

# Care Quality Commission

## Inspection Evidence Table

### Dr Webb and Partners (1-550670216)

Inspection date: 1st and 5<sup>th</sup> July 2021

Date of data download: 11 June 2021

## Overall rating: Good

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

At the previous inspection January 2020, we rated the practice as requires improvement overall. This was because the practice was rated as requires improvement for providing safe and well-led services.

At the inspection on 1 and 5 July 2021, we found that the practice had actioned and put measures in place to comply with the regulatory breaches.

## Safe

## Rating: Good

**At the previous inspection on 13 January 2020 we rated the practice as requires improvement for providing safe services.** This was because the practice could not provide evidence of progress against action plans for fire and legionella risk assessments; could not fully demonstrate their response to safety alerts or provide assurance regarding all aspects of medicines management.

**As a consequence of the improvements seen during the inspection in July 2021, the practice was rated as Good 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.**

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies and procedures were monitored, reviewed and updated.	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

<b>Safeguarding</b>	<b>Y/N/Partial</b>
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a safeguarding clinical lead, with deputising arrangements in place. The practice is a member of Erewash Health Partnership (EHP), which is a federation of 10 local GP practices who work collaboratively to ensure standardisation and efficiency. The safeguarding policies (written by representatives of Erewash Health Partnership (EHP) and implemented across the group) were last updated in March 2021, and these were accessible to all staff. The safeguarding lead advised that although the policies had been updated, additional information needed to be included and they had taken on the responsibility to update these policies.</p> <p>The practice regularly discussed any children deemed to be at risk at three monthly child welfare meetings, attended by the safeguarding lead, nurse practitioner and health visitor. The school nurse and midwife were also invited and attended when possible. Discussions were recorded in the clinical notes and appropriate electronic codes applied. Safeguarding discussions also took place at clinical and practice meetings when appropriate.</p> <p>We found there were systems to identify and follow up children, who were at risk, for example, children and young people who were not brought for appointments, did not attend secondary care appointments or who had a high number of accident and emergency (A&amp;E) attendances.</p> <p>We saw staff had received the appropriate level of safeguarding training. Staff spoken with were fully aware of their responsibilities in respect of safeguarding.</p>	

<b>Recruitment systems</b>	<b>Y/N/Partial</b>
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We saw that staff files were well organised and appropriate recruitment checks were in place for a most recently recruited member of staff. The nurse practitioner was responsible for checking staff vaccination and immunisation status, and ensuring they were up to date.</p>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person.	Yes

Date of last inspection/test: October 2020	
There was a record of equipment calibration. Date of last calibration: March 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
A fire risk assessment had been completed. Date of completion: <ul style="list-style-type: none"> <li>Practice – April 2021</li> <li>NHS Property Services – January 2019</li> </ul>	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: At the previous inspection in January 2020, we found that although a fire risk assessment had been completed by NHS Property Services, the practice had not taken ownership of the plan or recognised their responsibilities as a tenant. At the inspection in July 2021, we found that the practice had completed their own fire risk assessment for the area of the building which they leased. All identified actions had been addressed or an explanation given for any delays.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: <ul style="list-style-type: none"> <li>Practice - December 2020</li> </ul>	Yes
Explanation of any answers and additional evidence: At the previous inspection in January 2020, we found that not all risk assessments were embedded and used in response to any areas of potential or identified risk at the practice. We found that the legionella risk assessment action plan had not been updated since 2019. Although the plan was overseen by NHS Property Services, the practice had not taken ownership of the plan or recognised their responsibilities as a tenant. At the inspection in July 2021, we found the practice had completed their own health and safety risk assessments for the areas where they had responsibility. The practice manager told us that the legionella risk assessment had recently been completed, and the report was awaited. Systems were in place to mitigate any risks, for example, water temperature checks and the running of water outlets.	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2021	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: We saw that appropriate risk assessments had been completed in line with current guidance in relation to Covid-19. Staff were provided with the required personal protective equipment. Staff told us they had received additional training on the new guidance and were kept informed of any changes. Contract cleaners were employed, who had access to cleaning schedules and information was available for the products used in relation to Control of Substances Hazardous to Health (COSHH).	

## 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
Explanation of any answers and additional evidence: We saw that staff received training on how to respond to medical emergencies and had access to equipment and emergency medication as appropriate. Reception staff explained the action they would take in response to a deteriorating or acutely unwell patient.	

## 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 summarizing 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: There were systems in place to share information regarding do not attempt cardiopulmonary resuscitation plans and/or anticipatory care planning for palliative care patients. Recall dates were added to the clinical system to ensure decisions and care plans were reviewed regularly.	

## 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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.60	0.68	0.70	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2020 to 31/03/2021) (NHSBSA)	6.9%	9.3%	10.2%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2020 to 31/03/2021) (NHSBSA)	5.47	5.09	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	171.7‰	147.1‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	1.16	0.57	0.66	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	9.3‰	7.2‰	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

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.	Yes
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 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.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>As the inspection in January 2020, we identified a number of medicine management issues of concern. These included out of date medicines in GP bags, lack of a system for monitoring blank prescription stationary, monitoring of high risk medicines, not all patient group directions signed, lack of a risk assessment for emergency medicines not held at the practice and the lack of documented evidence of the review of non-medical prescribing.</p> <p>At the inspection in July 2021, we found that the practice had taken action to address these issues. We found that:</p> <ul style="list-style-type: none"> <li>• The GPs no longer held their own supply of medicines. If medicines were required to be taken on home visits, they were taken from the practice supply or obtained from the local pharmacy.</li> <li>• A system had been introduced for monitoring blank prescription stationary into and around the practice. Prescription stationary was removed from printers and stored securely when the practice was closed.</li> <li>• All patient group directions were up to date and signed.</li> <li>• A risk assessment had been completed for emergency medicines not held at the practice, including the rationale and how to obtain supplies if required in an emergency. The practice</li> </ul>	



Medicines management	Y/N/Partial
<p>acknowledged that the risk assessment required updating to reflect that the local pharmacy was now located over the road from the practice and not in the same building.</p> <ul style="list-style-type: none"> <li>Non medical prescribers received regular supervision, which included a review of their prescribing.</li> </ul> <p>We undertook a remote review of clinical records as part of the inspection. The review demonstrated systems and processes were in place for monitoring patients' health in relation to the use of medicines including high risk medicines, with appropriate monitoring and clinical review prior to prescribing. We found the practice operated a recall system to ensure patients attended for blood tests as appropriate. Systems were in place for the safe handling of repeat prescriptions. The majority of patients ordered their medicines through the Medicines Order Line (MOL) and there was a standard operating procedure (SOP) in place to support this process. Patients were also able to order medicines online or by email direct to the practice. We saw evidence of medicine reviews recorded in patient records. The nursing team had recently completed an audit of patients who had requested more than 12 inhalers over a 12 month period, and the findings were in the process of being written up.</p>	

## 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.	Partial
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	4
Number of events that required action:	4
<p>Explanation of any answers and additional evidence:</p> <p>Significant events were discussed at both clinical and practice meetings. Significant events were shared across Erewash Health Partnership, which provided the opportunity for learning to be disseminated across the wider group.</p> <p>Discussion with practice staff indicated that the vaccine fridge had failed in 2020. Staff described how they had followed the cold chain procedure, quarantined the vaccines, contacted the relevant people and then disposed of the vaccines safely. As this had not been recorded as a significant event, the opportunity to discuss how staff had followed procedures and maintained patient safety, thus providing a positive example had been missed.</p>	



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

Event	Specific action taken
Community staff had not recorded the practice code on blood bottles when taking patient blood samples on behalf of the practice. This led to the practice not receiving the blood tests results.	A nurse practitioner noted that the practice had not received some patients' blood results. An investigation highlighted incorrectly labelled blood bottles. The investigation findings were raised with community staff management team. Safety measures were put in place as a result which included an administrative task which was created when community staff were requested to take bloods for patients registered at the practice. The task was to ensure that blood test results had been received, and if not, for those to be accessed from the pathology system.

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> <p>The practice engaged with the Clinical Commissioning Group (CCG) medicines management team, through regular meetings with the GPs and nurses. These meetings focused on recent safety alerts and maintaining the safety alert register, as well as any changes to the CCG list of medicines that could be prescribed and other relevant information.</p> <p>We saw examples of actions taken on recent alerts for example, sodium valproate and carbimazole (Medicines used to treat epilepsy, bipolar disorder and over active thyroid). Where relevant, the patient had been informed of the risks of taking the medicine.</p>	

## Effective

## Rating: Good

### 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
Explanation of any answers and additional evidence: We saw that clinicians made good use of the templates and guidance that was available in the electronic patient record. We saw that these had been completed appropriately. We saw that effective patient recall systems were in place and the clinicians involved patients in their care. Clinical staff had a designated mentor and clinical supervision and support was provided. Clinical meetings were held and included discussion of any new guidance and best practice.	

## Older people

## Population group rating: Good

### Findings

- Vulnerable older adults were discussed at the Community Delivery Team (multidisciplinary team) meetings, which were held monthly.
- The practice identified older patients who were unable to attend the practice due to their health and mobility and/or had complex needs. These patients could be referred to a local frailty team to help in supporting them to live independently at home, where appropriate. Those identified received a full assessment of their physical, mental and social needs. The frailty team (community based team consisting of a community GP and advanced nurse practitioners) supported patients who lived in care homes.
- The practice was supported by the care co-ordinator to follow up on older patients discharged from hospital, as part of the Over 80s Elderly Wellbeing Project. Each patient was contacted by telephone following discharge and referred to the community teams as appropriate. They

ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, the nurses had completed accredited spirometry training and insulin initiation training.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice worked closely with specialist nurses/teams such as the heart failure nurse, IMPACT (respiratory) team and diabetic specialist nurse.
- The practice referred diabetic patients to Xpert Diabetes and retinal screening, and to the Diabetes Prevention Programme.
- 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 home blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	86.2%	78.6%	76.6%	Tending towards variation (positive)
PCA* rate (number of PCAs).	2.1% (6)	12.5%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an	93.0%	89.6%	89.4%	No statistical variation

assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	4.4% (6)	14.4%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.3%	82.2%	82.0%	No statistical variation
PCA rate (number of PCAs).	2.9% (2)	5.0%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	76.1%	68.5%	66.9%	No statistical variation
PCA rate (number of PCAs).	22.4% (46)	19.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	77.3%	73.3%	72.4%	No statistical variation
PCA rate (number of PCAs).	4.2% (22)	7.0%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	98.4%	93.2%	91.8%	Tending towards variation (positive)
PCA rate (number of PCAs).	7.5% (5)	4.8%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	78.3%	76.2%	75.9%	No statistical variation
PCA rate (number of PCAs).	3.4% (7)	11.6%	10.4%	N/A

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had met the World Health Organisation (WHO) based national target of 95% (the recommended standard for achieving herd immunity) for all of the five childhood immunisation uptake indicators. The practice had achieved 100% for each uptake indicator.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice held regular child welfare meetings to discuss any child deemed to be at risk. The health visitor, school nurse and midwife were invited to these meetings and attended when possible.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) (i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	31	31	100.0%	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) (01/04/2019 to 31/03/2020) (NHS England)	25	25	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) (01/04/2019 to 31/03/2020) (NHS England)	25	25	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) (01/04/2019 to 31/03/2020) (NHS England)	25	25	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) (01/04/2019 to 31/03/2020) (NHS England)	40	40	100.0%	Met 95% WHO based target

### Any additional evidence or comments

The practice monitored those children who did not attend for immunisations and contacted the parent / guardian to rebook an appointment. Children who consistently failed to attend for immunisations were referred to the health visitor when it was appropriate to do so.

### Working age people (including those recently retired and students)

Population group rating: **Good**

### Findings

- The practice were involved in the catch up programme for the meningitis vaccine, for example for those who had not been vaccinated at school.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) (Public Health England)	77.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	73.5%	72.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	63.7%	66.1%	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	92.9%	93.0%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	53.1%	51.2%	54.2%	No statistical variation

### Any additional evidence or comments

The practice was below the 80% target for cervical cancer screening. However, there had been a slight increase between September 2020 to December 2020. Systems were in place to follow up patients who did not respond to invites to book appointments or who did not attend for their appointment. Appointment reminders were sent via text message and included links to charitable organisation for additional information. Systems were also in place to check patients attended appointments when referred to secondary care, and screening results had been returned to the practice within six weeks. Breast and bowel screening uptake was in line with or above the national averages.

### People whose circumstances make them vulnerable

Population group rating: **Good**

### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

### People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

### Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive,	84.2%	87.2%	85.4%	No statistical variation



agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)				
PCA rate (number of PCAs).	5.0% (1)	19.5%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	73.0%	82.9%	81.4%	No statistical variation
PCA rate (number of PCAs).	5.1% (2)	9.3%	8.0%	N/A

## Monitoring care and treatment

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

Indicator	Practice	England average
Overall QOF score (out of maximum 559)	557.7	533.9
Overall QOF score (as a percentage of maximum)	99.8%	95.5%
Overall QOF PCA reporting (all domains)	4.4%	5.9%

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

<p>The practice had undertaken an audit of antibiotic prescribing during the time of Covid-19 and remote consultations. They found that 19 patients had been prescribed broad spectrum antibiotics for 16 different diagnoses, and 12 patients (75%) had been appropriately prescribed antibiotic therapy.</p> <p>Of the 12 diagnoses which were appropriately prescribed antibiotic therapy, six required a prior investigation before antibiotic therapy could be prescribed. Findings were that:</p> <ul style="list-style-type: none"> <li>• Four of the six conditions had the necessary investigation conducted.</li> <li>• Reviews of the 12 appropriate prescriptions indicated that seven adhered to the recommended choice of antibiotic therapy and five did not.</li> <li>• Of the seven prescriptions adhering to recommended choice, five also adhered the recommended dosage, but only four adhered to recommended course length.</li> </ul> <p>The audit recognised that the practice has low levels of antibiotic prescribing but identified areas where improvement could be made. These included replacing the retired printed guidelines with the latest</p>
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appropriate guidelines and circulate electronic versions and increase the use of the decision support tool on the electronic clinical system which flags potential inappropriateness of the antibiotic for the diagnosis.

The practice had also undertaken an audit of patients prescribed specific medicine for osteoporosis, to assess whether current best practice guidance was being adhered to.

#### **Any additional evidence or comments**

The nursing team also undertook a range of audits using the clinical reporting system. These included:

- Patients requesting more than 12 specific type of inhalers in a year (quarterly)
- Cervical screening results on received after six weeks (monthly)
- Diabetes patients not meeting blood pressure targets (quarterly)
- Diabetes patients not meeting two different types of blood test targets (quarterly)
- Insulin initiations (six month follow up reviews)

## 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
Explanation of any answers and additional evidence:  Staff told us how the practice had encouraged and supported them to develop in their roles. The health care assistant had moved from the role of receptionist and was in the process of completing the Care Certificate. A member of reception staff had completed additional training and as part of the practice's succession planning would be working closing with the practice/business manager to learn their role.  Staff told us they had protected learning time and were able to up keep up to date with their required learning. Staff were offered appraisals annually, but the practice hoped to move towards six monthly appraisals.  During the last twelve months, the practice had recruited an additional practice nurse. This member of staff had been supported to complete training relevant to their role and had recently completed the independent prescriber's course. They told us they had been mentored and supervised throughout their training by the nurse practitioner.	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence:	

Staff attended a range of meetings with other health and social care professionals to discuss the care and treatment of patients. These included community delivery meetings, palliative care meetings and child welfare meetings.

## 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: The practice offered health checks which included the completion of a health questionnaire, and provided staff with the opportunity to discuss smoking cessation, alcohol reduction advice and weight loss. Patients were signposted to support organisations as appropriate. The practice provided printed information and electronic links to relevant guidance and literature for patients.	

## 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: We saw that clinicians 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 (i.e. if cardiopulmonary resuscitation should be given or not). The practice used the recall system to ensure that these plans were reviewed and updated on a regular basis.	

## Well-led

## Rating: Good

**At the previous inspection on 13 January 2020 we rated the practice as requires improvement for providing a well-led service.** This was because some areas which had been identified for action at our previous inspection had not been fully addressed. These included lack of ownership for site-related matters following assessment; oversight of practice systems was not always effective and additionally leaders were not always receptive to the requirements needed to provide assurance as part of their registration with the Care Quality Commission.

**As a consequence of the improvements seen during the inspection in July 2021, the practice was rated as Good for providing a well-led service.**

### 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
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection in January 2020, we found that sufficient improvements had not been made following the previous inspection in February 2019. Some issues which had been previously highlighted remained as concerns, alongside some additional matters which we observed on the day of the inspection. This was a result of a lack of leadership and oversight meaning that systems were not always robust. In addition, the partners did not fully acknowledge the importance of demonstrating their compliance with regulations supported by documented evidence.</p> <p>At the inspection in July 2021, we found that the leaders demonstrated that they understood the challenges to quality and sustainability, and therefore, changes had been made to the management team within the practice. Staff commented that these changes had been beneficial in bringing about the required improvements in working practices and staff morale. Staff spoke highly about the management team and commented that leaders were visible and approachable. Staff felt supported and valued in their work.</p> <p>The management team had recognised the need for succession planning and the need to future proof the staff team. A review of staffing requirements had taken place and the following action taken:</p> <ul style="list-style-type: none"><li>• Recruitment of an additional practice nurse with the last 12 months, plus ongoing development for example, completion of the independent prescribers' course.</li><li>• Development of an existing member of staff to the role of health care assistant, including completion of the Care Certificate and ongoing training.</li><li>• Development of a member of reception staff, working towards the role of practice manager.</li><li>• Recruitment and development of an additional practice nurse to supplement the existing nursing team.</li><li>• Ongoing recruitment of additional reception team member.</li></ul>	

## Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
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
Explanation of any answers and additional evidence:	

## 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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
Staff told us that during the Covid-19 pandemic the management team had demonstrated a strong emphasis on the safety and well-being of staff. Changes had been made to the rotas, resulting in staff working in defined groups to reduce the number of contacts with different people. The waiting room had been reconfigured to provide additional space, so staff were able to take breaks together whilst maintaining social distancing.	

Staff told us they were able to raise any issues or make suggestions, either during meetings or as issues arose, and they would be listened to and supported as required. Staff knew they had access to a Freedom to Speak up Guardian.

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

Source	Feedback
Staff interviews	<p>Staff told us that they enjoyed working at the practice, and the practice team felt like family. They felt empowered to make suggestions or raise any concerns. They said they were able to raise queries or concerns with any member of the management team, and they would be listened to and their comments taken on board. They told us support for their wellbeing, both professionally and personally, was available and confidentiality would always be maintained.</p> <p>Staff told us that as a team they had discussed the changes to staff arrangements at the beginning of the Covid-19 pandemic and decided upon and agreed the changes that were implemented. A number of the staff preferred their revised working pattern and planned to continue with it. They told us that additional risk assessments had been completed as required and reviewed on a regular basis.</p> <p>Staff said they were offered the opportunity to develop, either within their existing role or to another role. Protected learning time was provided, and they were supported to attend external courses where appropriate.</p> <p>Staff commented that the introduction of IT systems such as AccuRx text messaging had enabled them to communicate more efficiently with a greater number of patients. They were able to send appointment reminders, links to relevant information and request information to support long term condition reviews via text. This resulted in staff having more time to contact those patients who did not have access to a mobile phone by more traditional methods, such as via a landline telephone.</p>

#### 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
Explanation of any answers and additional evidence:	
We saw during the inspection in July 2021 that the health and safety issues identified during the previous inspection in January 2020 had been addressed. Staff were clear about their roles and responsibilities, and what was expected of them.	



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## 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
Explanation of any answers and additional evidence:  The issues around assurance systems and arrangements for identifying, managing and mitigating risks identified at the inspection in January 2020 had been addressed. Governance arrangements had been strengthened and were working effectively. The management team had oversight of any identified risks and action had been taken to mitigate these.	

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

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

Explanation of any answers and additional evidence:

- To meet the demands of the COVID-19 pandemic, a GP appointment triage system had been introduced. Consultations were carried out remotely. At a GP's discretion, face to face appointments were offered. Patients could access appointments by visiting or telephoning the practice. Information to inform patients of the change in accessing appointments was included on the practice's website and telephone answerphone system.
- Staff told us that patients contacting the practice for an urgent or on the day consultation, would receive a telephone/video consultation with a GP either the same day or the next day. Routine consultations usually took place within two weeks.
- Staff were also able to offer patients urgent appointments through the 'on the day service' operated by Erewash Health Partnership from a nearby GP practice. The practice was allocated a specific number of appointments on each weekday.
- To support the communication needs of patients, carers and parents with a disability, impairment or sensory loss, there was an accessibility link on the practice's website.

## 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
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes
Explanation of any answers and additional evidence:	
The practice used the Quality and Outcomes Framework (QOF) to improve performance. We saw that QOF data was discussed at clinical staff meetings.	

## 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
Explanation of any answers and additional evidence:  We saw that policies and systems were in place to manage the governance of remote services.	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
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
Explanation of any answers and additional evidence:  The practice did not currently have an active Patient Participation Group. However, the practice had sought the views of patients via a survey monkey (an on-line survey service) carried out in November 2020. The survey asked patients about their views on access to and type of appointment. Overall the results were positive and did not identify any issues. The practice also looked at the NHS website for patient reviews and responded individually to each patient.  The Care Quality Commission had received two comments from patients during the previous six months. One comment was positive regarding the exceptional service and the time and understanding received from the GPs and nursing staff. The other comments was less positive and made reference to a change in medication following a long term condition review.	

#### Any additional evidence

We spoke with representatives from two local care homes. They told us they have a very good relationship with the GP practice. They said that patients were well supported by the Frailty Team, who will liaise with the GP practice on their behalf. However, they told us the GPs will visit when requested, and will also carry out video and telephone consultations. Repeat prescriptions were ordered through the practice and any discrepancies were dealt with promptly.

## Continuous improvement and innovation

**There were 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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice engaged with the Clinical Commissioning Group medicines management team and implemented any changes as required. The practice had worked closely with medicines management to implement the distribution of Steroid Emergency Cards.</li><li>• We saw examples of quality monitoring to improve care and treatment for patients. This included the structured recall systems in place for patients with long term conditions, prescribed high risk medicines and audits undertaken by the nursing team.</li><li>• Learning from the significant events was discussed at both clinical and practice meetings. Significant events were shared across Erewash Health Partnership, which provided the opportunity for learning to disseminated across the wider group.</li></ul>	

## 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

## Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- PHE:** Public Health England.
- QOF:** Quality and Outcomes Framework.
- STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- \*PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#) ).
- %** = per thousand.