburgh Medical Practice one day per week and the Stoke Village Hall branch surgery one day per week.

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

Indicator	
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)	Yes
Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assist as well as plan ongoing care and treatment.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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

The practice identified patients who may be in need of extra support. This included patients in the last 12 months of their lives, those at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health. For example, stop smoking campaigns and tackling obesity.	Yes

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 (01/04/2018 to 31/03/2019) (QOF)	93.0%	94.2%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.9% (22)	1.2%	0.8%	N/A

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

Clinicians understood the requirements of legislation and guidance when considering consent and decision making.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes

Caring

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing caring services because:

- Since our last inspection in November 2018, results of the national GP patient survey related to patients' experience of services provided at St Werburgh Medical Practice had deteriorated for two indicators.

Kindness, respect and compassion
Staff treated patients with kindness, respect and compassion.

CQC comments cards	
Total comments cards received	5
Number of CQC comments received which were positive about the service	4
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	1

Examples of feedback received	Source
• Most patients stated staff were friendly, helpful and caring.	Patient interviews, CQC comments cards, reviews left on the NHS Choices website and experience shared with CQC directly via our website.

National GP Patient Survey Results published in July 2019				
Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
11328.0	341.0	119.0	34.9%	1.05%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	81.3%	84.9%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	72.3%	83.0%	87.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	93.2%	94.1%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	61.5%	75.3%	82.9%	Variation (negative)

Additional evidence or comments

Since our last inspection in November 2018, results of the national GP patient survey had deteriorated for two indicators. For example:

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 was 79.9% in July 2018. This had deteriorated to 72.3% in July 2019 and was now below local and national averages.

The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice was 70.3% in July 2018. This had deteriorated to 61.5% in July 2019 and was now below local and national averages.

Involvement in decisions about care and treatment

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

Facilities to help patients be involved in decisions about their care	
Interpretation services were available for patients who did not have English as a first language.	Yes
A hearing loop was available for patients who had a hearing impairment.	Yes
Patient information leaflets and notices were available in the patient waiting areas which told patients how to access support groups and organisations.	Yes
Information about support groups was available on the practice website.	Yes

Examples of feedback received	Source
• Most feedback we received from patients about their experience of being involved in decision about care and treatment was positive.	Patient interviews, CQC comments cards, reviews left on the NHS Choices website and experience shared with CQC directly via our website.

National GP Patient Survey Results published in July 2019				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	90.2%	91.1%	93.4%	No statistical variation

Carers	Narrative
Number and percentage of carers identified	Records showed that the practice had identified 190 patients on the practice list who were carers (1.6% of the practice list).
How the practice supports carers	The practice had a system that formally identified patients who were also carers and written information was available to direct carers to the various avenues of support available to them. The practice's computer system alerted staff if a patient was also known to be a carer.

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

Curtains or private areas were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues	Yes
Written guidance was available for staff to follow that helped to maintain patient confidentiality.	Yes

Responsive

Rating: Inadequate

We rated the practice as Inadequate for providing responsive services because:

- The practice did not always have enough staff to deliver services to meet patients' needs.
- People were not always able to access care and treatment from the practice within an acceptable timescale for their needs.
- Since our last inspection in November 2018, results of the national GP patient survey relating to patient access to services at St Werburgh Medical Practice had deteriorated for four indicators.

Responsive to and meeting people's needs

The practice organised services to meet patients' needs. However, they did not always have enough staff to deliver these services.

The practice understood the needs of its patients and tailored services in response to those needs.	Partial
Telephone consultations and home visits were available for patients from all population groups who were not able to visit the practice.	Yes
Urgent appointments were available for children and those patients with serious medical conditions.	Yes
The practice had a website and patients were able to book appointments or order repeat prescriptions on line.	Yes
The facilities and premises were appropriate for the services delivered.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Partial
There was a system for flagging vulnerability in individual patient records.	Yes
Records showed the practice had systems that identified patients at high risk of admission to hospital and implemented care plans to reduce the risk and where possible avoid unplanned admission to hospital.	Yes
There was a range of clinics for all age groups as well as the availability of specialist nursing treatment.	Yes
All patients had been allocated to a designated GP to oversee their care and treatment.	Yes

Additional evidence or comments

Staff told us the practice used a capacity planning matrix to calculate the number of appointments required per 1,000 patients. On the day of our inspection of St Werburgh Medical Practice, the capacity planning matrix showed that 24 additional hours of additional GP time, 118 hours of additional advanced nurse practitioner time and 81 hours of additional practice nurse time were necessary to meet the number of appointments required per 1,000 patients. Therefore, the practice was not employing enough clinical staff to meet the number of appointments required per 1,000 patients calculated by their own capacity planning matrix.

Staff told us that patients were not always directed to the correct member of staff in the first instance. For example, there were occasions when requests for repeat prescriptions for antibiotics were directed

in the first instance to the locum clinical pharmacist instead of an advanced nurse practitioner or GP. Staff told us that if patients were directed to them in the first instance and their needs were outside of their protocols, they would re-direct patients to the relevant clinician. Staff told us this sometimes resulted in delays to patient care and treatment.

Although there was a ramp at the branch surgery, access for wheelchair / mobility scooter users was hampered by: no means by which patients in wheelchairs / mobility scooters could summon entry support from staff at the main entrance; a raised threshold at the main entrance doorway.

Older people

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. The practice was responsive to the needs of older people in its population and offered longer appointments and urgent appointments for those with enhanced needs. All patients over 75 years of age were allocated a named GP to oversee their care to help ensure their needs were being met. Appropriate seating for older people was provided at the practice and the branch surgery. Home visits were available for all patients who were not able to travel to the practice. Eligible older patients were offered shingles vaccination in line with national programmes.

People with long-term conditions

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. There were longer appointments available for patients with some long-term conditions. All patients with a long-term condition were allocated a named GP to oversee their care to help ensure their needs were being met. Appropriate seating for most patients with long-term conditions was provided at the practice and the branch surgery. However, there was no specific seating available for bariatric patients. The practice liaised with relevant health and care professionals to deliver a multidisciplinary package of care for those patients with the most complex needs.

Families, children and young people

Population group rating: **Inadequate**

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate.

There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, the system that monitored children and young people who had a high number of accident and emergency attendances.

Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. Appointments were available outside of normal working hours. Online access to appointments and repeat prescriptions were available. Telephone consultations were available.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. The practice offered longer appointments for patients with a learning disability. People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode. The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings
The provider has been rated as Inadequate for providing responsive services. The areas that require improvement impacted all patient population groups, so we have rated them all as Inadequate. Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. The practice informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Timely access to the service
People were not always able to access care and treatment from the practice within an acceptable timescale for their needs.

Practice Opening Times	
St Werburgh Medical Practice	
Day	**Time**
Monday	8am to 6.30pm
Tuesday	7am to 6.30pm
Wednesday	7am to 6.30pm
Thursday	8am to 6.30pm
Friday	7am to 6.30pm
The Healthy Living Centre Balmoral Gardens	
Day	**Time**
Monday	8.30am to 12.30pm and 3pm to 6pm
Tuesday	8.30am to 12.30pm and 3pm to 6pm
Wednesday	8.30am to 12.30pm and 3pm to 6pm
Thursday	8.30am to 12.30pm
Friday	8.30am to 12.30pm and 3pm to 6pm
Stoke Village Hall	
Day	**Time**
Monday	8.30am to12.30pm
Tuesday	Closed
Wednesday	8.30am to 12.30pm
Thursday	Closed
Friday	8.30am to 12.30pm
There were arrangements with other providers to deliver services to patients outside of the practice's working hours.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes

Patients had timely access to initial assessment, test results, diagnosis and treatment.	Partial
Waiting times, delays and cancellations were minimal and managed appropriately.	Partial
Patients with the most urgent needs had their care and treatment prioritised.	Yes

Additional evidence or comments

On the day of our inspection the next available routine appointments were: with a GP - 1 December 2019; with an advanced nurse practitioner – 12 November 2019; with a practice nurse – 13 November 2019.

National GP Patient Survey Results published in July 2019

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	91.2%	93.2%	94.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	15.3%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	27.5%	57.8%	67.4%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	28.3%	56.8%	64.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	48.0%	68.1%	73.6%	Variation (negative)

Additional evidence or comments

Since our last inspection in November 2018, results of the national GP patient survey had deteriorated for four indicators. For example:

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 by telephone was 37.3% in July 2018. This had deteriorated to 15.3% in July 2019 and was now significantly below local and national averages.

The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment was 50.4% in July 2018. This had deteriorated to 27.5% in July 2019 and was now significantly below local and national averages.

The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times was 46.5% in July 2018. This had deteriorated to 28.3% in July

2019 and was now significantly below local and national averages.

The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) offered was 64.5% in July 2018. This had deteriorated to 48% in July 2019 and was now below local and national averages.

Where national GP patient survey results were below average the practice had developed an action plan to help improve patient satisfaction. For example, in order to reduce incoming telephone calls the practice planned to offer patient online appointment. There were plans for staff to receive customer service training on navigating patients to services better suited to their needs. Records showed this was due to be reviewed in 2020 but did not state a date by which the plans were to be implemented.

We looked at the practice's booking system and saw that there were urgent appointments available with a GP on 7 November 2019. The next available routine appointment with a GP was 1 December 2019. The next available routine appointment with an advanced nurse practitioner was 12 November 2019 and with a practice nurse was 13 November 2019.

Examples of feedback received	Source
• Feedback regarding access to services at St Werburgh Medical Practice was predominantly negative. • Almost all patients indicated they found it difficult to get through to the practice by telephone at times and were not always able to book appointments that suited their needs. • Some patients indicated they found it difficult to obtain an emergency appointment with a GP. • Some feedback indicated patients felt there were insufficient staff (mainly GPs) at the practice.	Patient interviews, CQC comments cards, reviews left on the NHS Choices website and experience shared with CQC directly via our website.

Listening and learning from concerns and complaints

The practice had a system to manage complaints and used them to help improve the quality of care.

Listening and learning from complaints received	
The practice had a system for handling complaints and concerns.	Yes
The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.	Yes
Information was available to help patients understand the complaints system.	Yes
Number of complaints received in the last 12 months.	35

Additional evidence or comments

We looked at the practice's log of complaints for the last 12 months and saw there were common themes regarding patients complaining that they found it difficult to get through to the practice by telephone and were not always able to book an appointment that met their needs.

Well-led

Rating: Inadequate

We rated the practice as Inadequate for providing well-led services because:

- Leadership was complex and did not always function as intended by the provider.
- The practice had a culture of high-quality sustainable care. However, high-quality care was not being sustained at St Werburgh Medical Practice.
- Improvements to governance arrangements were insufficient.
- Improvements to their processes for managing risks, issues and performance were insufficient.
- The practice involved the public, staff and external partners to help sustain high-quality and sustainable care. However, they had not acted sufficiently on the feedback they had received.
- The practice had established a patient participation group.
- There were systems and processes for learning and continuous improvement. However, these were not yet sufficiently effective.

Leadership, capacity and capability

Leadership was complex and did not always function as intended by the provider.

Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
Leaders had identified the action necessary to address challenges to quality and sustainability.	Partial
There was a clear leadership structure and staff felt supported by the GP partners and practice management.	Partial

Additional evidence or comments

Overall leadership was provided by Dulwich Medical Centre (DMC) centrally by staff at their head office. This included a managing director, a chief executive officer, a medical director, a finance director, a chief technology officer, a head of governance, a head of marketing, a head of planning, a head of human resources, a head of planning and a head of legal. Staff told us that DMC head office staff were not visible in the practice at any time.

The practice did not have a permanent clinical lead locally. Clinical leadership was provided locally at St Werburgh Medical Practice by a local acting clinical lead supported by the DMC head office team. However, the local acting clinical lead only worked at St Werburgh Medical Practice one day per week and the Stoke Village Hall branch surgery one day per week. Staff told us that this member of staff was contactable by email and telephone on the days they did not work at the service.

Records showed that there was a regional clinical lead for the organisation. However, this named individual no longer worked for the organisation.

Staff told us that the local clinical lead and practice management were approachable and always took time to listen to all members of staff. They also told us that they were able to approach the DMC head office team for help and support. However, they told us that help and support from the DMC head office team was sometimes limited or slow to be provided.

Staff said that local leadership at the practice was open, transparent and inclusive. However, they also

told us that changes were not always communicated to staff in an effective or timely manner. For example, emergency medicines had been moved at St Werburgh Medical Practice and were now stored in a locked cupboard. They used to be in a secure area of the practice stored in a portable box. Staff told us this change had not been communicated to all staff in a timely manner.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

The practice had a statement of purpose which reflected their vision.	Yes
All staff we spoke with were aware of the practice's vision.	Partial
The practice planned services to meet the needs of their patient population.	Yes

Additional evidence or comments

Some staff were spoke with were not aware of the practice's vision.

Culture

The practice had a culture of high-quality sustainable care. However, high-quality care was not being sustained.

Staff told us there was an open culture within the practice and they felt confident and supported to raise any issues.	Partial
Openness, honesty and transparency were demonstrated when responding to incidents.	Yes
The provider complied with the requirements of the duty of candour.	Yes

Additional evidence or comments

Staff told us they felt respected, valued and supported by the practice locally and by their colleagues locally. However, staff also told us that DMC head office staff did not always support them when they raised issues.

Governance arrangements

There were processes and systems to support good governance and management. However, they were not always effective.

There was a clear staffing structure and staff were aware of their own roles and responsibilities.	Yes
The practice had systems that helped to keep governance documents up to date.	Yes
Governance documents that we looked at were up to date.	Partial

Additional evidence or comments

There was written guidance for staff to follow in the event of a major incident. For example, the business continuity plan. The guidance contained details of the Dulwich Medical Centre (DMC) Incident Management Team (IMT) who were to be contacted in the event of any business continuity issue

occurring. For example, telephone failure or power loss. The written guidance gave the names of the IMT, one of whom no longer worked for the organisation. The guidance was therefore not up to date.

Managing risks, issues and performance

The practice's processes for managing risks, issues and performance were not always effective.

The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions were effective.	Partial
The practice had processes to manage current and future performance.	Partial
Clinical and internal audit was used to monitor quality and to make improvements.	Yes
Records showed that the practice had analysed all clinical audit results and implemented action plans to address findings.	Yes
Records showed that all clinical audits had been repeated or were due to be repeated to complete the cycle of clinical audit.	Yes
The practice had written guidance for staff to follow in the event of major incidents.	Yes
Written major incident guidance contained emergency contact telephone numbers for staff.	Partial

Additional evidence or comments

At our last inspection on 20 November 2018 the practice was unable to demonstrate they had taken the following risks into consideration: risks associated with prescribing high-risk medicines without having up to date blood test results recorded in the patient record; risks associated with medicines that require refrigeration not being stored in line with Public Health England guidance.

At this inspection on 5 and 6 November 2019 the practice was unable to demonstrate they had taken the following risks into consideration: risks associated with fire safety at the Stoke Village Hall branch surgery; all risks associated with infection prevention and control at St Werburgh Medical Practice as well as at the Stoke Village Hall branch surgery; risks associated with employing insufficient staff at St Werburgh Medical Practice to meet the needs of patients; risks associated with patients not always being directed to the correct member of staff in the first instance to meet their needs; health and safety risks at the Stoke Village Hall branch surgery; risks associated with prescribing high-risk medicines without having up to date blood test results recorded in the patient record; risks associated with medicines that require refrigeration not being stored in line with Public Health England guidance.

The practice's response to the Requirement Notices issued at our previous inspection of St Werburgh Medical Practice on 20 November 2018 was inadequate. Requirement Notices had been issued for breaches in regulations related to medicines management, assessment, monitoring and improvement of quality and safety of the services provided in the carrying on of the regulated activity as well as provision of appropriate support, training, professional development, supervision and appraisal for persons employed in the provision of a regulated activity. Breaches in regulation related to all of these issues were found to be continuing during our inspection on 5 and 6 November 2019.

The practice was also unable to demonstrate they had effective systems for the routine management of legionella at the Stoke Village Hall branch surgery.

Processes to manage current and future performance were not effective. For example, improvements to performance for some antibiotic and hypnotic prescribing, performance for diabetes indicators, hypertension indicators and cancer indicators. Also, improvements to performance for exception rates for diabetes indicators, asthma indicators, COPD indicators and mental health related indicators.

Appropriate and accurate information
The practice acted on appropriate and accurate information.

Quality and operation information was used to help improve performance.	Yes
The practice submitted data or notifications to external organisations as required.	Yes
There were arrangements in line with data security standards for the integrity and confidentiality or patient identifiable data, records and data management systems.	Yes

Engagement with patients, the public, staff and external partners
The practice involved the public, staff and external partners to help sustain high-quality and sustainable care. However, they had not acted sufficiently on the feedback they had received.

A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.	Partial
The practice had an active patient participation group.	No
The practice gathered feedback from patients through the patient participation group.	No
The practice gathered feedback from patients through analysis of the results of the national GP patient survey.	Yes
The practice gathered feedback from staff through staff meetings, surveys, appraisals and discussion.	Partial
The service was transparent, collaborative and open with stakeholders about performance.	Yes

Additional evidence or comments

Since our last inspection in November 2018, results of the national GP patient survey relating to patients' experience of using services provided at St Werburgh Medical Practice as well as access to services there had deteriorated. Although there were plans to improve patient satisfaction scores, the practice's action in relation to this feedback had not been sufficiently effective.

The practice had formed a patient participation group which was due to meet for the first time on 8 November 2019.

Not all staff had received a regular appraisal.

Continuous improvement and innovation
There were systems and processes for learning and continuous improvement. However, these were not yet sufficiently effective.

There was a focus on continuous learning and improvement at all levels within the practice.	Partial

The practice made use of reviews of incidents.	Yes
Learning was shared and used to make improvements.	Yes
Additional evidence or comments	
Learning and improvements as a result of patient feedback was insufficient.	

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.