

Care Quality Commission

Inspection Evidence Table

Dudley Wood Surgery (1-7315549388)

Inspection date: 23 January 2020

Date of data download: 15 January 2020

Overall rating: Inadequate

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

Safe

Rating: Inadequate

We rated the practice as inadequate for safe because:

- Not all staff had received the appropriate level of safeguarding training, fire safety training or infection prevention and control training.
- 525 patient records had not been summarised. The practice was unable to give us reassurance that there was no safeguarding information held in these records.
- The system for monitoring and reviewing recruitment files needed strengthening as there was no overarching system to ensure this was monitored and reviewed in accordance with the regulations.
- The practice did not provide evidence they had oversight of all staff vaccinations in line with current Public Health England guidance.
- Disclosure and barring checks (DBS) had not been carried out for all staff and there were no risk assessments in place.
- We found health and safety, fire safety risk assessment and security risk assessments had not been completed at the practice premises.
- Infection control audits had not been carried out.
- There was no effective induction for newly appointed staff.
- There was no effective approach to managing staff absences.
- There was no comprehensive record or analysis of significant events, complaints or patient safety that would lead to practice improvements. There was no clear learning from these events.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding

Y/N/Partial

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding 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.	Partial
There was active and appropriate engagement in local safeguarding processes.	Partial
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.	Partial
Staff who acted as chaperones were trained for their role.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice had an up to date adults and children’s safeguarding policy and had safeguarding registers in place, however the safeguarding policies in the locum pack were out of date. We saw evidence that a safeguarding audit had been carried out and clinical records of patients who had safeguarding concerns were highlighted in the patient records. • The GP was trained to safeguarding level three, however staff training records had gaps for the completion of appropriate safeguarding training for adults and children for both clinical and non-clinical staff. For example, there was evidence to demonstrate safeguarding children level three had lapsed for some clinical staff and newly appointed clinical staff had no records of appropriate training. The practice told us training had been booked for one clinician but this had been cancelled externally, however they were unable to evidence this had been re-arranged. We were told that reception staff had been booked to receive training but had not attended as they were required to provide reception cover for staff absences. • The practice had up to date safeguarding registers and told us that they regularly reviewed these patients. However, the practice were unable to evidence that they reviewed safeguarding with external organisations as there was no up to date minutes available. Regular meetings with health visitors did not take place. The practice told us that they had invited midwives and health visitors as part of their multi-disciplinary safeguarding meetings however there was no proactive approach to follow this up. The practice told us they were in the process of reviewing this and that discussion’s took place with relevant agencies on a case by case basis. • The practice had a backlog of patient notes that had not been summarised and were unable to provide assurance that there was no safeguarding information held in these notes. <p>There was no risk assessment in place for Disclosure and Barring Service (DBS) checks not</p>	

Safeguarding	Y/N/Partial
<p>undertaken for clinical and non-clinical staff and the policy had not been reviewed since 2017. There was no evidence of DBS checks being carried out for all staff including two newly recruited members of staff. After the inspection the practice sent us evidence that this had been completed.</p> <ul style="list-style-type: none"> • There was an updated policy for chaperoning. Clinical staff acted as chaperones, however training for all clinical staff was either out of date or incomplete. Three out of four non-clinical were up to date with online training and were due to attend face to face training. Clinical staff who acted as a chaperone had a DBS in place, however this had not been updated or risk assessed. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	N
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We reviewed staff employment and recruitment records and found gaps in the practice system. For example, long term members of staff had the appropriate evidence in their recruitment files which included curriculum vitae, interview schedules, references, photographic identification and contracts, however there was no recruitment files available for two new members of staff and the provider could not demonstrate they had carried out an interview process, recruitment checks and an induction. The locum pack currently held by the practice contained policies and procedures that were all out of date. After the inspection the practice sent us evidence that appropriate information was held by the practice for the missing recruitment files. • The practice told us during our inspection that personnel files had been held electronically on a computer hard drive, however this had crashed and they had sought advice but were unable to retrieve data so were in the process of reviewing and updating these manually. • There was no documentation to show that an effective employee immunisation programme was in place for any staff. This included demonstrating new employees had a pre-employment health assessment and were up to date with immunisation against infectious diseases. • Not all recruitment checks were completed in accordance with regulations. Professional registration checks on initial employment were demonstrated for some individual files however there was no overarching system to ensure that reviews of clinical staff revalidation or professional registration renewal had taken place. 	

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: July 2019	Y
There was a record of equipment calibration. Date of last calibration: August 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	N
There was a record of fire extinguisher checks. Date of last check: December 2019	Y
There was a log of fire drills. Date of last drill:	N
There was a record of fire alarm checks. Date of last check:	N
There was a record of fire training for staff. Date of last training: February 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion:	N
Actions from fire risk assessment were identified and completed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had one fire marshal however the 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. • Fire extinguisher and emergency lighting checks had been completed. There was no evidence that fire drills and fire alarm checks had been completed for staff working in the practice. • It was identified that reception staff worked regularly on their own, however there was no lone working policy or risk assessment in place to mitigate risks to their welfare. During our inspection staff told us, they would lock the front door on occasions when working on their own during early morning and late evenings, however there were risks posed if staff left the reception area and needed to proceed to other parts of the building. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	N
Health and safety risk assessments had been carried out and appropriate actions taken.	N

Date of last assessment:	
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Explanation of any answers and additional evidence:

- The practice was unable to provide us with 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. After the inspection the practice sent us evidence that they had revised this policy, however we currently have no assurance that the policy is embedded and followed.
- The practice policies for premises, security and health and safety policies and assessments were out of date. The control of substances hazardous to health (COSHH) policy and cold chain had not been updated since 2016. We saw evidence that legionella testing had been carried out in December 2019. The practice had a waste contract in place, buildings insurance, data protection certification, electrical certificate and gas certificate which were all in date.
- Due to a flood to the downstairs area of the practice in October 2019 the boiler had been replaced and relocated. Carpets were missing from areas in the practice and were yet 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. After the inspection the practice confirmed that building rubble to the rear of the building had been removed.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	N
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: September 2018	Partial
The practice had acted on any issues identified in infection prevention and control audits.	N
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> 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. The practice showed us evidence that they were in the process of completing an audit tool, however this was not fully embedded and actions had not been completed to mitigate any risks. The practice had recently been flooded three months prior to our inspection and although areas of carpets had been removed to the lower ground floor there was areas inside and outside of the building that required attention. We saw evidence of spillage kits available for staff and they were able to demonstrate what they would do in the event of a spillage. However, the practice policy for dealing with spillage for bodily fluids and the sharps injury policy was out of date. Following the inspection, the practice told us they had arranged a visit from the Clinical Commissioning Group infection, prevention and control lead. 	

Risks to patients

There were gaps in 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.	N
There was an effective induction system for temporary staff tailored to their role.	N
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.	Partial

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.	Partial

Explanation of any answers and additional evidence:

- There were significant issues with staffing in the practice and no effective system to manage the workload when staff were absent. The practice manager was covering all aspects of reception and some staff were working longer hours to cover reception and administration tasks. At the time of our inspection the practice were in the process of recruiting staff, however this was impacting on areas of leadership, performance, governance and monitoring. Staff told us they felt stretched due to the staff shortages.
- 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. Staff told us they felt confident in identifying a patient who was acutely unwell and told us they would notify a clinician should a patient need to be seen urgently.

Information to deliver safe care and treatment

Staff did not have 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.	N
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The system for summarising patient records was lacking and there was a backlog of notes. 525 records has not been summarised. The practice told us this was due to staff absences and inability to cover this workload. The practice was unable to give assurance of how far the summarising dated back and that safeguarding information had been dealt with for these patients. After the inspection the practice sent us an action plan of the process they would undertake to ensure this was completed. We found evidence that the practice were handling and actioning correspondence appropriately however the overall system needed to be embedded. For example, clinical correspondence was being actioned appropriately, however we were not assured this was being filed correctly. The practice told us they had recently had their system upgraded and had plans to carry out further training, however this had not taken place yet due to other priorities such as lack of staffing and recruitment. 	

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) (01/10/2018 to 30/09/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.99	0.90	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	3.6%	5.3%	8.5%	Variation (positive)
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 (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	6.13	5.16	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	1.45	1.80	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	N
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	Y

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	N/A
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
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice participated in the local quality prescribing incentive scheme. Data provided by the practice showed that their prescribing indicators were positive. Systems to monitor patients prescribed high risk medicines that required regular monitoring were in place. We saw that patients received appropriate monitoring. • 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. • There was a system in place to monitor fridge temperatures daily both manually and electronically. We saw one incident on 4 December 2019 where the medicines fridge had been recorded manually as 12 degrees which was outside of the recommended range. We discussed this with the practice manager who was unaware of this incident and advised this would be discussed with the practice nurse and investigated as a significant event. The practice had a data logger for the fridge, however staff did not know how to use the datalogger and were unclear about the importance of the cold chain and the policy did not highlight the need to get advice if a break in the cold chain was identified. After the inspection the practice told us they would seek advice regarding the safety of 	

Medicines management	Y/N/Partial
the vaccines.	

Track record on safety and lessons learned and improvements made

The practice did not have a system to learn and make 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.	N
Number of events recorded in last 12 months:	10
Number of events that required action:	3
Explanation of any answers and additional evidence:	
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. There was no mechanism in place to review actions needed. We saw evidence that some significant events were discussed at practice meetings however these were not minuted. Significant events, incidents and the actions had not been documented or shared with the team and there was no analysis of trends or themes for improvements.	

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

Event	Specific action taken
The practice had run out of laboratory bags at the start of the afternoon session and had to use handwritten pathology laboratory bags in the interim.	The practice reviewed the order forms and the process to ensure there was a ready supply available at all times.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence:	

There was a process in place to review and action all 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 in meetings. Although there was no evidence of these discussions through minutes we saw evidence that alerts were being monitored and actioned appropriately.

Effective

Rating: Inadequate

We rated effective as inadequate because:

- The practice's uptake of cervical screening was below the 80% target rate; the practice were aware of this data but had no plan in place at the time of inspection to improve it.
- The practice's uptake of childhood immunisations rates were below the national averages and action taken had not yet demonstrated improved outcomes.
- There was limited evidence of quality improvement activity.
- We saw evidence that staff were working outside of their sphere of competence.
- The provider could not demonstrate they undertook regular appraisals and clinical supervision with staff.
- These concerns affect all population groups and therefore they have all been rated as inadequate.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was not delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics	0.59	0.80	0.74	No statistical

Prescribing	Practice performance	CCG average	England average	England comparison
prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>				variation

Older people

Population group rating: Inadequate

Findings
<ul style="list-style-type: none"> • The concerns identified with the effectiveness of the practice affected all population groups. • 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 medication reviews for older patients. • Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. • Health checks, including frailty assessments, were offered to patients over 75 years of age. • Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	79.5%	77.1%	79.3%	No statistical variation
Exception rate (number of exceptions).	4.7% (8)	8.5%	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) <small>(QOF)</small>	75.5%	74.2%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.6% (6)	8.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.6%	80.8%	81.3%	No statistical variation
Exception rate (number of exceptions).	11.8% (20)	10.3%	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) <small>(QOF)</small>	74.8%	75.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	9.3% (15)	5.3%	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) <small>(QOF)</small>	88.9%	89.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	10.0% (6)	6.4%	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) <small>(QOF)</small>	86.4%	83.7%	83.0%	No statistical variation
Exception rate (number of exceptions).	1.6% (7)	4.0%	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) <small>(QOF)</small>	87.3%	90.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.5% (2)	4.2%	5.9%	N/A

Families, children and young people

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- The practice has not met the minimum 90% target for all four childhood immunisation uptake indicators.
- 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, 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)	20	24	83.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	22	25	88.0%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	22	25	88.0%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	22	25	88.0%	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 all four indicators. The practice told us that they had struggled to recruit a practice nurse for 15 months and had identified that clinical coding may have not been carried out appropriately. A review of this had been instigated and at the time of our inspection, the practice were sending weekly results via telephone. They had now recruited a nurse and were working to improve the uptake of childhood immunisations and had a recall system in place and sent text message reminders as well as following 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.

Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

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). (31/03/2019 to 30/06/2019) (Public Health England)	72.7%	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%	70.3%	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%	52.6%	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. (01/04/2018 to 31/03/2019) (PHE)	64.3%	48.9%	68.1%	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%	51.9%	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 they may have potential issues with clinical coding and had plans to improve this, however we saw no evidence of this during our inspection.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- 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: Inadequate

Findings

- The concerns identified with the effectiveness of the practice affected all population groups.
- 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 (01/04/2018 to 31/03/2019) (QOF)	0.0%	9.3%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.0% (0)	14.4%	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)	72.2%	75.5%	90.2%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.0% (0)	9.7%	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)	42.9%	39.7%	83.6%	Variation (negative)
Exception rate (number of exceptions).	12.5% (1)	13.7%	6.7%	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.
- Although we found that the National QOF outcomes for mental health indicated significant negative variation we reviewed the local CCG data (DQOFH) for mental health indicators for the practice and found that they were meeting the threshold for all of the indicators with the exception of dementia care plan reviews which was below the threshold for one out of the two indicators. The practice told us that the GP was in the process of completing an audit for dementia to determine the appropriate action to take.

Monitoring care and treatment

The practice had a programme of quality improvement.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	437.9	441.1	539.2
Overall QOF score (as a percentage of maximum)	79.6%	79.0%	96.7%
Overall QOF exception reporting (all domains)	4.4%	4.9%	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.	Partial
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 carried out two cycle audits for the number of patients who were being prescribed methotrexate to ensure patients were being monitored as part of best 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 in this. This audit remains ongoing and monthly searches were being carried out to support this process.

Any additional evidence or comments

The practice undertook regular medicines audits which was led by the practice-based pharmacist to ensure they were compliant. For example, audits had been completed regarding fentanyl patch prescribing (pain medicines), amoxicillin (antibiotics for bacterial infections) and C-drug antibiotic prescribing.

Effective staffing

The practice was unable 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.	N
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	N
There was an induction programme for new staff.	N
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	N
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	N
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found a system to provide assurance of competence for staff such as nurses, nurse practitioners and health care assistants through monitoring and/or supervising was not in place. During our inspection we found evidence that some clinical staff were completing tasks such as chronic obstructive pulmonary (COPD) 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 practices statutory and mandatory 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. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
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
Explanation of any answers and additional evidence:	

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) <small>(QOF)</small>	97.4%	92.9%	95.0%	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
Explanation of any answers and additional evidence:	

Caring

Rating: Good

Kindness, respect and compassion

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

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

Source	Feedback
Staff Observations	During our inspection we saw that staff were helpful, kind and sympathetic to patient's needs. We evidenced staff assisting patients with the check in service and booking of appointments and arranging repeat prescriptions.
Patient interviews	On the day of inspection, we spoke to a patient who told us their dignity and privacy was respected and they felt involved in their care and treatment.
NHS Choices	Feedback on NHS choices reported that staff were kind, caring and listened to patients.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2586.0	300.0	98.0	32.7%	3.79%

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)	82.6%	89.0%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	80.8%	87.5%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	91.0%	96.4%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	77.1%	83.9%	82.9%	No statistical variation

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

Any additional evidence
The practice completed the friends and family test. A suggestion box was available for patient feedback in the reception area. On the day of inspection, we reviewed four comments and found that patients were positive about the service provided and would recommend the service.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with patients.	On the day of inspection, we spoke with a patient who told us they felt involved in decisions about their care and treatment and staff were helpful.
NHS Choices	Feedback on NHS choices was overall positive about the care and treatment from staff. Feedback included that staff are polite, respectful, caring and re-assuring. There were a number of examples where feedback reported that the GP and staff provided a professional and caring service.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	91.9%	94.6%	93.4%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 53 carers which was approximately 2% of the practice population.
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.

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.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The reception area was open so at times conversations could be overheard for patients. Staff told us if patients were distressed or wanted to discuss confidential issues then a room could be provided. 	

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.	Partial
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 a flood in the practice areas to the ground floor of the building such as carpets had been removed and were yet to be replaced. Areas to the external building such as the car park needed risk assessing due to lack of lighting and building rubble which had not been removed from a building extension in 2018. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am – 8.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	7am – 8am (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

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
2586.0	300.0	98.0	32.7%	3.79%

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)	91.0%	95.4%	94.5%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Good

Findings

- 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

- Additional appointments were available until 8.30pm on a Monday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. 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 8.30pm on a Monday. Pre-bookable appointments were also available to patients between 7am and 8am on a Monday for medicine reviews.

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.

National GP Survey results

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

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	71.5%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	64.8%	64.7%	67.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	57.4%	64.7%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	76.0%	71.4%	73.6%	No statistical variation

Source	Feedback
NHS Choices	The overall feedback on NHS choices was positive about the service received. Feedback reported appointments were easy to book and were available to suit.
Patient interview	On the day of inspection, we spoke to a patient who told us they were able to get an appointment when they needed and appointments ran on time.

Listening and learning from concerns and complaints

Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	0
Number of complaints we examined.	0
Number of complaints we examined that were satisfactorily handled in a timely way.	N/A
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.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice told us they had not received any written complaints in the past 12 months and all matters were dealt with immediately. 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.• A complaints leaflet was available for patients and had recently been updated on the practice website and staff were aware of the process. However, the leaflet was not available in the practice and an out of date complaints form was on display in reception. The practice told us they would make sure this was replaced so information was accurate.	

Well-led

Rating: Inadequate

We rated the practice as inadequate for well-led because:

- Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care
- The practice was not able to demonstrate good governance or awareness of the risks or challenges they face.
- There were gaps in the practice's governance systems and processes and the overall governance arrangements were ineffective.
- There was no clinical lead to oversee governance issues.
- The practice did not have a credible strategy to provide high quality care.
- The practice had not implemented a clear and effective process for managing risks, issues and performance.
- The practice did not involve patients or staff in shaping the service.
- We saw limited evidence of learning and continuous improvement.

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• We found a number of concerns during our inspection which the practice leadership team had failed to take action to address. The practice informed the inspection team of some challenges faced, such as recruitment and a priority to keep the day to day service functioning, however this had impacted on 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. For example, there was no active supervision of clinicians including advanced nurse practitioners, nurses and HCA working at the practice. 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. They were aware that areas of the premises required repair and that staffing was a priority to improve the service, however there was no realistic strategy or contingency planning in place to identify how this would be measured.	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	N
There was a realistic strategy to achieve their priorities.	N
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> 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. We were not assured that staff knew and understood the vision, values and strategy and their role in achieving them. They had a reactive rather than proactive approach regarding this. We found that there was a lack of oversight in key areas relating to the safety systems in place, staff provision, and governance structures all of which had the ability to compromise the quality of care provided by the practice and impact on its vision, aims and objectives. The practice had recently formed a Primary Care Network (PCN) with other local practices and were working towards plans for future delivery, however there was a limited engagement to these meetings due to limited resources internally. 	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
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.	N
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Although all staff had specific roles and responsibilities 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. Staff told us they felt well supported to carry out their roles and there was an open-door policy with leaders. The relationship between managers and staff was positive. Staff felt able to raise concerns and although staffing was being addressed this did have an impact on staff morale. There were no staff meetings taking place with practice staff and no up to date record of appraisals. At the time of our inspection, the practice had instigated appraisals with staff and these were in the process of taking place. Some staff were working extra hours to manage the current reception and admin workload and this was impacting on staff morale and wellbeing. Staff told us, they enjoyed working in the practice but the lack of staffing was putting pressure on staff. The practice were trying to recruit new staff, however the emphasis on the safety and wellbeing had not been prioritised and leaders were not addressing these areas of concern. 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. 	

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

Source	Feedback
Staff interviews	Staff told us they loved working at the practice, however staffing issues were impacting on their overall morale.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Staff told us they were aware of their roles and responsibilities, however due to significant staffing issues this had impacted on the overall running of the service. 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. For example, there was a lack of appropriate recruitment and health and safety assessments which led to patients potentially being exposed to risk of harm There was no policy or system in place for the shredding of confidential waste. The practice told us they would review this in line with information governance guidelines and best practice. 	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	N
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
<p>Explanation of any answers and additional evidence:</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 were no mechanisms in place to ensure that up-to-date guidance was circulated to staff. There was a lack of clinical supervision of clinical staff, including a lack of active supervision of advanced nurse practitioner, nurses and HCA working at the practice. A limited number of policies had been updated, however assessments such as health and safety premises and fire 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. There had been no effective systems in place to review this until a flood took place in the practice. The practice told us they were in the process of updating this and was in discussions with a nearby practice to review their buddy arrangements. The recent flood demonstrated that there was no alternative site to deliver the service from and the event has had a detrimental effect on staff who dealt with the incident. 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. 	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • 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. 	

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	N
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice was aware that it had not engaged patients effectively to ensure their views had been taken into account. The practice told us they had met with their patient participation group in August 2019 but this was currently under review. The practice were part of a primary care network (PCN), however due to a lack of staffing were unable to engage with local initiative meetings. The practice encouraged patient feedback through a suggestion box and the NHS Friends and Family Test. This feedback was reviewed individually, however not analysed for themes to make practice improvement and shape the service. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence:	
<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. There was evidence that staff were due to attend external training events, however this was cancelled due to the impact this would have on keeping the service from running. 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. 	

- We were not assured that systems and process for learning and continuous improvement were fully developed and implemented. The practice could not demonstrate a comprehensive approach to quality improvement and did not always review the effectiveness and appropriateness of care provided.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

Variation 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 rule 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.