

## Inspection Evidence Table

Staffa Health

(1-564281746)

Inspection Date: 9, 11 and 12 January 2023

Date of data download: 22/12/2022

## Overall rating: Outstanding

At our previous inspection in September 2015 we rated the practice as outstanding overall. At this inspection we have continued to rate the practice as outstanding overall because the practice was providing an outstanding service in delivering effective and well-led services.

## Safe

Rating: Good

### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
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.	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
<ul style="list-style-type: none"> <li>• There were clear policies and guidance for staff to refer to and staff were aware of the safeguarding leads within the practice.</li> <li>• From records of meetings we reviewed we found that the practice met regularly with multidisciplinary teams to discuss the care of children with a safeguarding concern and vulnerable adults such as patients with a learning disability or patients near the end of their lives.</li> <li>• There were systems in place to follow up patients who frequently attended A&amp;E or children that failed to attend hospital or immunisation appointments.</li> <li>• Alerts were added to the records of vulnerable adults, children with a known safeguarding concern and people living in the same household as the child.</li> <li>• Clinical staff had completed the appropriate level of training to safeguard children and vulnerable adults. However, we found that non-clinical staff had not completed the appropriate level of training for safeguarding children. The provider updated their policy as soon as this was brought to their attention and emailed all affected staff requesting them to complete the higher level of training. Protected time was offered to support staff to complete the training quickly.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<ul style="list-style-type: none"> <li>• We reviewed the records of 5 permanent members of staff and a locum GP. We found that most of the required recruitment checks were in place for the 5 permanent members of staff. However, an explanation of gaps in employment history was not available for one member of staff. The provider was aware of the need to check for gaps in employment histories and showed us that this question had recently been added to the template used when interviewing staff. We reviewed the records of a newly recruited member of staff and found that this question had been embedded into practice.</li> <li>• We reviewed the records of a locum GP. We found that most of the required checks had been completed however, satisfactory evidence of conduct in previous employment was not available and the checks that their professional registration was in date were a month out of date. The provider contacted the locum agency immediately to request this information and advised the agency of the need to supply this information for future locum GPs working in the practice.</li> <li>• There were systems in place to ensure that staff employed by the Primary Care Network and working within the practice were recruited and supported appropriately to carry out their role.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Yes
Date of last assessment: 25 May 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 20 June 2022 for all 3 practices	Yes
Actions from fire risk assessment were identified and completed.	Yes

- The provider had completed a suite of risk assessments to mitigate identified safety risks for patients and staff.
- We found that systems for monitoring the safety of electrical equipment, gas and electrical checks were in place. Where issues had been identified we found that remedial work to address the concerns had been completed.
- Legionella risk assessments had been completed at all 3 practices on 19 October 2022. Several issues had been identified. We found that action plans were in place to address the concerns. These identified the person responsible for actioning the required changes and deadlines or completion dates.

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit: 15 September 2022 for all 3 practices.	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<ul style="list-style-type: none"> <li>• Following the infection prevention audit on 15 September 2022 an action plan was put in place to address the issues identified. For example, the hepatitis B immunisation status for all staff and the presence of carpets in several consultation rooms at the main practice. We found that there was a system in place for monitoring the progress of the actions required.</li> </ul>	

## Risks to patients

**There were adequate systems to assess, monitor and manage risks to patient safety.**

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
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
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<ul style="list-style-type: none"> <li>• To ensure that adequate staffing levels were maintained within the practice the staffing rotas were reviewed on a daily basis. Meetings were held to plan and monitor that staff annual leave requests were balanced alongside the demands of the service. This allowed flexibility within the service to cover any unplanned staff absences.</li> </ul>	

## 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.	Yes
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.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Our clinical searches identified that patients' care records were managed in line with current guidance. For example, past medical history, examination, management plans, safety netting and follow-up were all documented appropriately.	

## Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.90	0.78	0.82	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). (01/10/2021 to 30/09/2022) (NHSBSA)	6.8%	8.0%	8.5%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	4.44	5.11	5.28	Tending towards variation (positive)

Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	212.2‰	154.2‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) <small>(NHSBSA)</small>	0.53	0.50	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) <small>(NHSBSA)</small>	9.0‰	7.4‰	6.7‰	No statistical variation

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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
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.	Yes
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 and Improvement 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.	Not applicable
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.	Yes
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 UKHSA guidance to ensure they remained safe and effective.	Yes

- There was a policy in place for the monitoring of high-risk medicines which clearly detailed the required checks to be completed to keep patients safe. The enhanced clinical pharmacy team ran regular prescribing and medicine searches and used a risk stratification tool to monitor that their systems were effective and care complied with national alerts and guidance. Where patients had not attended for the required monitoring, there was a process in place to address this.
- From our remote clinical searches, we found that there were effective systems in place to monitor the prescribing of high-risk medicines and medicines used in the treatment of auto-immune conditions. For example, our remote clinical searches identified that 4 out of 92 patients prescribed a medicine used in the treatment of auto-immune conditions had not received the required blood test monitoring. We reviewed the records of these 4 patients and found that none of the 4 patients were issued this medicine by the practice, it was issued and monitored by the hospital. We found there was a system in place to record this on the patient's record to avoid any potential complications. We found that the practice followed up patients that had failed to attend for their follow up blood test monitoring and restricted their prescriptions when it was safe to do so. We found examples where risk assessments had been completed to mitigate any potential risks.
- From our remote clinical searches, we appraised medication reviews for 5 randomly selected patients. We found that all of the required safety monitoring was up to date when the review was carried out, that the reviews were detailed with evidence and good coding of the review.
- Due to the higher than average prescribing of Pregabalin or Gabapentin, we reviewed the prescribing of these medicines as part of our remote clinical searches. We reviewed the records of 5 patients that had not received the required review in the last 12 months. We found that 3 patients had been called for their review, another patient had been reviewed in hospital and another patient was only just due a review. Along with the Primary Care Network, the practice was in the process of establishing a multi-disciplinary team including pharmacists, GPs and physiotherapists to develop a strategy to decrease the prescribing of controlled drugs to patients.
- The practice had recently introduced a system of audit to monitor the prescribing competence of non-medical prescribers. A policy was in place to support this. Non-medical prescribers were provided with regular debriefs and informal clinical supervision however formal clinical supervision had not been fully embedded into practice at the time of our inspection.

## Track record on safety and lessons learned and improvements made

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
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.	Yes
Number of events recorded in last 12 months:	28
Number of events that required action:	28



- We reviewed the minutes from the significant events and found that the events were discussed, learning was clearly documented and staff members identified to carry out the actions required.
- To drive improvements throughout the practice, the provider had developed regular Lessons Learned Newsletters to share learning and best practice with all staff. This include complaints, significant events, audits, national alerts or events that had happened in other organisations. We reviewed one of the newsletters and found changes to processes had been shared with staff. For example, actions from discharge summaries, checking of expiry dates on medicines and timely completion of referrals to secondary care.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A hospital letter informing the practice to stop the prescribing of a high-risk medicine for a patient was filled instead of being sent to a GP to review. The patient had continued to receive repeat prescriptions for the medicine.	The high-risk medicine was removed from the patient's medicine order list and the scanning team were informed of the omission. Learning from the event was to ensure that any actions in letters from secondary care were forwarded to the relevant clinician.
Copies of medical records for patient A were sent to the Tibshelf Practice for patient A to collect them. A week later copies of medical records for patient B were sent to Tibshelf practice for patient B to collect them. A task was sent from reception to confirm that patient A had picked up their medical records but there was no form for them to sign. However, this task was added patient B's records. This was a near miss because although the medical records had been given to the correct patient there had been the potential they could have been given to the wrong patient if patient B had attended the practice first.	The task was deleted from the wrong patient's records and added to the correct patient's records. A significant event form was completed. In response to the analysis of the significant event, a template was developed which included a checklist for both administrative and reception staff to complete. This provided an audit trail to ensure that the same process was followed for each request.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<ul style="list-style-type: none"> <li>• Medicines and Healthcare products Regulatory Agency (MHRA) alerts were reviewed by the clinical pharmacy team and actions required discussed at clinical meetings. There was a designated GP who was responsible for summarising the MHRA alerts and sharing them with the clinical team.</li> <li>• From our remote clinical searches we found that appropriate actions had been taken in response to MHRA alerts and they were embedded into practice. For example, the maximum dosage of a medicine used in the treatment of low mood or panic attacks for patients over the age of 65.</li> <li>• A log was in place to record and review The Central Alerting System (CAS) alerts and patient alerts relating to patients with drug seeking behaviours.</li> </ul>	

## Effective

## Rating: Outstanding

At our previous inspection in September 2015 we rated the practice as good for providing an effective service. At this inspection we rated them as outstanding because there was a holistic approach to assessing, planning and delivering care and treatment to patients to improve health outcomes:

- The practice had extended their home visiting service and team to support housebound patients who were unable to attend the practice for a review of their long-term conditions. The provider had reviewed nationally published data which demonstrated the effectiveness of this service in reducing unplanned hospital admissions for vulnerable housebound patients. A representative from Derby and Derbyshire Integrated Care Board informed us that Staffa Health had been pioneers of this model of care which had influenced other service providers both locally and nationally.
- The practice had supported a GP to develop the role of a menopause champion to support staff and patients at the practice.
- The practice's cancer champion sent letters and information leaflets to newly diagnosed patients with cancer and offered a cancer care review with a GP. They also offered supportive telephone calls. The champion had established a cancer support network that met on a 2-monthly basis for patients to attend for support or to share their fears and experiences.
- The practice had gained accreditation from the Royal College of General Practitioners (RCGP) for being an active practice, an initiative to address sedentary lifestyles which have negative impacts on the health, social and economic outcomes for individuals and communities. The practice had partnered with Bolsover District Council Physical and Lifestyle services to establish a gymnasium within the Tibshelf Practice where patients prescribed exercise by their GP could attend for 12 supervised training sessions.

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
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.	Yes
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
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
The practice prioritised care for their most clinically vulnerable patients	Yes

## Effective care for the practice population

### Findings

- There was a holistic approach to assessing, planning and delivering care and treatment to patients to improve health outcomes. From 2017, the practice had developed a bespoke home visiting team for patients that were housebound. The team comprised of 4 advanced clinical practitioners, care co-ordinators and access to a health needs advisor. As part of a quality improvement project the practice had extended this service to support housebound patients who were unable to attend the practice for a review of their long-term conditions. In response to this the home visiting team had been expanded to include practice nurses and a health care assistant who had the required skills and knowledge. The practice had identified there was a large housebound population registered with the practice. We found that in December 2022 alone the service had provided a total of 186 home visits including 17 follow up visits. The provider had reviewed data from the Rapid Actionable Insight Driving Reform (RAIDR) database, a national health intelligence tool that analyses health data, to review the effectiveness of this service. The data demonstrated that they had been effective in reducing unplanned hospital admissions for housebound patients, patients with moderate or severe frailty and for patients over the age of 75 years old when compared with data from other practices within the same Primary Care Network (PCN) and Derby and Derbyshire Integrated Care Board (ICB). Unverified data from the PCN for April to November 2022 demonstrated that Staffa Health had the lowest A&E attendance for all populations and frequent A&E attenders within the local PCN and, below average non-elective care home admissions and care home frequent attenders to A&E. A statement from a representative for Derby and Derbyshire ICB confirmed that Staffa Health had been pioneers of this model of care which had influenced other service providers both locally and nationally. They told us the provider had proved the clinical and financial case for the service and helped the ICB to understand how to support other providers who planned to deliver this type of service. We found that there were systems in place for reviewing the ongoing effectiveness of this service for example, analysis through case reviews.
- 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.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients.
- 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.
- A GP within the practice had a special interest in the menopause. The practice had supported the GP to develop the role of a menopause champion to support staff and patients at the practice.
- The practice had supported a member of staff with training to become a cancer champion within the practice. The champion sent letters and information leaflets to newly diagnosed patients with cancer and offered a cancer care review with a GP. They also offered supportive telephone calls. Along with a patient, the champion had set up a cancer support network that met on a 2-monthly basis for patients to attend for support or to share their fears and experiences.
- The practice had gained accreditation from the Royal College of General Practitioners (RCGP) for being an active practice. The Active Practice Charter is an initiative to address sedentary lifestyles which have negative impacts on the health, social and economic outcomes for individuals and communities. To gain this accreditation the practice had to demonstrate that they had taken steps to increase activity and reduce sedentary behaviour for patients and staff and partnered with a local physical activity. The practice had partnered with Bolsover District Council Physical and Lifestyle services to establish a gymnasium within the Tibshelf Practice. Patients prescribed exercise by their GP could attend for 12 sessions. Supervised training sessions were provided on a Tuesday and Friday.
- The practice had established a jogging group for staff to improve their fitness and were working with the Patient Participation Group (PPG) to establish an exercise group for patients.
- 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 had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

# Management of people with long term conditions

## Findings

- As part of our inspection and with the provider’s consent, we used a suite of remote clinical searches and reviewed some patients’ records. We reviewed patients with long-term conditions and found patients were followed up in line with national guidance. For example, our clinical searches showed that out of 626 patients with a diagnosis of hypothyroidism 2 had not received the required blood test monitoring. We looked at the records for these 2 patients and found that there was an effective recall system in place and a process of medicine reduction to encourage patients that did not attend for their monitoring.
- We identified 95 out of 1,645 patients with asthma that had been prescribed 2 or more courses of rescue steroids for an exacerbation of their asthma. We found that there was a good assessment of their asthma at the time of the issuing of the steroids and appropriate safety netting and recalls were in place. The practice was proactive in following patients up for routine asthma reviews however, in line with National Institute for Health and Care Excellence (NICE) guidance, patients should have received a follow up appointment 48 hours after being issued the steroids. Whilst the provider had informed the patients of the need to book the appointment, the appointments had not been pre-booked for them. The provider told us that they would review the NICE guidance and develop a mechanism to embed this into practice.
- Patients with long-term conditions were offered an effective annual review in their month of birth 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.
- Clinical staff and the home visiting service followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

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) (01/04/2020 to 31/03/2021))(UKHSA COVER team)	167	174	96.0%	Met 95% WHO based target

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) <sub>(UKHSA COVER team)</sub>	176	182	96.7%	Met 95% WHO based target
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) (01/04/2020 to 31/03/2021) <sub>(UKHSA COVER team)</sub>	176	182	96.7%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) <sub>(UKHSA COVER team)</sub>	176	182	96.7%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) <sub>(UKHSA COVER team)</sub>	221	225	98.2%	Met 95% WHO based target

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
<ul style="list-style-type: none"> <li>The practice had achieved the 95% WHO based target for all 5 childhood immunisation targets.</li> </ul>

Cancer Indicators	Practice	SICBL average	England	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/06/2022 to 30/06/2022) <sub>(UKHSA)</sub>	75.6%	N/A	80.0%	Below 80% target
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) <sub>(UKHSA)</sub>	55.9%	53.0%	55.4%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) <sub>(UKHSA)</sub>	63.2%	62.3%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) <sub>(UKHSA)</sub>	68.6%	70.4%	66.8%	N/A

### Any additional evidence or comments

Cervical screening uptake rates were slightly below the national 80% target. The provider was aware of this and showed us a cervical screening questionnaire they had developed and sent out to patients that had failed to attend for their screening. The survey identified areas where changes could be made to improve the uptake. For example, patients could book appointments between 8am and 6pm instead of attending set screening clinics; facilitation of cervical screening through the extended access service; and to send text messages to patients who feared attending for their screening inviting them in for an informal consultation with a practice nurse to discuss their fears. The provider told us that they were in the process of updating their recall letters to offer patients an informal appointment with the practice nurse to discuss any fears.

### 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.**

	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.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes
<p>The practice maintained a log of audits to drive improvements in the quality of care provided. We found there were 10 quality audits identified on the log and timescales if it was identified they needed to be repeated. We reviewed two of these audits:</p> <ul style="list-style-type: none"><li>• An audit had been completed to review the treatment of patients with familial high cholesterol. The aim of the audit was to improve the identification of people with this condition, promote appropriate management and assess if patients receiving treatment were being managed appropriately. An action plan was put in place to address the findings of the audit.</li><li>• An audit had been completed to review the effectiveness of the prescribing of oral emergency contraception. The aim of the audit was to analyse and reflect on current practice of prescribing oral emergency contraception and additional responsibilities associated with emergency contraception against the guidelines set by the Derbyshire Joint Area prescribing committee. Following the audit recommendations were made. For example, to use the proforma for contraception and create an algorithm within the practice's IT system for patients with no previous contraception who had participated in unprotected sexual intercourse.</li></ul>	

### Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Yes
The practice had a programme of learning and development.	Yes

Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<ul style="list-style-type: none"> <li>Staff we spoke with were very positive about the support they received from managers in completing training and developing their roles. We found that where staff had particular interests in a health topic or had identified ways of improving the service for patients, they had been supported through appraisal, mentorship and training to develop new roles. For example, champions for staff well-being, cancer and the menopause.</li> </ul>	

### Coordinating care and treatment

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

	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-centred care when they moved between services.	Yes

### Helping patients to live healthier lives

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

	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 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
<ul style="list-style-type: none"><li>We reviewed the records of 3 patients where a DNACPR decision had been recorded. We found that where possible the patients' views had been sought and respected and that information had been shared with relevant agencies.</li><li>We spoke with representatives of 3 care homes where the practice provided care and treatment. They told us that where patients had a DNACPR plan in place that the plans were reviewed and updated in a timely manner. They told us that patients and family members were included in decisions where possible.</li></ul>	

## 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

Patient feedback	
Source	Feedback
We asked the practice to provide a link to their patients to share their experience of care and treatment with the CQC.	We received 29 positive comments from patients regarding the care provided by the practice. Patients told us the care provided was exceptional. That staff were kind, caring , professional, helpful, friendly and compassionate. Patients gave examples where the staff working in the practice had gone the extra mile. For example, providing bloods tests at home for a housebound patient, facilitating a swift referral to A&E and compassionate and effective end of life care.

A representative from a care home where the practice provided care and treatment.	The representative told us that the practice was caring and respectful and that they felt as though the practice really cared about the residents living in the care home.
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### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	89.9%	84.3%	84.7%	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 (01/01/2022 to 30/04/2022)	83.1%	83.8%	83.5%	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 (01/01/2022 to 30/04/2022)	91.8%	93.4%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	80.5%	72.5%	72.4%	No statistical variation

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

### Any additional evidence

- The practice had carried out a patient survey report for online access.
- The practice gathered patient feedback from the NHS Friends and Family Test. In December 2022 Staffa Health received 80 text messaging responses. Overall, the unverified data showed that 95% of respondents said that they had had a positive experience of the service. This was a higher percentage than the previous month and the joint highest percentage since the surveys started in June 2022.

## 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
<ul style="list-style-type: none"> <li>• Easy read and pictorial materials were available for patients with a learning disability.</li> <li>• To support patients with a hearing impairment who were unable to use the telephone, patients were provided with a text messaging service and where required, home visits were provided by the practice's home visiting team.</li> </ul>	

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	93.8%	90.2%	89.9%	No statistical variation

	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.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes
<ul style="list-style-type: none"> <li>• Information on notice boards in the practice's waiting rooms signposted patients to support. For example, health information on sepsis, lifestyle advice, cancer support and support for carers.</li> </ul>	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 235 patients who were carers. This was approximately 1.4% of the practice population.
How the practice supported carers (including young carers).	There was supportive information displayed on the practice website that signposted carers to advice and support. There was a carer's leaflet for carers to complete and an information pack was sent to carers. There was a carer's champion available within the practice to provide additional support.

How the practice supported recently bereaved patients.	Supportive information was displayed on the practice's website to support patients at times of bereavement. When the practice was aware that a patient had suffered a bereavement, they sent a condolence card to the bereaved. The CQC received a positive comment from a patient who described the care provided as exceptional at all levels within the practice. They told us that when their relative had died the practice had contacted them to offer support and sent a very kind condolence card too.
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## Privacy and dignity

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

	Y/N/Partial
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
<ul style="list-style-type: none"> <li>Patients were offered a trained chaperone when it was appropriate to do so. Nursing staff told us that during an intimate examination privacy curtains were drawn and, with the agreement of the patient, the consultation door was locked.</li> </ul>	

## Responsive

## Rating: Good

At our previous inspection in September 2015 we rated the practice as outstanding for providing a responsive service. At this inspection we rated the practice as good because:

- In response to carer's concerns, the practice had worked with a member of the Patient Participation Group (PPG) and their relative to develop a carer's support plan to provide care instructions and advice specific to the person being cared for in the event of the carer being unable to carry out their caring role. This plan was accessible for all carers within the practice.
- The provider had considered their demographics, the needs of their patient population and disease prevalence. Due to a higher than average older population, the practice had developed a bespoke home visiting team for house bound patients to provide improved continuity and quality of care. The 3 care home representatives we spoke with and feedback received by the CQC from patients living in their own homes was extremely positive about this service.
- There was a system in place to monitor and respond to peak times of demand for telephone access and demand for appointments and systems to monitor patient satisfaction with access to appointments and online facilities. Learning from these systems was implemented to improve the overall patient experience.
- The practice had worked with a member of the PPG to provide drop-in sessions to support patients to register on the NHS App to book appointments, order prescriptions and view their medical records on line.
- Following an analysis of trends in complaints over a 12-month period, the practice had developed systems to share the learning and the changes made with staff and patients such as newsletters and an analysis exercise with their PPG.

### 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
<ul style="list-style-type: none"> <li>• The practice had various ways of identifying the needs of patients. For example, patients' needs were identified through the new patient questionnaires. Alerts were added to patients' records to inform staff if a patient needed additional support for a hearing, visual, mobility, learning or hidden disability.</li> <li>• Leaflets had been developed to support carers to inform the practice if they were a carer and required additional support. The practice had hosted sessions provided by The Derbyshire Carer's Association to support this group of patients.</li> <li>• To meet the needs of the expanding practice population, there were plans in place to extend the main practice to provide additional consultation rooms and refurbishment improvements.</li> </ul>	

Practice Opening Times	
Day	Time
<b>Opening times: Tibshelf Surgery</b>	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	7am - 8pm
Friday	7am – 6.30pm
Saturday	7.30am – 10.30am
<b>Opening Times: Stonebroom Surgery</b>	
Monday	8am - 6pm
Tuesday	8am - 6pm
Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 1pm
<b>Opening Times: Holmewood Surgery</b>	
Monday	8.30am-6pm
Tuesday	8.30am-1pm
Wednesday	8.30am-6pm
Thursday	8.30am-6pm
Friday	8.30am-1pm

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>• Patients had a named GP who supported them in whatever setting they lived.</li> <li>• 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.</li> <li>• The provider had considered their demographics, the needs of their patient population and disease prevalence. Due to a higher than average older population, the practice had been expanding their multi-disciplinary home visiting team since 2017 for housebound patients to provide improved continuity and quality of care. The team comprised of 4 advanced clinical practitioners, care co-ordinators and access to a health needs advisor. The team provided proactive care and continuity of care to patients in their own homes or care home settings. We spoke with 3 care home representatives where this service was provided. All 3 representatives were very positive about the support they received from this service. Feedback received by the CQC from patients living in their own homes was also extremely positive. We</li> </ul>



found that in December 2022 the service had provided a total of 186 home visits. For example, patients with exacerbations of their health conditions, patients at risk of falls, patients with chronic pain or constipation.

- The practice had worked with a member of the Patient Participation Group and their relative to develop a carer's support plan. The aim of the plan was to provide care instructions and advice specific to the person being cared for in the event of the carer being unable to carry out their caring role. This plan was accessible for all carers within the practice.
- The practice worked collaboratively with Bolsover District Council Physical and Lifestyle services and provided exercise equipment at the Tibshelf Surgery where patients prescribed exercise by their GP could attend for 12 sessions. Supervised training sessions were provided on a Tuesday and Friday.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8pm on a Thursday where telephone consultations were available between 6.30-8pm. Pre-bookable telephone appointments were also available on a Saturday morning between 7.30-10.30am as part of the extended access service.
- 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, asylum seekers and refugees. Details of how to register with the practice were displayed on the practice's website.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
<ul style="list-style-type: none"> <li>• Patients' individual needs and preferences were central to the planning and delivery of access to appointments either at the practices or in the home environment by the home visiting team. The practice had systems in place to provide flexibility, choice and continuity of care. There was a system in place to monitor peak times of demand for telephone access and demand for appointments. The practice analysed this information on an ongoing basis and moved administrative and clinical capacity to address identified additional patient demand.</li> </ul>	

- The practice had worked with a member of the Patient Participation Group to provide drop-in sessions to support patients to register on the NHS App to book appointments, order prescriptions and view their medical records on line.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2022 to 30/04/2022)	46.0%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	62.5%	54.3%	56.2%	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 (01/01/2022 to 30/04/2022)	60.7%	52.8%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	75.6%	71.4%	71.9%	No statistical variation

### Any additional evidence

- The practice had carried out a patient survey to assess patient satisfaction with telephone consultations. A total of 116 patients responded to the survey. The unverified survey results were very positive. For example, 97% of respondents were satisfied with the waiting time, 97% were satisfied with the timing of the telephone consultation and 99% of respondents said that their experience was excellent or good.
- The practice had also carried out a survey of patient satisfaction with online appointment requests. A total of 150 patients had responded. Unverified feedback to the questionnaire was positive. For example, 76% of respondents were satisfied with the response time and 82% were satisfied with the outcome. The practice had reviewed any negative comments and made suggestions to improve them. For example, to provide greater clarity about when to complete the online request form or when to call the practice.

Source	Feedback
NHS Website	There were 3 negative comments on the NHS website relating to a mix up or cancellation of booked appointments at the practice.
Care home representatives.	We spoke with representatives of 3 care homes where the practice provided care and treatment. They told us that the practice was very responsive to the needs of their residents and provided a weekly ward round and home visits when required.
We asked the practice to provide a link to their patients to share their experience of care and treatment with the CQC.	As part of this inspection we received 20 positive comments about access to appointments. Patients told us telephone or face to face appointments were always on time and patients were never rushed during their consultations. Patients were very positive about the text messaging service and the online form they had completed when requesting an appointment. They told us that after completing the form their request was responded to very promptly and they were provided with an appointment at an appropriate time. We received 2 negative comments, one regarding dissatisfaction with the online system and another relating to telephone consultations. The provider was aware of these concerns and had previously carried out patient surveys to understand the issues and how they could address them.

### Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	62
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None
Any additional evidence	
<ul style="list-style-type: none"> <li>The practice recorded and investigated complaints received in writing, email, verbally or posted on social media sites and the NHS website. We found that the complaints we reviewed had been investigated fully and that patients were informed of the outcome of the investigation. If they were dissatisfied with the outcome of the investigation, patients were informed of their right to complain to the Parliamentary and Health Service Ombudsman.</li> <li>We found that the practice had reviewed themes and trends in complaints over the previous 12 months and taken action where required. The findings of the review had been shared with all staff through the practice's Lessons Learned Newsletter. Staff we spoke with were aware of the themes identified. Learning was shared with patients through the practice's We're Listening poster, which was displayed within the practices, on the television information screens and on the practice's website.</li> <li>We spoke with a representative from the PPG. They told us the practice was open and transparent and had recently completed an exercise with the PPG that looked at trends in complaints and what the practice had done to address them. The provider shared with us the complaints analysis document they had shared with the PPG.</li> </ul>	

Examples of learning from complaints.

Complaint	Specific action taken
A patient complained about a series of discussions and appointments at the practice regarding an ongoing health condition. They were concerned about a number of delays and an issue with a delayed prescription. They felt that their overall care had been below the standard expected.	The complaint was investigated and a letter of apology was sent to the patient with an explanation of all the delays. The practice acknowledged how frustrating the delays and errors were and through their investigation made appropriate staff aware of the correct procedures to follow.
A patient had been informed they would receive a telephone appointment at a specific time however, they did not receive the call. The patient had arranged time off from work to be available for the call.	The practice’s policy of informing patients that the time of their telephone consultation could not be guaranteed had not been followed. The practice’s policy was to offer a morning or afternoon appointment. Staff were reminded of this policy and an apology was offered to the patient. A face to face appointment was offered to the patient which they were happy to accept.

## Well-led

## Rating: Outstanding

At our previous inspection in September 2015, we rated the practice as outstanding for providing a well-led service. At this inspection we rated the practice as outstanding because:

- There was a very strong commitment to supporting staff well-being. For example, wellbeing champions, a menopause champion, yoga and aerobic sessions for staff, a free wellbeing raffle and an acknowledgement by the GP partners of the demands on on-call GPs and an offer to remove this stress for salaried GPs.
- Feedback from the Patient Participation Group (PPG) was extremely positive. There were many examples of where the practice had worked closely with the PPG to improve the service for patients. For example, a carer's plan, improving accessibility for patients with limited IT literacy and analysis of trends in complaints.
- Leaders drove continuous improvement for patients and staff. Staff innovation was encouraged, supported and celebrated by the leaders.
- There was clear evidence of continuous improvement and change. For example, the home visiting service, accreditation for being an active practice and influencing of local engagement processes in carrying out service wide consultations with patients.
- There was a culture of learning, evolving and sharing learning with others.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
<ul style="list-style-type: none"><li>• We found that a service improvement log had been developed to support leaders to address challenges to quality and sustainability. The key areas identified in the log were corporate, patient care and demand, information governance, patient and community engagement and training and development of staff. We found that the log was actively reviewed and updated regularly with timescales of completion recorded.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes

Progress against delivery of the strategy was monitored.	Yes
The practice's vision was: <ul style="list-style-type: none"> <li>To be a trusted general medical service offering innovative, flexible patient centred quality care to people to support their health and social care needs throughout life.</li> <li>To provide a rewarding place to work in a supportive multidisciplinary team with a healthy work / life balance for staff working in the organisation.</li> </ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
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.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
There was a very strong commitment to supporting staff well-being. <ul style="list-style-type: none"> <li>The practice had trained 2 wellbeing champions to support staff. Staff spoke very positively about the support they provided and told us that they received motivational emails from the champions especially at difficult times.</li> <li>The practice had provided yoga and aerobic sessions for staff to improve their wellbeing.</li> <li>The GP partners had provided a free wellbeing raffle for staff which included treats such as a spa day or afternoon tea.</li> <li>The GP partners acknowledged that the demands on the on-call GPs was very stressful and informed salaried GPs they could opt out of the on-call duty rota if they wished to.</li> <li>The practice had reviewed the demographics of the practice population and its staff and in response to their findings appointed a menopause clinical lead to raise awareness of the menopause within the workplace and to signpost staff to additional support.</li> <li>We found that there was a culture of learning, evolving and sharing learning with others.</li> </ul>	

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

Source	Feedback
Interviews with staff	There were high levels of staff satisfaction within the practice. Some staff told us the practice felt like a family. Staff we spoke with told us that there was an open,



	inclusive, transparent, supportive and non-hierarchical culture within the practice. They told us that the GP partners and managers were approachable and that staff were actively encouraged to raise any issues or concerns. They also reported high levels of constructive staff engagement.
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### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

### Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
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.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<ul style="list-style-type: none"> <li>The provider had developed a suite of risk assessments to mitigate and manage risks to patients and staff.</li> <li>The provider maintained a plan of risks which they reviewed twice a year or more frequently if required. For example, staff recruitment and retention, winter pressures, staff morale and financial risks.</li> </ul>	

**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.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

**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.	Yes
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.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

**Engagement with patients, the public, staff and external partners**

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes

- The practice had run surveys to understand and improve the patients' experience. For example, telephone consultations and online access to appointments.

Feedback from Patient Participation Group.

### Feedback

As part of our inspection we spoke with a representative of the PPG. They were extremely positive about how the practice worked with the PPG and how they had supported them to continue to meet remotely throughout the Covid-19 pandemic. They told us that the provider always listened to their views and concerns and acted upon them. For example, the closure of the third branch practice. They told us they had been consulted on the plans to extend the practice at Tibshelf and had made suggestions for improvement. For example, additional car parking and solar panels to reduce energy costs. The practice was working with the PPG to develop a group to engage patients in more physical activity.

### Any additional evidence

Another member of the PPG had shared their experience of working with the practice through the share their experience of care and treatment link with the CQC. They told us that the practice was open about the challenges they faced and where issues were identified the practice responded quickly to address them. For example, the PPG discussed with the provider concerns about the prescription order line and the issues were addressed promptly.

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<ul style="list-style-type: none"> <li>• The provider used complaints and significant events to drive improvements within the practice. We found that significant events and complaints were reviewed on a regular basis and learning was shared with staff. There was evidence that trends in complaints and significant events had been identified. For example, an increase in complaints regarding telephone access to appointments and the text messaging service. The practice had developed a Lessons Learned newsletter for staff and a We're Listening newsletter for patients to share learning and best practice from complaints, significant events, audits, national alerts or events that had occurred within the practice.</li> <li>• Where appropriate, detailed practice team debriefs had taken place. For example, improving the continuity of care for patients, opioid prescribing and colorectal cancer recognition and referral.</li> <li>• There was a culture of surveying patients to address areas where the provider had identified patient dissatisfaction or lack of engagement. For example, access to online appointments and attendance for cervical screening.</li> </ul>	

### Examples of continuous learning and improvement

There was clear evidence of continuous improvement and change.

- The practice had gained accreditation from the Royal College of General Practitioners (RCGP) for being an active practice. The Active Practice Charter is an initiative to address sedentary lifestyles which have

negative impacts on the health, social and economic outcomes for individuals and communities. The practice had partnered with Bolsover District Council and established a gymnasium within the Tibshelf Practice. The sessions involved personal supervised instruction on the exercise equipment for a 12-week period.

- Previously, the provider had 3 branch practices. In 2019, following a review of service provision and an extensive engagement and consultation process with patients and stakeholders, an application to close one of their branch practices was approved by the Clinical Commissioning Group (CCG). The CCG identified that the provider's approach had been an exemplar of an engagement process and told us they had adopted the process for other practices within the CCG to follow.

Staff innovation was encouraged, supported and celebrated.

- A member of staff at the practice had a cancer diagnosis. From their experiences they identified the need to provide additional support for patients with cancer registered with the practice. The champion sent letters and information leaflets to any newly diagnosed patients with cancer and offered a cancer care review with a GP, supportive telephone calls to patients and had established a cancer support network for patients to attend for support or share their fears and experiences.
- Two members of staff had an interest in staff wellbeing and were supported with training to become wellbeing champions within the practice.
- A GP within the practice had a special interest in the menopause. The practice had supported the GP to develop the role of a menopause champion to support staff and patients at the practice.

There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment.

- The provider had considered their demographics, the needs of their population and disease prevalence. They had analysed published data to inform the provision of their service. Due to a higher than average older population, the practice had expanded their multi-disciplinary home visiting team to housebound patients. The provider had reviewed data from the Rapid Actionable Insight Driving Reform (RAIDR) database, a national health intelligence tool that analyses health data, to review the effectiveness of this service. The data demonstrated that despite a large housebound population the service had been effective in reducing unplanned hospital admissions for housebound patients, patients with moderate or severe frailty and for patients over the age of 75 years old when compared with data from other practices within the same Primary Care Network and Derby and Derbyshire Integrated Care Board (ICB). A statement from a representative for Derby and Derbyshire ICB confirmed that Staffa Health had been pioneers of this model of care which had influenced other service providers both locally and nationally.
- There was a culture of carrying out quality improvement projects and analysis of learning. For example, improving the continuity of care of patients.
- The practice maintained a log of audits to drive improvements in the quality of care provided. It also contained suggestions for future audits to consider.

To continue to build on and develop existing or new initiatives there was a schedule of projects in place that the practice had identified for future action:

- Workforce capacity.
- The development of clinics involving clinical pharmacists and pharmacy technicians to improve high blood pressure targets and heart failure reviews.
- Enhanced methods for tackling abuse against staff.
- The development of a wellbeing strategy.
- The development of a multi-disciplinary team to review and decrease the prescribing of controlled drugs.

**Notes: CQC GP Insight**

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a “z-score” (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice’s data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice’s data looks similar across two indicators, but they are in different variation bands. The percentage of practices which show variation depends on the distribution of the data for each indicator but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren’t will not have a variation band.  
The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

**Glossary of terms used in the data.**

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.