

Care Quality Commission

Inspection Evidence Table

Baslow Health Centre (1-561931188)

Inspection date: 23 and 31 August 2022

Date of data download: 15 August 2022

Overall rating: Requires Improvement

We completed an unrated review of Baslow Health Centre in December 2021 in response to whistleblowing concerns we received around safety, for example infection prevention and control and the overarching governance at the practice. We identified two breaches in regulation and issued two regulation notices.

At the inspection on 23 and 31 August 2022, we found the practice had made improvements in areas. However, the practice was rated requires improvement overall because effective governance systems were not in place to ensure a safe and well-led service was provided.

Safe Rating: Requires Improvement

At our unrated review in December 2021 we found:

- The health and safety of patients and staff was not always maintained, or appropriate action taken to identify and mitigate any risks.
- Safe and effective prescribing was not always seen, for example for controlled medicines and co-prescribing of medicines in line with medicine safety alerts.

At the inspection on 23 and 31 August 2022 we saw that improvements had been made to the processes for safe handling for requests for repeat medicines, including appropriate monitoring for patients prescribed high risk medicines. However we also found:

- The practice did ensure that the recruitment checks as outlined in Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were obtained.
- The practice could not evidence that staff received Infection Prevention and Control training, either as part of their induction or through periodic refresher training.
- Not all staff were aware of the location of emergency equipment and medicines.
- Incomplete review and implementation of changes for significant events.

Therefore we have rated this practice as requires improvement for providing a safe service.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse, but these were not always effective.

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.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice had systems and processes in place to ensure that patients were protected from harm. Evidence of safeguarding alerts on adult and children's records were seen during the remote records review. • Weekly multidisciplinary meeting were in place to discuss any patients deemed to be at risk or of concern. This meeting was attended by a range of external health and social care professionals, including the district nurse and community matron. However, we saw that names were used to identify patients in the minutes. This potentially could lead to confusion if there was more than one patient with the same name. The practice also referred patients to the social prescriber for support and advice. • There were systems in place to monitor and follow up failed attendances following referrals to secondary care or children who frequently attended the emergency department. Any concerns were discussed at the monthly meetings between the children's safeguarding lead.GP and the health visitor. • We saw that Disclosure and Barring Service (DBS) checks had been completed for staff, although from the records was unclear whether the DBS check was an enhanced or standard check. The lead GP told us that all clinicians had enhanced DBS checks. 	

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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The written recruitment policy seen did not make reference to all of the required recruitment information as outlined in Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, or the guidance on immunisations as outlined in the 'Green Book' Immunisation Against Infectious Diseases. • We looked at the records of four staff members who had recently commenced employment at the practice. Not all of the required recruitment information was available in the files. For 	

example, full employment histories were not available in three files as an application form or curriculum vitae was not available; satisfactory evidence of conduct in previous employment was not seen in one file, and only one reference was seen in three files; and satisfactory information about any physical or mental health conditions had not been obtained.

- Prior to this inspection, the practice was unaware of the guidance around immunisation of staff. This was shared with the office manager prior to the site visit. Action had been taken and we saw that immunisation status was available in the staff files seen, albeit incomplete for two members of staff.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 12/2021	Partial
There was a fire procedure. Date of fire risk assessment: 11/2021	Yes
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: The completed risk assessments had identified a number of areas that required attention. The practice had taken appropriate action where possible, and there was an ongoing programme to address the remaining actions.	

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.	No
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 09/08/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The infection prevention and control (IPC) audits identified a number of issues that required attention. These included upgrading flooring in two clinical rooms, installing elbow taps in one clinical room and updated the staff induction to include training on IPC. We did not see any evidence to support that staff had received IPC training, either as part of their induction or through periodic refresher training. However, staff spoken with told us they had completed infection control training on the electronic learning system. • The lead GP partner continued to have overall responsibility for IPC within the practice. There were plans for a member of the nursing team to take on this role, although this was on hold until suitable IPC training could be sourced. The practice told us following the inspection that they had engaged the GP Quality Team to advise on the training and appointment of the IPC Lead from the nursing team. 	

- A legionella risk assessment had been completed in March 2020. A risk assessment highlighted a number of action points. We saw that the partners had signed a service level agreement with NHS Estates in December 2021 to undertake the required work and ongoing monitoring.
- The practice forwarded a report for legionella temperature monitoring for the period 01/05/2022 to 08/08/2022. This report highlighted that the temperature of the hot water was below the required temperature as certain outlets. It was not clear from the report if any remedial action had been taken.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • During the review in December 2021 we identified that staff turnover within the practice had impacted on staff availability. Since the previous review in December 2021, the practice had successfully recruited additional clinical and non clinical staff. GP availability had increased following the appointment of two salaried GPs who provided nine additional sessions a week. (A session covers a morning or afternoon). A new practice manager had also been appointed and a member of reception staff promoted to office manager to provide additional managerial support. 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had a process for managing two week wait, urgent and routine referrals to secondary care. Systems were in place to ensure that patients had received correspondence from the hospital, and if not, practice staff contacted the relevant department to follow up. Clinical searches the Care Quality Commission (CQC) conducted during the inspection indicated there were no active referrals in place.• There was a process for managing pathology results. Test results in the pathology inbox were reviewed and the oldest result was dated 3 days prior to the inspection.• Clinical searches the Care Quality Commission (CQC) conducted during the inspection indicated that systems were in place to review and act upon information received by the practice.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.88	0.76	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	7.2%	8.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	4.70	5.01	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	108.6‰	150.3‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.72	0.52	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.2‰	7.3‰	6.8‰	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

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.	NA
There was a process for the safe handling of requests for repeat medicines and evidence of structured 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.	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.	NA
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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Access to the dispensary was restricted to authorised staff and medicines within the nurse's room were locked away when the room was unoccupied. • Controlled Drugs were receipted, stored and recorded in line with legislation. Balance checks were not completed as frequently as advised in national guidance. Staff told us this would be addressed immediately. • The practice held suitable emergency medicines and had risk assessed the need to hold treatments for suspected sepsis. Staff in the dispensary were not all confident they knew where emergency medicines were held, acknowledging the risk that staff members who knew of their location may not always be in the building . We discussed ensuring emergency medicines were accessible in line with British Resuscitation Council's guidance as well as ensuring all staff were aware of their location. • We saw improvements had been made to the processes for the safe handling of requests for repeat medicines since the previous review in December 2021. 	

Medicines management**Y/N/Partial**

- The practice had completed a number of medicine audits linked to high risk medicines to identify any required actions. The practice used a mixture of scheduled tasks and recalls to record monitoring requirements and ensured that monitoring checks were done. Evidence of this was seen during the records review. The CQC searches performed for high risk drugs showed that patients were being monitored appropriately and followed up when they failed to attend for appointments.
- The records review showed that the practice had taken steps to reduce the prescribing of some hypnotic medicines to reduce the risk of addiction. Medicine reviews had been completed and there was evidence that the risks and addictive nature of these medicines had been discussed and efforts made to wean patients off these medicines. Control measures had been put in place to monitor prescription requests to prevent over ordering through ordering early.

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures (SOPs) which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
The Electronic Prescription Service was not used prescriptions were signed before medicines were dispensed and handed out to patients.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Partial
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.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
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"> • Dispensary processes were described well in SOPs. Staff felt supported in their roles and we saw evidence of effective competency checks to ensure safe care. • Some patients were supported to take their medicines with large print labels, administration prompt forms or Monitored Dosage Systems. Dispensary staff ensured patients and/or carers were comfortable and confident with these measures before implementation. • All dispensers had a suitable qualification and staffing levels were in excess of national guidance ensuring capacity within the team to manage fluctuating levels (for example, due to sickness or annual leave). • The dispensary did not have access to a purple lidded waste bin to dispose of cytotoxic and hormone based medicines. The dispensary lead manager advised she would speak with the waste services collection company to rectify this. Nursing staff did have access to purple lidded bins. • The liquid nitrogen vessel was in locked outside storage. Following the inspection, the practice told us they had removed all additional items from this storage area and were making arrangements to have the vessel removed. 	

Track record on safety and lessons learned and improvements made

The practice had a system to learn and make improvements when things went wrong, but this was not always used effectively.

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.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	30
Number of events that required action:	28
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a process for raising and investigating incidents/significant events. There was a Significant Event Policy and Process which was seen during the inspection. Staff understood the process and were encouraged to report incidents. The practice had a log to record significant events/incidents, which recorded action taken. However, we did not see reports that included information gathering, analyse of the significant event including what happened and why, what could be done differently, what could be learnt from the incident and any changes required, following by the implementation and monitoring any changes. We found that forms were not always fully completed, as often only the incident itself was recorded. We saw a number of examples where the same issue had arisen, for example: staff had saved information, made appointments or added tasks into the incorrect patient record. Although staff had been reminded to check patient identifiers, the learning had not become embedded into day to day practice. We saw that significant events were a standing agenda item and discussed at multidisciplinary team meetings and dispensary and reception staff meetings. 	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Monitored Dosage System (MDS) packaged incorrectly when alternate day dosing of a treatment had been prescribed.	Identified on second check prior to reaching the patient. Altered process for printing dosing grids for dispenser to follow when filling MDS. Highlighted this as an unusual and complex case.
Task created in the wrong patient's notes for a request for antibiotics for a potential urinary tract infection.	Dispensary staff contacted the patient to advise the prescription was ready for collection, and the patient was confused as they had not requested a prescription. The patient attended the surgery to provide a urine sample for testing. It was established that the task had been sent for the wrong patient. The correct patient was issued with a prescription. Both patients had the same first name. It was not clear if this incident had been fully investigated or any learning identified and disseminated.

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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Following the review in December 2021 the practice introduced a more structured system for managing safety alerts, and the lead GP acknowledged that the system was still being embedded. The practice maintained a safety alert log to record actions in response to alerts and a number of searches for historical safety alerts had been set up to run at three or six monthly intervals. We saw that safety alerts had been discussed at the multidisciplinary team meetings and followed up with summary emails to clinicians. • The records reviewed showed that appropriate action had been taken in response to safety alerts. For example: Women of child bearing age prescribed certain medicines that may cause congenital malformations in babies had been advised about the risk of pregnancy and the use of effective contraception and/or had a pregnancy prevention programme in place to make patients fully aware of the risks and the need to avoid becoming pregnant. • Dispensary staff managed medicine recalls and we saw evidence of a log detailing actions taken from recalls. 	

Effective

Rating: Good

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.

At the unrated review in December 2021 we found:

- Long term condition and medicine reviews lacked detail and minimal information was recorded in care plans.
- Patients prescribed rescue medicines did not always have a follow up review after the exacerbation of their asthma.

At the inspection on 23 and 31 August 2022, we found although some improvements had been noted, further improvements were still required. Therefore we have rated this practice as good for providing an effective service.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• The practice had strengthened the procedures in place around medicine reviews. The practice had medication review procedures in place which were becoming embedded into day to day practice. The practice had made improvements in the recording of medicine reviews. Reviews were coded although it was not always possible to see information that underpinned the review. In addition, professionals outside of the practice had used the code for a full medicine review code even though all of the prescribed medicines had not been reviewed.	

- The dispensary team were clear in their role of advising patients when reviews were due and demonstrated ensuring people were contacted to enable a review to be offered.
- The practice also completed care plans for long term conditions and dementia. The care plans seen showed that some reviews coded when only looking at an acute need and not referencing a full holistic review. We saw that not all staff made use of the Ardens templates when reviewing patients. On occasion it was documented that the patient had a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form in place, although the form was not available to view in the notes.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- A named GP provided weekly visits to a local care home, and the practice worked closely with the care home manager to provide continuity of care both in and out of hours.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had met the WHO based target for all five childhood immunisation uptake indicators.
- The practice's cervical cancer screening uptake was above the target of 80%. Uptake for breast and bowel cancer screening was above local and national averages.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who 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

From our remote clinical searches we found that there was a good mechanism in place for following up patients with:

- Chronic kidney disease level four and five.
- For patients with diabetic retinopathy however, a number of patients were coded as having a full medicines review when a full review had not occurred.

Our remote searches also identified:

- Clinicians were not consistently following up patients identified as having had two or more courses of oral steroids for asthma exacerbations in the last 12 months to check if they had improved. We also saw that care plans were being used intermittently, and when steroids were being issued inhaler usage was not being considered / discussed with the patient. It was not clear if steroid alert cards were being issued. Dispensary staff told us that they issued steroid cards in relation to alerts that automatically flagged on their IT system when a steroid was prescribed. It was unclear whether the alert was triggered when combinations of topical and inhaled steroids were prescribed so staff could not confirm that all eligible patients were receiving a card.
- There were 36 potential patients with a missed diagnoses of chronic kidney disease (CKD). We looked at the records for five of these patients. The records indicated that the current evidence based guidance was being applied inconsistently, as some patients had a diagnosis and did not meet the criteria and other patients had not been diagnosed and did meet the criteria. The practice had carried out audits of patients with a potential diagnosis of CKD in November 2021 and planned to repeat the audit in November 2022. In light of the finding the remote searches, the lead GP stated that they would repeat this audit as soon as possible and address any identified issues.

We also found that:

- The long-term condition searches indicated that the majority of patients were offered a review to check their health and medicines needs were being met in line with current guidelines.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. The practice acknowledged that challenges within the nursing team had impacted on the number of long-term conditions that had been completed.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory and home 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) (NHS England and Improvement)	26	27	96.3%	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) (NHS England and Improvement)	31	31	100.0%	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) (NHS England and Improvement)	31	31	100.0%	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) (NHS England and Improvement)	31	31	100.0%	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) (NHS England and Improvement)	28	29	96.6%	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

The practice had met the WHO based target for all five childhood immunisation uptake indicators. Systems were in place to follow up children who were not brought for their immunisations.

Cancer Indicators	Practice	CCG average	England average	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). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	82.2%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	77.0%	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) (UKHSA)	76.1%	70.4%	66.8%	N/A
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) (UKHSA)	55.9%	53.0%	55.4%	No statistical variation

Any additional evidence or comments
The practice's cervical cancer screening uptake was above the target of 80%. The practice had exceeded the target consistently since March 2016. Uptake for breast and bowel cancer screening was above the local and national averages.

Monitoring care and treatment

The practice had a 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

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

The practice was conducting quality improvement projects and audits. Examples of audits seen:

- Audit of patients with potential chronic kidney disease (CKD) (one cycle: November 2021). The audit identified 156 patients, of which 82 patients had no recorded CKD diagnosis but met the criteria. Some patients required repeat blood tests to confirm or discount diagnosis and recalls added to their notes for regular blood tests. The results to the audit were discussed at the partner's meeting and multidisciplinary team clinical meeting, and the audit emailed to all clinicians. The learning points from the audit were that the GPs needed to be aware of the need to code new diagnosis of CKD, and nursing staff to be aware of the need for annual blood tests and observations incorporated into the long term condition review for patients with CKD.
- Audit of patients with blood pressure readings outside of the optimal range (one cycle: August 2022). Twenty-five patients who met the criteria had been identified, including eight patients whose blood pressure was within range. The remaining patients had been contacted and appointments arranged, asked to contact the practice to book an appointment or asked to submit their home blood pressure readings. For those patients who had been reviewed, treatment had been amended if required and a follow up appointment arranged or further home blood pressure readings recorded.
- Audit of patients with raised blood sugar levels who did not have a diagnosis of diabetes (Two cycle: November 2021 and July 2022). The first cycle identified 11 patients, a number of these patients did not have the correct code on their notes and this was added. Four of the patients with a diagnosis of diabetes did not have the code added to their notes and had not been informed of their diagnosis. These patients were advised of the diagnoses, coded correctly and referrals made for appropriate diabetic screening checks. One further patient was invited for a repeat blood test. The second cycle identified nine patients, two patients had been newly diagnosed and needed to see a clinician, codes were added to their notes; one patient's last three blood results were within the normal range, and six patients required repeat blood tests to confirm the diagnosis and had appointments for blood tests.

Any additional evidence or comments

The practice had reflected on the CQC remote searches carried out at the time of the previous review to inform their quality improvement work. The practice had undertaken a number of audits linked to safety alerts. These included:

- patients prescribed medicines to prevent or treat heart rhythm disorders;
- patients prescribed disease modifying antirheumatic drugs;
- patients prescribed medicines that may cause congenital malformations in babies.

The practice had also been supported by a pharmacist from the local medicines optimisation team, who had undertaken searches and medicine reviews for patients prescribed hypnotic medicines; searches for patients prescribed direct oral anticoagulants to ensure the dosage was correct when the creatinine clearance (a calculation to assess how well a patient's kidneys were working) was calculated.

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.	Partial
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Partial
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.	NA
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"> We saw that the practice had an induction checklist. We only saw one completed induction in the four staff files reviewed. We did not see evidence of a role specific or individualised induction / training programme for new staff, which included assessment of competencies, except for dispensary staff. There was a Locum Induction and New Doctor Information Pack in place for new GPs/locums. The practice used an eLearning training programme for essential training. The practice could not easily evidence that nursing staff were up to date with training specific to their role, for example: childhood immunisations, cervical screening and travel immunisation updates as this information was not held centrally. 	

Coordinating care and treatment

Staff worked work 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-centred care when they moved between services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We spoke with a representative of a care home for older people where the practice provided care and treatment. They told us that the practice worked closely with them and provided a good service for their residents. 	

- The practice used special notes to share important patient information with out of hours services.
- The practice worked in collaboration with other local GP practices to deliver the annual flu and covid vaccination programmes.
- The practice worked closely with community based specialised teams to support patients, for example, the community matron and mental health teams.

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Patients moving towards or receiving end of life care were discussed at the weekly multidisciplinary team meeting. 	

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"> • There was a consent policy in place to provide support and guidance to staff. • The practice completed health and social care plans called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which targeted patients' wishes and the care they required. This incorporated an assessment of mental capacity and details of the patient's resuscitation status (for example, if cardiopulmonary resuscitation should be given or not). 	

- From our remote clinical searches when reviewing care plans for patients living with dementia, we noted that although coded as having ReSPECT forms in place, these were not always available in the electronic record.
- We reviewed the records of three patients coded as having a DNACPR decision / Respect form in place. One DNACPR dated from 2012 and it was not clear if this form was still relevant. One ReSPECT form had been completed but not signed. The practice told us the signed copy was kept at the patient's home. Good practice would be to scan the signed form onto the electronic record. The other record contained a completed out of hours (OOH) form (special notes) which detailed the patient's wishes and had been shared with the OOH provider.

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
NHS Website	One positive review had been posted during the last twelve months. The review commented on the prompt, efficient and friendly service which included treatment for their condition.
Patient feedback sent to the CQC	The CQC received positive feedback from one patient registered with the practice. They told us that staff genuinely cared about their patients and were helpful, friendly and welcoming.

National GP Patient 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 (01/01/2022 to 30/04/2022)	95.8%	84.3%	84.7%	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 (01/01/2022 to 30/04/2022)	97.9%	83.8%	83.5%	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 (01/01/2022 to 30/04/2022)	99.5%	93.4%	93.1%	Variation (positive)
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)	92.5%	72.5%	72.4%	Variation (positive)

Any additional evidence or comments

All four indicators from the national patient survey were above the local and national averages for patient satisfaction with the care provided by the practice.

Question

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

Y/N

Yes

Any additional evidence

- In January 2022 the patient participation group (PPG) had supported the practice with a telephone access questionnaire. The survey looked at the ease of getting through to the practice by telephone at certain times of the day, the reason for contacting the practice, patient views on a queueing system, options for reception or dispensary and the recorded message.
- Suggestions for changes to the system were mainly seeking solutions to the congestion early in the day. Most patients said they would prefer a call waiting system. The recorded message was too long, and many patients did not find it helpful.
- The practice had acted upon the results and shortened the recorded message, added a small number of online appointments and offered patients their preferred choice of appointment, for example face to face or telephone consultation.

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"> The practice worked closely with the social prescriber to support patients and their relatives to find further information and access community and advocacy services. 	

Source	Feedback
Interview with a representative from a care home where the practice provided care and treatment.	The representative told us that when a decision was made to put in place or review a do not attempt cardiopulmonary resuscitation (DNACPR) form, the practice involved patients and their families in the decision making process.

National GP Patient 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 (01/01/2022 to 30/04/2022)	97.4%	90.2%	89.9%	Tending towards 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.	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

Carers	Narrative
Percentage and number of carers identified.	We saw that the practice had identified 134 patients as carers. This represented 2.8% of the practice population.
How the practice supported carers (including young carers).	Information for carers was available on the practice website and referrals were made to the social prescriber as appropriate.
How the practice supported recently bereaved patients.	When patients passed away, the relatives were routinely contacted to offer support. Patient deaths were also discussed at the multidisciplinary team meeting.

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

Responsive

Rating: Good

At our unrated review in December 2021 we found:

- Verbal complaints were not being recorded and acted upon.

At the inspection on 23 and 31 August 2022, we found that improvements had been made to the recording of complaints although the practice did not always follow the procedure in place.

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"> • The practice had developed a guide for staff on The Accessible Information Standard. A poster asking patients to make staff aware of their communication preferences was on display in the reception area. • During the pandemic, the practice had been flexible by allowing a small number of frail elderly patients (assessed on a case by case basis) to order repeat medicines over the telephone. • One member of staff had learnt sign language to assist communication with patients with a hearing impairment. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Dispensary Opening Hours:	
Monday	9am to 6pm
Tuesday	9am to 6pm
Wednesday	9am to 6pm

Thursday	9am to 6pm
Friday	9am to 6pm

Further information about how the practice is responding to the needs of their population

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised with the local community transport service to support patients to attend appointments.
- There was a medicines delivery service for housebound patients. This has been extended during the pandemic to include vulnerable patients who were shielding.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Patients had access to appointments every evening and weekend at local GP surgeries via the Derbyshire Dales Primary Care Network.
- All parents or guardians calling with concerns about a child five years old and under were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice had good working relationships with the various mental health teams and requests for support by patients were actioned promptly.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The majority of appointments available were same day appointments bookable from 8am, although patients were able to pre-book appointments in advance. Patients could choose if they received a face to face appointment or telephone consultation. Staff told us that if a patient required an urgent appointment and none were available, they would instant message the GPs working on the day. One of the GPs would either contact the patient and or advice reception staff to contact the patient with an appointment time. • Patients requesting urgent appointments or home visits were triaged by the GPs. The practice had also signed up to the local acute home visiting service for housebound patients. 	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	87.8%	N/A	52.7%	Significant Variation (positive)
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)	77.8%	54.3%	56.2%	Tending towards variation (positive)
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)	83.4%	52.8%	55.2%	Variation (positive)
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)	80.5%	71.4%	71.9%	No statistical variation

Any additional evidence or comments

All four indicators from the national patient survey demonstrated that patient satisfaction with access to appointments was above local and national averages.

Source	Feedback
A representative from a care home where the practice provided care and treatment	We spoke with a representative from a local care home where the practice provided care and treatment to older people. They told us that residents living in the homes had a named GP who provided a weekly onsite ward round, and the GPs were available to contact by telephone at other times.
Patient feedback sent to the CQC	The CQC received positive feedback from one patient registered with the practice. They told us that the booking system was excellent and they could almost always get an appointment when they rang at 8am. They told that if they were offered a telephone consultation, they were informed of the date and time, with the caveat that the call may not be exactly on time.

Listening and learning from concerns and complaints

Complaints were listened and responded to, although not always used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	21
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	1
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Almost half of the complaints received in the last year were from the same complainant. • Information about how to complain was available on the practice's website and the complaint form was available at reception. • We saw that the practice did not always follow its own procedure as one verbal complaint looked at had not been recorded on a complaints form, acknowledged in writing or written response provided. In addition there was little evidence to support complaints were used to improve the quality of care. For example that when complaints were raised about specific members of staff, the concerns were discussed with them and any learning identified. 	

Examples of learning from complaints.

Complaint	Specific action taken
The patient's relative contacted the practice to complain about the discussion that had taken place during the consultation with a specific GP.	A GP partner spoke with the patient to discuss their concerns and it was concluded that the patient may have misinterpreted the discussion during the consultation.
A patient's relative wrote to the practice about their perceived lack of care for the patient during the pandemic.	The relative was offered the opportunity to discuss their concerns in person but they declined. A letter was sent to the complainant responding the concerns raised. Further conversation with patient and relative was had to discuss their concerns and the level of care provided by different services.

Well-led

Rating: Requires Improvement

At our unrated review in December 2021 we found:

- Effective governance structures and systems were not in place.
- Effective processes for managing risks, issues and performance were not in place.

At the inspection on 23 and 31 August 2022, we found that although improvements had been made in to the governance structures and systems in place, these needed to be strengthened and improved further to manage risk, issues and performance. Staff roles and responsibilities needed to be clearer and shared with all staff, and action taken so that all staff working at the practice felt supported and valued by the leaders.

Therefore we have rated the practice as requires improvement for providing a well-led service.

Leadership capacity and capability

Leaders tried to provide a 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.	Partial
Explanation of any answers and additional evidence: Staff we spoke with told us that the greatest challenge was staffing levels. There have been ongoing changes to the management team since the review in December 2021. A new GP partner had been appointed prior to the retirement of the long standing GP partner, and two additional salaried GPs have also been appointed. The new practice manager started in January 2022, and a member of reception staff promoted to office manager so provide additional managerial support. The practice produced an action plan following the unrated review in December 2021 which detailed how the issues identified would be addressed. Reference to succession planning was made in the vision and strategy document. This referenced consolidation of the new partnership in the first instance, looking towards succession planning in the next couple of years. There was reference to succession planning within other teams, for example, dispensary, administration or nursing.	

Vision and strategy

The practice had a vision and credible strategy that aimed to provide high quality sustainable care although not all staff were aware of these.

	Y/N/Partial
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The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had developed a mission statement and practice culture document in late 2021, and a vision and strategy document that outlined the major priorities for 2022. A number of the priorities were ongoing, for example: sharing leadership role between new staff and refurbishment of the premises. Progress against the delivery of the priorities had not yet been formally monitored.</p> <p>Not all staff spoken with were aware of the mission statement and values. Other staff know that the mission statement was on display.</p>	

Culture

The practice was developing a culture to drive 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.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
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.	Partial
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> <p>Not all staff were aware of who the Freedom to Speak up Guardian was but were aware the details would be included in the policy.</p> <p>Staff did not complete training on equality and diversity.</p>	

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

Source	Feedback
Interviews with staff	<p>Staff told us that it had been challenging working at the practice since the last review in December 2021. They told us the retirement of the senior GP partner had impacted on both staff and patients. Although they told us the new GP partner and salaried GPs had settled in well, it was still early days.</p> <p>Not all staff spoken with felt supported in their role or thought that management was proactive in promoting staff safety and wellbeing. They did not feel they were always listened to or consulted over ways of working, particularly when there was the potential to work more efficiently to create capacity to see a greater number of patients.</p> <p>Staff told us morale had been affected by staffing levels, particularly in reception. Staff told us they were short staffed, partly due to sickness and holidays. They told us additional staff were being recruited but this process took time. Staff spoke positively about the office manager role, whilst acknowledging that the member of staff was relatively new to the role and still learning.</p> <p>Staff told us that although some aspects of communication had improved, this was not the case within all teams. The weekly multidisciplinary team meetings were working well and the minutes shared with staff. Reception staff tried to hold weekly meetings but due to staffing challenges these did not always occur</p>

	<p>although the office manager produced a weekly bulletin to update staff. Monthly dispensary staff meetings were held, and these staff told us that they valued the opportunity to meet and discuss any updates or issues. No meetings were organised for the nursing team.</p> <p>Not all staff felt that everyone within the management team was approachable or understood the day to day challenges of running the practice.</p>
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Governance arrangements

The overall governance arrangements were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We found that governance structures and systems had been strengthened in areas following the review in December 2021. However not all staff were clear about the roles and responsibilities, particularly around the overlap between the practice manager and the office manager.</p> <p>Following the inspection the practice shared a copy of the Practice Structure and Responsibilities (dated September 2022). This clearly defined the roles and responsibilities of the practice manager and office manager.</p> <p>There were plans to move the practice policies and procedures to a web based platform for storing and sharing information. This would enable policies and procedures to be updated and shared with staff more easily.</p> <p>Improvements had been made to:</p> <ul style="list-style-type: none"> • The safe monitoring and issuing of repeat prescriptions for high risk medicines and controlled medicines. • The system to respond to Medicines and Healthcare products Regulatory Agency (MHRA) alerts, including historical alerts to support safe and effective prescribing, although it was recognised the system still needed to become embedded. <p>However we found that effective governance structures and systems were not in place:</p> <ul style="list-style-type: none"> • To ensure that required recruitment checks were obtained for all staff, including obtaining the immunisation status for all staff. • To ensure the health and safety of patients and staff, including infection prevention and control. • To ensure that staff received and were up to date with training appropriate for their role through induction and regular updates, and evidence available to support this. • To ensure the significant event and complaint processes were completed fully to identify learning, required actions, implementation and monitoring of any changes. 	

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.	Partial
There were processes to manage performance.	Partial
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.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The partners had recognised when preparing for the review in December 2021 that improvements needed to be made to the processes in place for managing risk, issues and performance. The partners provided a summary of learning points, areas for development and the plans to address these. We saw that improvements had been made in some areas. For example:</p> <ul style="list-style-type: none"> • The practice had developed and implemented formal competency reviews for dispensary staff. • The practice had encouraged and empowered administrative staff to identify, record and report significant events. However, a full analysis of significant events following by implementation and monitoring of any changes was not always taking place. • The safe monitoring and issuing of repeat prescriptions for high risk medicines and controlled medicines. <p>However, improvements had not been made in the following areas. For example:</p> <ul style="list-style-type: none"> • Infection control: upskill the nursing team to take over leadership of the infection prevention and control (IPC). • Staff training and induction: to have a clearer structure for staffing training, induction and documentation to support this. The practice planned to use a web based intranet and a sharing platform specifically built for use in primary care for recording staff information, managing alerts for staff training updates and registration renewals, and develop a yearly rolling plan for essential training on designated learning afternoons, • To improve the recall system for patients with long-term conditions: to develop and implement a structured search-based system to identify patients on a monthly basis. • Immunisation status of staff. 	

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

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <p>Not all staff felt that they were always listened to or consulted over ways of working, particularly when there was the potential to work more efficiently to create capacity to see a greater number of patients. Staff told us they had been working towards using birth month for long term condition reviews and using the registers to identify and invite patients in to streamline the process. They had now been told to continue using scheduled tasks for each condition to identify patients who required a long term condition review.</p> <p>The patient participation group (PPG) had supported the practice during the pandemic through newsletters to patients and carrying out patient surveys. The PPG had not met with the practice in person during the pandemic. The PPG had requested a face to face meeting although the practice had not been able to facilitate this.</p>	

Any additional evidence

We spoke with a representative from a care home, who told us that they were satisfied with the service provided by the practice and that the GPs were approachable. They said that the practice was responsive and supportive and advice was available promptly via the telephone. There had been change in the GP partner aligned to the home following the retirement of the previous GP partner. Routine weekly visits to review residents as required continued to take place. The representative told us that both the home and the GP partner were getting used to working together and they were beginning to develop mutual trust and respect.

The representative told us the GPs engaged with residents and families to discuss health and social care plans called ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) which targeted patients' wishes and the care they required. This incorporated an assessment of mental capacity and details of the patient's resuscitation status (i.e. if cardiopulmonary resuscitation should be given or not). The GPs were proactive in prescribing anticipatory medicines (medicines prescribed to manage distressing symptoms) to ensure there was no delay in people receiving the care they required, although this no longer included the use of syringe drivers to deliver pain relief.

Continuous improvement and innovation

There were evidence of developing 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.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice did not always complete the significant event and complaint processes in full, thereby reducing the opportunity to learn from and amend practice accordingly. • The nursing team did not have the opportunity to meet and discuss any suggestions for improvement or share any learning. 	

Examples of continuous learning and improvement
<ul style="list-style-type: none"> • The practice had completed a number of audits linked to safety alerts and there were plans in place to repeat these audits at three and six month intervals. • The practice supported staff to develop their skills and knowledge. For example, the development of the office manager role, support for a health care assistant to train to become a nurse associate, and the development of the care co-ordinator role. • The practice had improved the control measures in place to prevent the over ordering of controlled medicines.

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:

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.