

Care Quality Commission

Inspection Evidence Table

Brailsford and Hulland Medical Practice (1-566538968)

Inspection date: 23 and 24 June 2021

Date of data download: 14 June 2021

Overall rating: Inadequate

The practice is rated inadequate overall because effective governance systems were not in place to ensure safe, effective and responsive services were provided.

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

Safe

Rating: Inadequate

We rated the practice as inadequate for providing safe care and treatment. This is because:

- Not all staff had completed safeguarding training at a level appropriate to their role. Staff were unclear who the safeguarding lead within the practice was. There was no system in place to follow up frequent attenders to A&E or children who did not attend appointments in secondary care. Systems were not in place to share information regarding vulnerable adults with the ambulance service.
- Recruitment checks were not carried out in accordance with regulations. Evidence that all staff had the appropriate vaccination and immunity to potential health care acquired infections was not available.
- Risk assessments had not always been completed where required. Where risk assessments had been completed it was not always clear if the required action had been taken to mitigate risks.
- Effective infection prevention and control (IPC) processes were not in place. There was no IPC lead, audits, policies or evidence of staff IPC training. Some staff were observed not to be complying with COVID-19 guidance and seen walking around the practice without a face mask. Clinical waste was not stored securely. This included sharps containers and clinical waste bins. Systems for checking the cleanliness of privacy curtains were not in place.
- Temporary staff had not received a formal, structured induction when they started to work at the practice.
- Processes for the safe handling of requests for repeat medicines for long-term conditions and to monitor the health of patients prescribed some high-risk medicines were not effective. Patient Group Directions (PGDs) were out of date or unauthorised for some practice nurses who administered immunisations. The provider was unable to demonstrate that Patient Specific Directions (PSDs) were in place for health care support workers who administered flu vaccinations. There was no oversight of the prescribing activity of a non-clinical prescriber. Dispensary standard

operating procedures were not always adhered to. Blank prescriptions were not kept securely, and their use monitored in line with national guidance, at the branch practice.

- Systems for recording significant events did not always identify the learning, actions or trends. There were missed opportunities to raise and analyse significant events.
- The provider could not demonstrate that Medicines and Healthcare products Regulatory Agency (MHRA) alerts were incorporated into clinical practice.

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
There was a lead member of staff for safeguarding processes and procedures.	Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	No
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	No
Staff who acted as chaperones were trained for their role.	Yes
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.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff we spoke with told us they had not been informed who the current safeguarding lead was. • Safeguarding policies for vulnerable adults and children were in place and had a review date of February 2021. However, there was no evidence that the review of the policies had been completed within the specified timescale. • We reviewed the safeguarding training list provided by the practice. We found that some staff had completed children's safeguarding training at a level appropriate to their role. However, a clinical member of staff had not updated their training since 2015 or within the required timescale identified by the practice. The training list did not evidence that temporary staff had completed children's safeguarding training at a level appropriate to their role. We reviewed the training list for staff that had completed safeguarding training for vulnerable adults. We found that not all staff had completed training at a level appropriate to their role, and that not all staff had completed an update within the practice's required timeframe. There was no evidence that the salaried GP or temporary staff had completed the training at a level appropriate to their role. • We reviewed the staff records of seven members of staff of which two were temporary and five were permanent members of staff. We found that DBS checks had been completed for the temporary members of staff by the agencies that employed them. However, DBS checks had not 	

Safeguarding	Y/N/Partial
<p>been completed for three permanent members of staff. Two members of permanent staff had a DBS check in place however, the DBS checks had been completed by a previous employer and were not transferrable. Risk assessments were not in place to mitigate potential risks.</p> <ul style="list-style-type: none"> We reviewed the minutes from multidisciplinary team meetings and found that there were systems in place to review children at risk and vulnerable adults. However, there was no system in place to follow up frequent attenders to A&E or children who did not attend appointments in secondary care. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	No
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the staff records of seven members of staff and found that DBS checks had been completed for the temporary, clinical members of staff by the agencies that employed them. However, appropriate DBS checks had not been completed for the permanent members of staff. There was no evidence in staff files that the professional registration was in date for a locum GP or a salaried GP working at the practice. There was no evidence that additional indemnity cover was in place for the clinical staff whose records we reviewed. Satisfactory evidence of conduct in previous employment was not available in three of the seven staff records we reviewed. Assessments to determine if staff had any physical or mental health conditions which were relevant to a person's ability to carry out their role had not been completed in three of the seven records we reviewed. Evidence that staff vaccination and immunity for potential health care acquired infections was not recorded in five of the records we reviewed. 	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection at both practices by a competent person.</p> <p>Date of last inspection/test: 9 November 2020</p>	Yes
<p>There was a record of equipment calibration at both practices.</p> <p>Date of last calibration: 9 November 2020</p>	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed.	Partial

Date of completion: 8 November 2017 at the branch practice.	
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Control of Substances Hazardous to Health (COSHH) risk assessments were in place for cleaning products used in the practice. We found that an in-house fire risk assessment had been completed at the branch practice and where concerns had been identified they had been addressed. However, the provider was unable to demonstrate that a fire risk assessment had been completed at the main practice. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 5 October 2015 Asbestos management certificate 1 December 2017 Legionella risk assessment for the main practice. 20 August 2019 Legionella risk assessment for the branch practice. 30 January 2021 Gas safety certificate for both practices. 27 January 2020 Five-year electrical certificate for the branch practice 4 July 2020 Five-year electrical certificate for the main practice	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10 November 2015 Lone working risk assessment June 2015 Overarching risk assessment for example, slips, trips and falls.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Legionella risk assessments had been completed at both practices however, the provider could not evidence if the issues identified in the assessments had been addressed. They told us that recent risks assessments for legionella had been completed and they were awaiting the final reports. Health and safety risk assessments shown to us on the day of inspection were six years old. There was no evidence of a recent review. The practice subcontracted the cleaning of the practices to an external cleaning company. Cleaners had unsupervised access to the dispensaries and prescription stationery. They had not been subject to DBS checks by either the cleaning company or the practice. Risk assessments had not been completed to mitigate potential risks. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
There was an infection risk assessment and policy.	No
Staff had received effective training on infection prevention and control.	No
Infection prevention and control audits were carried out.	No
The practice had acted on any issues identified in infection prevention and control audits.	No
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	No
Explanation of any answers and additional evidence:	
<p>There were cleaning schedules in place and the cleaning company employed by the provider carried out quality checks.</p> <p>However,</p> <ul style="list-style-type: none"> The management team and staff were unable to demonstrate that there was an infection prevention and control (IPC) risk assessment, audit or policy in place at the practice. There was no overarching system in place to monitor staff compliance with training. The provider was unable to demonstrate if staff had completed IPC training. Staff we interviewed told us they had received training in donning and doffing personal protective equipment. However, on the day of the inspection we observed several members of staff walking around the practice not wearing a face mask. Staff we spoke with told us they had not been informed who the lead for IPC was. We found that clinical waste was not stored securely. Clinical waste bins were not fitted with lids to minimize the spread of infection. Sharps containers had not been removed after three months of use. We found sharps containers in use dating back to 2015. There was no system in place to ensure the cleanliness of privacy curtains within the practice. We found one privacy curtain had not been changed since April 2019. 	

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.	Partial
There was an effective induction system for temporary staff tailored to their role.	No
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Several key members of staff had left the practice and several staff were, or had been, absent due to ill health. With the support from NHS Derby and Derbyshire Clinical Commissioning Group 	

(CCG), Derbyshire Dales Primary Care Network and Derbyshire Health United an action plan had been put in place to provide immediate and necessary support to patients. This included a temporary practice manager, temporary practice nurses and locum GPs. There was a requirement by the practice to inform the CCG daily of their staffing levels.

- Temporary staff we spoke with told us that they had not received a formal, structured induction when they started to work at the practice.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There were systems in place to share information with the out of hours service for patients who received palliative care or had a do not attempt cardiopulmonary resuscitation plan in place. However, systems were not in place to share this information with the ambulance service.• There was a system to review the management of test results. However, when the GP partners had been off, concerns had been raised with the CQC that test results had not been followed up in a timely manner.	

Appropriate and safe use of medicines

The practice did not fully have 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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.64	0.68	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	10.6%	9.3%	10.2%	No statistical variation
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 (01/10/2020 to 31/03/2021) (NHSBSA)	5.74	5.09	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	72.0‰	147.1‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.68	0.57	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	2.3‰	7.2‰	6.7‰	Variation (positive)

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	No

Medicines management	Y/N/Partial
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.	No
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	No
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
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Not applicable
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
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"> • Prescribing indicators demonstrated that the prescribing of medicines prone to abuse were in line with, or better, than local and national averages. • Prescribing indicators demonstrated that the prescribing of antibiotics was in line with local and national averages. <p>However, we found that:</p> <ul style="list-style-type: none"> • Cleaners had unsupervised access to the dispensaries at both practices and prescription stationery at the branch practice. Risk assessments to mitigate potential risks had not been completed. • Some of the Patient Group Directions (PGDs) were out of date. The provider was aware of this however, risk assessments to mitigate potential risks had not been completed. We found that 	

PGDs had been signed and authorised by a clinical prescriber for one of the temporary practice nurses. However, they had not been authorised for the permanent practice nurse.

- Health Care Assistants administered injections under Patient Specific Directions (PSDs). The appropriate authorisations were in place for some treatments, for example vitamin B12. However, the provider was unable to assure us these were in place for all treatments, such as the administration of flu vaccinations.
- A temporary member of staff, who was also a non-clinical prescriber, told us that reviews of their prescribing activity had not been completed whilst they worked at the practice.
- Processes for the safe handling of requests for repeat medicines were not effective. For example, we found that 40 patients had been prescribed more than 12 short-acting asthma inhalers over the last 12 months. Five of the 40 patients had been prescribed 26 or more inhalers within a 12-month period. There were no issue limits in place to trigger a medicine review to prevent over prescribing of these medicines. We found there not all patients had prescription issue limits in place for patients prescribed medicines to manage high blood pressure or diabetes. For example, one patient had not received a medication review since 2019 or appropriate blood test monitoring for their diabetes since 2017. Despite this, they had been issued repeat prescriptions 57 times. We found that another patient had not received the required blood test monitoring for a medicine used to control their blood pressure for nearly seven years.
- There were systems in place to monitor the health of patients prescribed some high-risk medicines. For example, medicines used in the treatment of rheumatoid arthritis. However, we found that 66 out of 813 patients had not received the required monitoring when prescribed medicines used for the treatment of high blood pressure. Nine out of 36 patients had not received the required monitoring when prescribed a combination of medicines issued for the treatment of high blood pressure. Sixty-seven out of 267 patients had not received the required monitoring when prescribed anticoagulants used in the prevention of stroke for people with atrial fibrillation.
- Vaccines were stored appropriately. However, the provider was unable to demonstrate that there was a cold chain policy in place. Systems for monitoring the fridge temperature had not always been followed. For example, the practice had identified that the information gathered from the data logger in one of the vaccine fridges, had not always been reviewed in a timely manner.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Partial
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Partial
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Not applicable
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Partial
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Partial
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <ul style="list-style-type: none"> Standard operating procedures (SOPs) were in place to mitigate risks for when medicines were collected by a patient representative or the local voluntary service. The practice participated in the dispensing services quality scheme (DSQS). The DSQS scheme is voluntary and rewards organisations for providing high-quality services to dispensing patients. The practice had completed a recent audit within the dispensary to explore how to effectively convert appropriate prescription requests from acute to repeat. Dispensary staff described GPs as accessible and supportive. However, two members of staff had recently left the dispensary and staff told us they felt unable to meet patient demand. SOPs were in place for the management of medicines within the dispensary however, they were not always adhered to. For example, the SOP for the management of controlled drugs (CDs) stated weekly balance checks of CDs should be completed. However, we observed this was not always done. The practice had audited the number of dispensing errors made within the dispensary. It identified that out of 115,116 items dispensed, 10 errors had occurred over a 12 month period. We found that actions had been taken to mitigate the risks identified. However, we found that opportunities to record dispensing errors had been missed. A dispensing error that had been brought to the attention of the CQC was not included in the practice's log of errors. 	

Track record on safety and lessons learned and improvements made

The practice did not have a clear 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.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	No
Number of events recorded in last 12 months:	19
Number of events that required action:	19
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a system in place for reporting and documenting significant events. However, where learning had been identified it was not always clear from the significant event analysis, how and if any changes had been made in response to the learning. • It was not clear how learning from significant events was shared with staff. For example, significant events were not a standard agenda item on the minutes of staff meetings that we reviewed and staff we spoke with were unable to describe the learning from any recent significant events. • There was no overarching system in place to identify trends in significant events or review the effectiveness of any possible changes made within the practice. • We found opportunities to raise significant events and learn from them had been missed. For example, learning from a significant event regarding the safeguarding of a child. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A patient online request for a consultation was not acted upon.	When the omission was identified an appointment was made for the patient. It was identified that there was no system in place for receiving and acting on online requests for appointments. From the records we reviewed, there were no action points to demonstrate how this risk would be mitigated.
A patient was administered a vaccine that was contraindicated with one of the medicines they were prescribed. This medicine was not identified as a contraindication on the national patient group direction (PGD).	Appropriate follow up and alerts were raised to monitor the safety of the patient. It was identified that all patients were to be called prior to the administration of the vaccine to inform them that the vaccine was a live vaccine. The national PGD was updated.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial

Staff understood how to deal with alerts.	Partial
<p data-bbox="51 226 1532 286">Explanation of any answers and additional evidence:</p> <p data-bbox="51 286 1532 365">We found that there was a system within the dispensary for staff to manage and act on medicine recalls. There was a log of alerts to ensure tracking of recalls if necessary.</p> <p data-bbox="51 365 1532 425">However:</p> <ul data-bbox="95 425 1532 775" style="list-style-type: none"><li data-bbox="95 425 1532 656">• We found that other Medicines and Healthcare products Regulatory Agency (MHRA) alerts were not always acted upon. For example, 10 patients had been co-prescribed a medicine used for the treatment for indigestion and heartburn and a medicine used for the prevention of blood clots. Seventeen patients had been co-prescribed a medicine used for the treatment of high blood pressure and a medicine used to lower cholesterol. MHRA alerts had been published in 2014 highlighting the risks associated with these two medicine combinations.<li data-bbox="95 656 1532 775">• There was no system in place to ensure medicine safety information was incorporated into clinical practice.	

Effective

Rating: Requires improvement

We rated the practice as requires improvement for providing an effective service. This is because:

- Health and medicine reviews for patients with long-term conditions had not always been completed in line with National Institute for Health and Care Excellence (NICE) guidance.
- The provider was not aware that the personal care adjustment rates were high for two of the diabetic indicators and an indicator for patients experiencing poor mental health. No action had been taken to review them.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles. There was no overarching system in place to monitor compliance with staff training.

These areas affected all population groups so we rated all population groups as requires improvement.

Effective needs assessment, care and treatment

Patients' needs were not always assessed, and care and treatment was not always 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.	Partial
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There was evidence of review of current evidence-based practice in clinical meeting minutes and audits based on National Institute for Health and Care Excellence (NICE) guidance. However, we found that 67 out of 267 patients prescribed a medicine for the prevention of stroke had not received the required blood test monitoring in line with NICE guidance.• Patients' immediate needs were fully assessed. However, health and medicine reviews for patients with long-term conditions had not always been completed in line with NICE guidance or Medicines and Healthcare products Regulatory Agency (MHRA) alerts.	

Population group rating: Requires improvement

Older people

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received an assessment of their physical, mental and social needs.
- The practice followed up older patients discharged from hospital.
- The practice carried out structured annual medicine reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice provided care and treatment to residents living in two care homes. To support the health and wellbeing of these patients, a GP from the practice provided weekly ward rounds.
- The practice participated in monthly meetings with the Community Support Team to monitor and support this group of patients. The aim of the meetings was to maintain a list of patients at a high risk of hospital admission and to facilitate the discharge of frail, elderly patients by providing care closer to or at home.

People with long-term conditions

Population group rating: Requires improvement

Findings

- 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.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs when appropriate to do so.

However:

- Systems to ensure that patients with long-term conditions were offered a structured annual review to check their health and medicine needs were being met, were not effective. We found several patients with hypertension or diabetes that had not received the required monitoring or review. For example, one patient with high blood pressure had not received a review since 2014. A patient with diabetes had not received the required blood test monitoring since 2017.
- Systems to monitor the prescribing of medicines for the treatment for asthma were not effective. For example, we found that 40 patients had been prescribed more than 12 short-acting inhaled beta-agonists (SABA) inhalers over the last 12 months. The high use of SABAs is associated with poorer health outcomes for patients.
- There were systems in place to offer adults with newly diagnosed cardio-vascular disease statins, however they were not always effective. We found that 39 patients had received a diagnosis of high blood pressure in the previous 12 months. Sixteen of these patients were prescribed statins. We reviewed the records of four of the 23 patients not prescribed statins. Two of these patients had been offered statins but refused the treatment however, two patients had not been offered statins.

- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately. However, we found that 67 out of 267 prescribed a medicine for the prevention of stroke had not received the required blood test monitoring in line with NICE guidance.

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. (01/04/2019 to 31/03/2020) (QOF)	82.2%	78.6%	76.6%	No statistical variation
PCA* rate (number of PCAs).	13.9% (66)	12.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	81.5%	89.6%	89.4%	No statistical variation
PCA rate (number of PCAs).	15.6% (12)	14.4%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	93.4%	82.2%	82.0%	Variation (positive)
PCA rate (number of PCAs).	7.3% (12)	5.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	91.8%	68.5%	66.9%	Significant Variation (positive)
PCA rate (number of PCAs).	35.4% (93)	19.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	79.4%	73.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	9.6% (75)	7.0%	7.1%	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 (01/04/2019 to 31/03/2020) (QOF)	92.6%	93.2%	91.8%	No statistical variation

PCA rate (number of PCAs).	9.8% (19)	4.8%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	79.5%	76.2%	75.9%	No statistical variation
PCA rate (number of PCAs).	16.7% (44)	11.6%	10.4%	N/A

Any additional evidence or comments

- The personal care adjustment (PCA) rates replaced exception reporting in 2019 to allow practices to differentiate between the reasons for adjusting care and removing a patient from an indicator. The provider was not aware that the PCA rates were above local and national averages for two of the diabetic indicators. They had not taken action to review them.

Families, children and young people

Population group rating: requires improvement

Findings

- The practice had met the minimum 90% target for four of the five childhood immunisation uptake indicators. The provider told us the uptake rate for five year olds who had received the MMR vaccine was probably below the 90% target due to nursing staff absences.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- Young people could access services for sexual health and contraception.

However:

- Systems were not in place to follow up children who failed to attend appointments in secondary care.
- Systems were not in place to follow up on children who frequently attended A&E.

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) (01/04/2019 to 31/03/2020) <small>(NHS England)</small>	40	43	93.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	36	37	97.3%	Met 95% WHO based target

Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	35	37	94.6%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	35	37	94.6%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	42	53	79.2%	Below 80% uptake

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: Requires improvement

Findings

- Remote consultations were available for all patients which improved access to appointments for working age people.
- The practice had exceeded the national 80% target for cervical screening.
- Screening uptake for breast cancer or bowel cancer was above local and national averages.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	81.9%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	78.9%	72.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	73.3%	66.1%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	70.6%	93.0%	92.7%	N/A

occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	64.4%	51.2%	54.2%	No statistical variation

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- Same day appointments and longer appointments were offered when required.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held monthly multidisciplinary meetings with other health and social care professionals to meet the needs of this group of patients.
- 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: Requires improvement

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- 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. The provider demonstrated a good knowledge of local support services and resources.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	83.3%	87.2%	85.4%	No statistical variation
PCA rate (number of PCAs).	36.8% (7)	19.5%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.2%	82.9%	81.4%	No statistical variation
PCA rate (number of PCAs).	2.9% (1)	9.3%	8.0%	N/A

Any additional evidence or comments

- We found that the PCA rate for patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in their record, in the

preceding 12 months was above local and national averages. The provider was not aware that the PCA rate was high and had taken no action to review them.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	545.3	533.9
Overall QOF score (as a percentage of maximum)	97.5%	95.5%
Overall QOF PCA reporting (all domains)	6.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

- The practice had carried out an audit to review all women using oestrogen only hormone replacement therapy (HRT) products over a 12 month period to ensure it was correct for their needs. An electronic patient search was completed which identified 37 patients prescribed HRT. Their records were reviewed and it was found that there was variability amongst clinicians regarding a review of treatment. The search also identified that 78% of patients in this group had received a face to face review, 58% had an indication document in their HRT review and 100% had a clear rationale recorded in their records why they were prescribed HRT. The learning identified was that an in-house HRT review template was to be developed to promote a standard approach to review and that reviews were to be completed annually with clearly documented reasons why a patient was on HRT therapy. However, it was not clear from the audit if these actions had been implemented and if so, what the impact had been.
- An audit was completed in response to a Medicines and Healthcare products Regulatory Agency (MHRA) alert which highlighted that the use of a medicine used to treat overactive bladders was contraindicated in patients with severely high blood pressure. The alert identified the need to measure a patient's blood pressure prior to commencement of the medicine with regular monitoring thereafter. An electronic patient search identified 10 patients where prescribed this medicine of which seven had received appropriate blood pressure monitoring and three had not. However, it was not clear from the audit what action was taken to address this finding.

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.	Partial
The practice had a programme of learning and development.	No
Staff had protected time for learning and development.	No
There was an induction programme for new staff.	No
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	No
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • An overarching system to monitor staff compliance with training required by the provider was not in place. No one in the practice was able to demonstrate what training each staff member had completed or what training was due. • One member of staff told us that they had been well supported when training to carry out a new role. They told us that they had set competencies which were signed off by a practice nurse when they were considered competent. However, another member of staff told us that they felt unsupported working in the practice and that their learning needs had not been assessed. • Most staff we spoke with told us that there was no protected time to complete training. Some staff told us they had completed training in their own time. • A formal induction programme for the temporary staff employed by the practice was not in place. • There was no oversight or review of the prescribing activity of a temporary non-clinical prescriber working within the practice. • We saw that appropriate action had been taken to manage a member of staff when their performance was poor. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes

Patients received consistent, coordinated, person-centered care when they moved between services.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We reviewed the minutes from multidisciplinary team meetings and found that there were systems in place to review children at risk and vulnerable adults. 	

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	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

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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The GPs described their system of managing DNACPR decisions. They described the migration from these decisions to Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) forms. This provided a summary of personalised recommendations for a patient's clinical care in a future emergency in which they may not have capacity to make or express choices. 	

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.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Source	Feedback
Patient compliments log	The practice maintained a log of compliments received. We found that they had received 17 compliments over the previous 12 months. The compliments covered areas such as positive patient care within each staff group and the support offered during end of life care.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	95.4%	89.7%	88.5%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	96.0%	88.9%	87.0%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	100.0%	95.9%	95.3%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	94.6%	83.7%	81.8%	Tending towards variation (positive)

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

Any additional evidence
<ul style="list-style-type: none"> A member of the patient participation group told us that they had worked with the practice to carry out patient surveys. Prior to the COVID-19 pandemic, changes had been made within the practice as a result of a patient survey. For example, the opening hours at the branch practice had been extended to meet patients' needs.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> To support the communication needs of patients, carers and with a disability, there was an accessibility link on the practice's website. It explained how text could be made larger and there was a link to additional support if needed for auditory, cognitive, neurological, physical, speech and visual needs. 	

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	99.4%	94.0%	93.0%	Variation (positive)

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

Carers	Narrative
Percentage and number of carers identified.	We saw that the practice had identified 210 patients as carers. This represented 3% of the practice population.
How the practice supported carers (including young carers).	The care co-ordinator provided additional support to carers. Carers were offered flu vaccines and alerts were added to their records to enable increased flexibility and access to appointments.
How the practice supported recently bereaved patients.	Not covered in the inspection.

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.	Partial
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
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Privacy curtains were not available in the two examination rooms at the branch practice. The provider told us that they would lock the door to ensure that no one accessed the rooms during an examination. 	

Responsive

Rating: Requires improvement

We rated the practice as requires improvement because:

- Information about how to complain was not readily available and staff did not have access to a complaint's policy to refer to. The practice could not always demonstrate learning from complaints and we found that opportunities to record complaints had been missed.

This area affected all population groups so we rated all population groups as requires improvement.

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> New housing estates were being developed in the surrounding practice areas. The provider told us that they had not developed plans to deal with the increased demand for the service. However, they had recognised that to support the additional demand they needed to review the way in which care was delivered. To support the communication needs of patients, carers and parents with a disability, impairment or sensory loss there was an accessibility link on the practice's website. It explained how text could be made larger and there was a link to additional support if needed for auditory, cognitive, neurological, physical and visual needs. 	

Practice Opening Times

Day	Time
Opening times: Brailsford and Hulland Medical Practice	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
	8am – 6.30pm
Opening times:	

Hulland Ward Medical Practice	
Monday	8.30am – 12pm
Tuesday	8.30am – 12pm
Wednesday	8.30am – 12pm
Thursday	8.30am – 12pm
Friday	8.30am – 12pm

Older people

Population group rating: Requires improvement

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. Urgent appointments for those with enhanced needs and complex medical issues were offered. Home visits were provided by Derbyshire Health United (DHU).
- The practice provided effective care coordination to enable older patients to access appropriate services. This was supported by the care co-ordinator.
- There was a medicines delivery service for housebound patients.
- The practice offered a phlebotomy service so that older people did not need to travel far for blood tests.
- We spoke with representatives of two care homes where the practice provided care and treatment. We received mixed feedback. One home told us that the practice was always responsive to requests for home visits and prescriptions. However, a representative from the other care home told us that until recently the practice was responsive to requests to home visits. However, there had been a recent decline in the service provided. They told us they had problems getting the GPs from the practice to provide face to face consultations within the home.

People with long-term conditions

Population group rating: Requires improvement

Findings

- 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 and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. We saw minutes from meetings that demonstrated this.

Families, children and young people

Population group rating: Requires improvement

Findings

- Practice nurse appointments were available between 8.30am until 6.30pm for school age children so that they did not need to take time out of school.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

However:

- 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, were not in place.

Working age people (including those recently retired and students)

Population group rating: requires improvement

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible and flexible, for example, telephone consultations. However extended access to evening and weekend appointments was not available.

People whose circumstances make them vulnerable

Population group rating: Requires improvement

Findings

- The practice held a register of patients living in vulnerable circumstances, patients nearing the end of their life and those with a learning disability.
- 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: Requires improvement

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.
- The GP partners described how they referred patients to local mental health services and were knowledgeable about local resources and crisis intervention services.

Access to the service

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

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes
Patients were able to make appointments in a way which met their needs.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Yes
Patients with urgent needs had their care prioritised.	Yes
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> In line with national pandemic guidance, patients could access appointments by phoning the practice, booking in person and through Consultant Connect. To support patients to understand how to access appointments, information was available on the practice's website and answerphone message. This information was also available in accessible form on the practice's website. For example, for people with a visual, hearing or cognitive impairment. Patients were informed that appointments were initially through telephone consultations and a GP assessed if a face to face consultation was required. Patient satisfaction with telephone access to appointments had declined since the latest national patient survey results were published. In response to this, the practice had increased the number of receptionists handling calls into the practice from one to two. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)	82.2%	N/A	65.2%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	86.8%	65.9%	65.5%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice	75.5%	64.2%	63.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
appointment times (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	85.4%	74.7%	72.7%	No statistical variation

Source	Feedback
NHS Website	There was one negative comment regarding poor access to appointments on the NHS website.
Complaints received by the Care Quality Commission (CQC)	The CQC had received five complaints from patients regarding poor access to appointments, telephone access or access to appropriate treatment or investigations.
Patient Participation Group	The Patient Participation Group (PPG) had received several complaints from patients regarding a decline in patient satisfaction with access to appointments and telephone access.
Care home representative	A representative from a care home told us that telephone access to the practice had deteriorated recently and that they had waited a very long time for their calls to be answered.
Staff interviews	Staff told us that patients had raised concerns regarding telephone access to the practice. To address this issue, the number of receptionists taking calls had been increased from one to two.

Listening and learning from concerns and complaints

Complaints were not always used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	nine
Number of complaints we examined.	nine
Number of complaints we examined that were satisfactorily handled in a timely way.	three
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	none

	Y/N/Partial
Information about how to complain was readily available.	No
There was evidence that complaints were used to drive continuous improvement.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was no information on the practice website informing patients how to complain. The practice was not able to demonstrate that there was a complaints policy in place. 	

- In six out of nine complaints received by the practice, there was no evidence of what action had been taken. In all nine complaints, there was no evidence of learning from the complaints to drive improvements within the practice.
- The CQC had received 11 complaints from patients regarding the quality of the service provided by the practice. Several patients told us that they had raised their concerns either formally or verbally with the practice however, they were not included in the practice's complaint's log.

Well-led

Rating: Inadequate

We rated the practice as inadequate for providing a well-led service. This is because:

- Leaders could not demonstrate that they had the capacity and skills to address the challenges within the practice.
- A clear vision or credible strategy to provide high quality sustainable care was not in place.
- Not all staff felt able to raise concerns. Some staff told us that they felt undervalued, unsupported and unhappy at work. Staff well-being had been affected resulting in staff resignations and staff off on long-term sick leave. Following our inspection, the provider forwarded information to the CQC regarding an Employee Assistance Programme that staff had been signposted to for support. This offered free and confidential counselling.
- Policies to support the governance and safe running of the practice were not available. For example, maintenance of the cold chain for the storage of vaccines, infection prevention control, patient access to remote services and whistleblowing. Policies were not always reviewed in line with planned review dates.
- Effective governance structures and systems were not in place. This included policies or systems to manage the governance and oversight of remote services.
- Effective processes for managing risks were not always in place.
- Systems to share learning from significant events and complaints were not in place. Staff told us that communication sharing within the practice required improvement as they felt confused and uncertain about recent changes in the practice.

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.	Partial
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The leaders had acknowledged that they did not have the capacity to address the challenges within the practice. To improve the quality of care delivered to patients, a care taking arrangement had been agreed with another provider and plans were in place for a merger.• We received mixed feedback from staff regarding the visibility and approachability of leaders. Some staff told us that they were well supported by the leaders and they were approachable, accessible and supportive. However, other staff told us that they were afraid to approach the leaders as they were nervous of doing something wrong.	

Vision and strategy

The practice did not have a clear vision or 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.	No
There was a realistic strategy to achieve their priorities.	No
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	No
Staff knew and understood the vision, values and strategy and their role in achieving them.	No
Progress against delivery of the strategy was monitored.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Staff told us they were not aware of a practice vision. The provider showed us examples of where they had engaged with staff to inform them of changes within the practice. However, some staff told us that the provider was secretive and staff were not informed of changes within the practice. All staff told us that communication within the practice was ineffective and needed to improve.	

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.	Not applicable
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	No
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	No
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • A clear vision and practice values had not been established within the practice. • Staff we spoke with told us that there was very poor communication within the practice leading to a secretive and disorganised culture. Some staff were fearful of raising concerns or approaching the GP partners and nervous of doing something wrong. They told us there was low morale amongst most staff members. • Several key members of staff had left the practice and others were on long-term sick leave. On the day of our inspection we saw that there was a temporary practice manager, temporary practice nurses and locum GPs due to staff absence or resignation. • Some staff told us that they felt undervalued, unsupported and unhappy at work. They told us that no support was offered to staff to promote their wellbeing. Following our inspection, the provider forwarded information to the CQC regarding an Employee Assistance Programme that staff had been signposted to for support. This offered free and confidential counselling. • Staff were unable to access policies and were not aware if a whistleblowing policy was in place. The provider was unable show us a whistleblowing policy when requested. • There was no overarching system in place to demonstrate if all staff had completed equality and diversity training. Two members of staff told us they had completed this training however, no one in the practice had access to the online training package to confirm this. 	

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

Source	Feedback
Staff interviews	Several members of staff informed us that the culture within the practice left them feeling abandoned and unsupported in their role. They told us there was a lack of

	clear leadership within the practice, no interest in the wellbeing of their staff and a lack of communication. They told us that when both of the GP partners were unavailable the practice was left to operate under the direction of locum and salaried GPs.
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Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	No
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a list of policies available to staff on the practice's computer system. However, when we asked staff to access them, they were unable to do so. The temporary practice manager told us that there were only three policies accessible online and a paper copy of the safeguarding policy was available within the practice. • We asked staff who the lead roles within the practice were for safeguarding or infection control and prevention. Staff told us that they had not been informed. 	
Effective governance structures and systems were not in place:	
<ul style="list-style-type: none"> • To follow up frequent attenders to A&E or children who did not attend appointments in secondary care. • To ensure that staff received immunisations and immunity to potential health care acquired infections that were appropriate their role. • To review and update policies, for example the vulnerable adults safeguarding policy or the business continuity plan. • To ensure staff compliance with mandatory training. • To ensure that recruitment checks were carried out in accordance with regulations. • To monitor infection prevention and control processes were in place within the practice. • To ensure the effective management of waste and clinical specimens. • To manage the safe review of medicines prescribed for patients with long-term conditions such as asthma or high blood pressure. • To demonstrate the effectiveness of learning from significant events and complaints. • To embed an effective system that responds to MHRA alerts and supports safe and effective prescribing. For example, the co-prescribing of medicines. • To ensure that National Institute for Health and Care Excellence (NICE) guidelines were adhered to. For example, appropriate blood test monitoring for patients prescribed medicines for the prevention of stroke. 	

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.	No
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	No
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Due to a high staff turnover, leaders had not had the capacity to carry out assurance systems. For example, risk assessments for a cleaner with unsupervised access to the dispensaries or audits to monitor infection prevention and control. • A business continuity plan to manage major incidents within the practice was in place. Staff were aware of the business continuity plan to refer to in the event of an emergency. However, the provider was unable to demonstrate if staff had received training on managing major incidents such as loss of information technology. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> To meet the demands of the COVID-19 pandemic, a GP appointment triage system had been introduced. Consultations were carried out remotely. At a GP's discretion, face to face appointments were offered. Patients could access appointments by visiting or telephoning the practice. Information to inform patients of the change in accessing appointments was included on the practice's website and telephone answerphone system. To support the communication needs of patients, carers and parents with a disability, impairment or sensory loss, there was an accessibility link on the practice's website. Due to concerns raised with the practice regarding telephone access to appointments, the number of receptionists taking incoming calls had been increased at peak times of demand. The provider told us that there were no backlogs of activity and delays to treatment. We saw there were no outstanding referrals during our inspection. 	

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice used the Quality and Outcomes Framework (QOF) to improve performance. However, they were not fully aware of the data. For example, personal care adjustment rates. Staff received annual appraisals to monitor their performance. Systems for managing risks were not always effective. For example, it was not clear if issues identified in the legionella risk assessments had been addressed. 	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes

Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	No
The practice ensured patients were informed how their records were stored and managed.	No
Patients were made aware of the information sharing protocol before online services were delivered.	No
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	No
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	No
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> The practice was not able to demonstrate that policies or systems were in place to manage the governance of remote services. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> In response to a patient survey, opening times at the branch practice had been reviewed. In response to patient complaints regarding telephone access to appointments and staff concerns regarding an increase in workload, reception staff answering phone calls had been increased from one to two at peak times. However, the CQC had received complaints from patients informing us that their complaints to the practice had not been acted on. Staff meetings were in place for staff to share their views. However, some staff told us they did not feel able to voice their concerns or that they did not feel they would be listened to. The provider had worked with the Clinical Commissioning Group to identify the challenges within the practice. Other stakeholders for example, the Derbyshire Dales Primary Care Network, had supported the practice to meet the needs of the practice population. 	

Feedback from Patient Participation Group.

Feedback

We spoke with a member of the Patient Participation Group (PPG) prior to our inspection. They told us that during the COVID-19 pandemic PPG members, with internet facilities, had continued to meet virtually. However, the format of the meetings was mainly for information sharing.

They told us that the PPG did not feel valued by the practice and that they were unable to make the changes that patients told them were required. Issues identified included staffing levels, the dispensary and blood test or scan results, access to appointments and telephone access to the practice. They told us there was a lack of information sharing with the PPG particularly around complaints and a lack of openness and honesty when staff resigned from the practice. The PPG representative told us they had been contacted by two patients who had not received a response to a complaint made to the practice.

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.	Partial
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw examples of quality monitoring to improve care and treatment for patients. For example, the provision of a weekly, remote ward round at two care homes where the practice provided care and treatment. Systems in place to share learning from significant events and complaints were not in place. Staff told us that communication sharing within the practice required improvement as they felt confused and uncertain about recent changes in the practice. For example, who the lead roles within the practice were for safeguarding or infection prevention and control. 	

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 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.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- $\%$ = per thousand.