

Inspection Evidence Table

Peak & Dales Medical Partnership

(1-560622343)

Inspection Date: 10 and 14 August 2023

Date of data download: 25/07/2023

Overall rating: Requires Improvement

At our previous inspection on 7 February 2020, we rated the practice as outstanding overall because it was rated as outstanding in the key questions responsive and well-led.

At this inspection, we found that those areas previously regarded as outstanding practice are now embedded throughout the majority of GP practices. The threshold to achieve an outstanding rating at this inspection had not been reached. The practice is now rated requires improvement overall because effective systems were not always in place to ensure safe, effective and well-led services were provided.

Safe

Rating: Requires improvement

At our previous inspection in February 2020, we rated the practice as good for providing a safe service. At this inspection we rated it as requires improvement for providing a safe service because:

- The provider had not ensured that all of the required recruitment checks were available for each person employed.
- Risk assessments had not been completed for staff without a Disclosure and Barring Service (DBS) check in place, to determine the frequency of repeating DBS checks or for staff who had not received the required vaccinations or immunity.
- A risk assessment had not been completed for the missing recommended emergency medicines available at the Bakewell Practice.
- Checks to mitigate potential risks of delivering vaccines outside of the manufacture's guidance had not always been completed in line with their cold chain policy.
- Our clinical searches identified small numbers of patients that had not received the required blood test monitoring for medicines that required monitoring. In addition, Medicines and Healthcare products Regulatory Agency (MHRA) alerts had not always been acted on.
- Opportunities to raise significant events had been missed.

Safety systems and processes

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

| Safeguarding | Y/N/Partial |
|--|-------------|
| Safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| Partners and staff were trained to appropriate levels for their role. | 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. | Partial |
| Disclosure and Barring Service (DBS) checks were undertaken where required. | Partial |
| There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm. | Yes |
| <p>At our previous inspection on 7 February 2020, we made the best practice recommendation:</p> <ul style="list-style-type: none"> Non-clinical staff should update their child safeguarding training to level 2 in line with updated guidance. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> Non-clinical staff had completed the appropriate level of training for safeguarding children and vulnerable adults. The safeguarding lead for the practice attended case conferences arranged by the local authority. The provider told us they held weekly meetings to discuss the care of patients living in care homes where they provided care and treatment. Meeting minutes to demonstrate this were not completed. The provider told us that they held weekly multidisciplinary meetings to discuss patients of concern and that guests such as social care, social prescribers and Health Visitors were invited to attend. They told us that decisions made about this group of patients were entered into patients' records. There was a system in place for recording and monitoring not just patients with known safeguarding concerns but also patients with the potential to become vulnerable. We reviewed the records of a mother of a child with known safeguarding concerns. An alert had not been added to their records. The provider told us that previously alerts had been added to all household members of children with safeguarding concerns however, they had recently changed IT systems and the alerts had not pulled through. Following our inspection, they confirmed that they had updated all the required alerts. <p>However:</p> <ul style="list-style-type: none"> We reviewed the records of 4 members of staff and found that DBS checks had been completed for the 4 staff members however, 1 dated back to 2012 and a risk assessment to determine the frequency of repeating DBS checks had not been completed. The provider had identified 5 members of staff who did not have a DBS check in place and DBS checks had been applied for. However, risk assessments had not been completed to mitigate potential risks whilst the results of the DBS checks were awaited | |
| Recruitment systems | Y/N/Partial |
| Recruitment checks were carried out in accordance with regulations (including for agency staff and locums). | No |

| | |
|--|----|
| Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role. | No |
| <ul style="list-style-type: none"> We reviewed the practice's recruitment policy and found that there was no reference to completing DBS checks or checking for gaps in employment histories. We reviewed the records of 4 members of staff. We found that a full employment history was not available in 1 of the records, evidence of satisfactory conduct in previous employment was not available in 2 of the records and satisfactory information about any physical or mental health conditions relevant to a person's ability to carry out their role was not available in 3 of the records. Following our inspection, the provider forwarded to us a health questionnaire they planned to use to assess the physical and mental health of staff employed by the practice. They told us to support their staff they used a well-being assessment form and that staff had access to private health insurance. A complete immunisation history was not available in any of the records we reviewed. Risk assessments had not been completed to mitigate potential risks. For example, a risk assessment had not been completed for a clinical member of staff whose immunity to hepatitis B was unknown. Following our inspection, the provider forwarded to us an immunisation history that they had since acquired for a clinical member of staff. The provider had identified these gaps in their recruitment and immunisation processes and had started to review this. We reviewed their risk based audits and found that 12 members of staff did not have an employment history, 10 did not have evidence of satisfactory conduct in previous employment and 5 members of staff did not have a DBS check in place. There were no immunisation records for 3 members of staff. We found that the provider was actively addressing the issues identified within their risk-based audits. We found that the practice had gained assurances that staff working in the practice and employed by the Primary Care Network had been recruited appropriately. | |

| Safety systems and records | Y/N/Partial |
|---|-------------|
| Health and safety risk assessments had been carried out and appropriate actions taken. | Partial |
| Date of last assessment: August 2023 | |
| There was a fire procedure. | Yes |
| Date of fire risk assessment: Bakewell Practice: 13 June 2018 Tideswell Practice: 10 May 2018 | |
| Actions from fire risk assessment were identified and completed. | Yes |
| <ul style="list-style-type: none"> Risk assessments were in place for hazardous substances such as liquid nitrogen and oxygen. Health and safety risk assessments had been completed. For example, legionella, lone working, gas installation, portable appliance testing and emergency lighting. A fire drill was last completed at the Bakewell Practice on 22 May 2023. However, a fire drill had not been carried out at the Tideswell Practice since 24 March 2022. We found that there had been learning from them. The fire risk assessments had not been reviewed since 2018. We raised this with the provider. They told us that there had not been any changes in the building since the fire risk assessments were completed in 2018. They developed a monthly fire check list and forwarded this to us the day after our inspection. <p>However:</p> <ul style="list-style-type: none"> Risk assessments had not been completed for staff without a DBS check in place or for staff who had not received the required immunisations. The 5 year electrical installation condition reports from 2018 and 2017 for the practices were rated | |

unsatisfactory and also overdue. The provider could not provide evidence that the issues identified had been addressed. The provider arranged for the reports to be repeated immediately and told us they would complete action plans to address any issues identified.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

| | Y/N/Partial |
|--|-------------|
| Staff had received effective training on infection prevention and control. | Yes |
| Infection prevention and control audits were carried out. | Yes |
| Date of last infection prevention and control audit: Bakewell Practice: March 2023 Tideswell Practice: December 2022 | Yes |
| The practice had acted on any issues identified in infection prevention and control audits. | Yes |
| The arrangements for managing waste and clinical specimens kept people safe. | Yes |
| The practices were visibly clean and personal protective equipment was readily available. | |

Risks to patients

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

| | Y/N/Partial |
|---|-------------|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| There was an effective induction system for temporary staff tailored to their role. | Yes |
| The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures. | Yes |
| Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients. | Yes |
| There were enough staff to provide appointments and prevent staff from working excessive hours. | Yes |
| <ul style="list-style-type: none"> Basic life support training updates had been arranged for all staff to attend on either 13 or 25 September 2023. Reception staff we spoke with told us they had completed sepsis training and had been provided with information to support them in the recognition of the early signs of sepsis. Due to a recent high staff turnover, some staff had been required to work additional hours to meet the demand for appointments. We found that new staff had recently been recruited to address this issue and that there was an ongoing recruitment drive to cover any staff vacancies. | |

Information to deliver safe care and treatment

Staff had most 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. 1 | Partial |
| 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 |
| <p>Through our remote clinical searches of patients' records we found that medical history, examination and management plans were in place. However, follow ups and safety netting were not always documented within the patients' records. For example:</p> <ul style="list-style-type: none"> • Patients with asthma who had been prescribed 2 or more courses of rescue steroids following an exacerbation of their asthma had not always been issued with a steroid card. • We reviewed 5 records for patients prescribed a medicine used in the treatment of rheumatoid arthritis. We found that it was not always clear if the GP practice or secondary care were responsible for the blood test monitoring required for this medicine or, if the GP practice were checking the results of the blood tests before issuing the prescriptions. The provider informed us that they could not always download the hospital blood test results into the patients' records although they did always check them. Immediately after our inspection they informed us they had made changes to their practice and would record they had checked the results to provide an audit trail | |

Appropriate and safe use of medicines

The practice did not have systems for the appropriate and safe use of medicines, including medicines optimisation.

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

| Indicator | Practice | SICBL average | England | England comparison |
|--|----------|---------------|---------|--------------------------|
| Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA) | 0.91 | 0.89 | 0.91 | 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). (01/04/2022 to 31/03/2023) (NHSBSA) | 7.4% | 7.5% | 7.8% | 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 | 5.20 | 5.07 | 5.23 | No statistical variation |

| | | | | |
|--|--------|--------|--------|--------------------------|
| uncomplicated urinary tract infection (01/10/2022 to 31/03/2023) (NHSBSA) | | | | |
| Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA) | 134.3‰ | 157.0‰ | 129.9‰ | No statistical variation |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2022 to 31/03/2023) (NHSBSA) | 0.45 | 0.49 | 0.55 | No statistical variation |
| Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2022 to 31/03/2023) (NHSBSA) | 5.5‰ | 7.4‰ | 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 |
| 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 effective medicines reviews for patients on repeat medicines. | Partial |
| The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services. | Yes |
| There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. | Partial |
| The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England 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. | Yes |
| The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates. | Partial |
| There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use. | Yes |

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|--|-----------|
| <p>Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.</p> | <p>No</p> |
| <ul style="list-style-type: none"> • We spoke with the provider and a non-medical prescriber. They described the task system in place for the auditing of the prescribing of the non-medical prescribers and the system of clinical supervision. The non-medical prescriber told us that their prescribing was audited by a GP partner on a weekly basis, and they received feedback from this audit. Written documentation was not available to review. • The lead GP for the practice completed medicine management quality improvement checks once a week using a medication-based risk stratification tool designed to help identify patients who were likely to be put at risk of harm from their medication. • Pulse oximetry for children was not available at either practice. The day after our inspection the provider forwarded evidence to us that this emergency equipment had since been ordered. <p>However:</p> <ul style="list-style-type: none"> • All of the suggested emergency medicines were not available at the Bakewell Practice. We found that a medicine used for the treatment of croup in children was not available. A risk assessment had not been completed to mitigate potential risks. • We reviewed the vaccine fridge temperature checks at the Tideswell practice to ensure that medicines that required refrigeration were stored appropriately and monitored in line with the manufacturer's recommendations and the practice's cold chain policy. We found that between 26 June 2023 and 6 July 2023 the temperature of the vaccine fridge was below the manufacturer's minimum temperature of 2 degrees. The provider informed us that the fridge had not been in use those days due to an electrical problem and that they had moved the vaccines to the Bakewell practice for storage. They transferred the vaccines back to the branch practice as required for their immunisation clinics at The Tideswell Practice. We asked the provider to submit an audit trail, or other evidence, to support this to the CQC. They submitted evidence that a smart meter was fitted on one of these days however, there was no evidence or audit trail for the other days. There was no evidence that the failure of the fridge had been escalated to NHS England. There was no evidence that they had recorded the temperature of vaccines that were stored in a cool bag during transit, as clearly documented in their cold chain policy. The provider confirmed that they had not documented the temperatures. Following our inspection, the provider forwarded evidence to us that was not available on the day of our inspection. The provider had contacted the manufactures of the vaccines to obtained assurance that when the fridge temperature went outside of range, that the medicines were safe to use. • We found that temperature checks of the fridge used to store vaccines at the Tideswell Practice had not been recorded on the daily temperature checking log for 31 July – 9 August 2023, 9-20 June 2023, 6-17 May 2023 and 1-11 April 2023. We identified many other days when the temperature had not been recorded. When temperatures had been recorded, they had only been recorded once a day. The practice's cold chain policy stated they should be recorded twice daily on working days, at the start of each working day and at the end of the afternoon clinic. We asked the provider to explain why the temperatures had not been documented as per their cold chain policy however, they were unable to explain this. The provider had not been aware of the gaps in recording daily fridge temperatures until we highlighted this to them. The provider told us they would raise this as a significant event and introduce a system to monitor that fridge temperatures were documented on the temperature log sheet. We checked the 10 minute interval temperatures recorded on the fridge data logger and found that the fridge temperature had fallen below the manufacturer's recommended minimum temperature 119 times between the period of 9 to 20 June 2023. The provider had not taken any action to review, investigate or escalate this information. <p>Our clinical searches identified small numbers of patients that had not received the required blood test monitoring:</p> <ul style="list-style-type: none"> • Out of 40 patients prescribed a medicine used in the treatment of rheumatoid arthritis, 4 were not recorded as having received the required blood test monitoring within the last 6 months. We | |

reviewed the records of these 4 patients and found that it was not clear in their records who was responsible for the monitoring of these medicines. There was no evidence that the provider had checked the results of the blood tests before issuing the repeat prescriptions. The provider informed us that they did check the hospital system however, they had failed to document this in the patients' records. Immediately after our inspection the provider informed us that they had reviewed their systems and would always record in patients' notes that they had checked the blood results before issuing any further prescriptions.

- Out of 328 patients prescribed a medicine used to prevent blood clots, only 5 had not received the required blood test monitoring. We reviewed these 5 records and found that attempts to recall patients for their monitoring had been made.
- We found 2 patients with impaired kidney function and prescribed a medicine used in the treatment of diabetes had not received the required monitoring.

| 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 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 |
| Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Yes |
| Medicines stock was appropriately managed and disposed of, and staff kept appropriate records. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective. | Yes |
| If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines. | Yes |
| If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability. | 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 |
| <ul style="list-style-type: none"> • We found that a DBS check had been completed for the driver responsible for the medicine's delivery service. • Following a significant event regarding a dispensing error, the practice had changed their procedures to include a dispenser on the reception desk to reduce the number of interruptions and distractions within the dispensary. • There were clear and detailed standard operating procedures for each process in the dispensary. • The practice had recently completed a Dispensing Service Quality Scheme audit on oral anticoagulant | |

safety. All patients were stabilised and 100% had received monitoring that was within range.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

| Significant events | Y/N/Partial |
|---|-------------|
| The practice monitored and reviewed safety using information from a variety of sources. | Yes |
| Staff knew how to identify and report concerns, safety incidents and near misses. | Yes |
| There was a system for recording and acting on significant events. | Yes |
| Staff understood how to raise concerns and report incidents both internally and externally. | Yes |
| There was evidence of learning and dissemination of information. | Partial |
| Number of events recorded in last 12 months: | 24 |
| Number of events that required action: | 24 |
| <p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice told us that staff were encouraged to report incidents as part of a no-blame culture, with the emphasis being on learning from events that had not gone as planned. Significant events and near misses were reviewed and discussed with appropriate staff members. If necessary, procedural changes were implemented to reduce the risk of any similar occurrence in the future. Recently, the practice had changed how the outcomes from significant event reviews were made more accessible to the practice team. Details of any learning were kept in a designated folder in the practice software management programme, so that staff knew how to locate this information. The practice had recently signed up to the national Learn from Patient Safety Events (LFPSE) service led by NHS England and NHS Improvement. This gave access to advice and guidance as well as contributing to a national analysis of incidents to highlight any wider actions or learning that may need to be considered across primary care. Leaders and staff told us that learning from significant events was shared with them at team meetings and some staff gave us examples of this. Minutes from team meetings had not been kept to enable us to review this. <p>However:</p> <ul style="list-style-type: none"> Some of the significant event forms we reviewed lacked detail and it was not always clear what the learning of the incident was. Opportunities to raise significant events had been missed. For example, a significant event had not been raised when the temperature of a fridge used to store vaccines in had not been monitored in line with their cold chain policy. | |

Examples of significant events recorded and actions by the practice.

| Event | Specific action taken |
|---|---|
| A 2 week wait referral for potential cancer was not sent urgently leading to a 6 day delay. | An apology was given to the patient and an investigation into the delay was carried out. Learning from the investigation was to ensure that 2 week wait |

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|---|---|
| | referrals are marked as urgent and should always be sent directly to the practice secretaries and not as a task. This information was added into induction processes for new staff. |
| Violent and aggressive behaviour was displayed by an individual towards practice staff. | The police were called and intervened. The practice held a debrief with staff after the event to offer support and staff were reminded of the need to press the panic button when emergencies occurred. |

| Safety alerts | Y/N/Partial |
|--|-------------|
| There was a system for recording and acting on safety alerts. | Partial |
| Staff understood how to deal with alerts. | Yes |
| <ul style="list-style-type: none"> As part of our remote clinical searches, we looked at Medicines and Healthcare products Regulatory Agency (MHRA) alerts. We looked at a MHRA alert relating to a higher dose of a medicine used in the treatment of low mood in patients over 65 years of age. We found there was no record in the notes of 3 patients that they had been informed of the risks associated with the higher dose of this medicine. There was no evidence that patients had been offered alternative options such as reducing the dosage of the medicine or the offer of an electrocardiogram (ECG) to assess potential cardiac risks. | |

Effective

Rating: Requires Improvement

At our previous inspection in February 2020, we rate the practice as good for providing an effective service.

At this inspection we rated them as requires improvement because:

- We found 21 patients had a potentially missed diagnosis of diabetes. Of the 5 patients we randomly reviewed we found they had not been identified or recorded appropriately in their records. They had not always been reviewed in line with national guidance including consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long-term harm.
- Some staff had not received a timely appraisal.

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

Effective needs assessment, care and treatment

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

| | Y/N/Partial |
|--|-------------|
| The practice had systems and processes to keep clinicians up to date with current evidence-based practice. | 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. | Partial |
| We saw no evidence of discrimination when staff made care and treatment decisions. | Yes |
| Patients' treatment was regularly reviewed and updated. | Partial |
| There were appropriate referral pathways to make sure that patients' needs were addressed. | Yes |
| Patients were told when they needed to seek further help and what to do if their condition deteriorated. | Yes |
| The practice had prioritised care for their most clinically vulnerable patients during the pandemic. | Yes |
| The practice prioritised care for their most clinically vulnerable patients. | Yes |
| <ul style="list-style-type: none"> • We found that 21 patients had a potentially missed diagnosis of diabetes. Of the 5 patients we randomly reviewed we found they had not been identified or, potential diabetes recorded appropriately in their records. They had not always been reviewed in line with national guidance including consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long-term harm. We found that the blood glucose level for 1 of the patients was high in November 2022 and had risen to an extremely high level in July 2023. The provider told us they had contacted the patient to request they attend a review, however they had failed to attend the review. No further action had been taken by the provider. • All of the required blood test monitoring for patients with long-term conditions had not always been completed within a timely manner. | |

Effective care for the practice population

Findings

- Patients received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- The practice provided weekly ward rounds to 3 care homes with support available in-between. Additional visits were provided if required.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- 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. We spoke with representatives from 3 care homes where the practice provided end of life care. Two of the representatives were very positive about the end of life care provided and described it as excellent. However, the other representative told us they would value more direct input from a GP to meet the needs of this group of patients.
- The practice had a system for vaccinating patients with an underlying medical condition according

to the recommended schedule. The practice had led the vaccination programme during the Covid-19 pandemic for their own patients and patients within the local Primary Care Network.

- 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

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

There were systems in place for the management of people with long-term conditions. Our remote searches identified a small number of patients whose management required further review:

- Out of 1050 patients with asthma we found 61 of these patients had been prescribed 2 or more courses of rescue steroids. We reviewed the records of 2 of these patients and found that steroid cards had not been issued as required.
- We found that out of 31 patients with chronic kidney disease, stages 4 or 5, that 6 patients were not recorded as having received the required monitoring in the last 9 months. We reviewed the records of 2 of these patients and found that the monitoring was being completed in secondary care.
- Out of 348 patients with a diagnosis of hypothyroidism we found that 9 patients were not recorded as having received the required monitoring within the last 18 months. We reviewed the records of 2 of these patients and found 1 patient had been recalled in December 2022 but no further action had been taken and the other patient had been sent a text message in August 2023 to have their bloods repeated.
- Out of a total of 548 patients with diabetes we found 42 patients with diabetic retinopathy whose latest blood glucose results were above the recommended limit. We reviewed 3 of these patients and found that they had been appropriately managed.

| 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 | 57 | 60 | 95.0% | Met 95% WHO based target |

| | | | | |
|--|----|----|-------|--------------------------|
| influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | | | | |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 52 | 53 | 98.1% | 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) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 52 | 53 | 98.1% | Met 95% WHO based target |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 52 | 53 | 98.1% | Met 95% WHO based target |
| The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team) | 49 | 51 | 96.1% | 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 |
|--|
| <p>At our previous inspection on 7 February 2020:</p> <ul style="list-style-type: none"> We made the best practice recommendation to improve uptake rates for childhood immunisations. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> All 5 indicators for the uptake of childhood immunisations had met or exceeded the 95% WHO based target |

| Cancer Indicators | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------|
| Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA) | 73.1% | N/A | 62.3% | N/A |
| Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA) | 76.9% | N/A | 70.3% | N/A |
| 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). (31/12/2023) (UKHSA) | 77.8% | N/A | 80.0% | Below 80% target |

| | | | | |
|---|-------|-------|-------|--------------------------|
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (04/01/2021 to 03/31/2022) (UKHSA) | 57.7% | 51.6% | 54.9% | No statistical variation |
|---|-------|-------|-------|--------------------------|

Any additional evidence or comments

- The uptake rate for cervical screening was slightly below the national target of 80%. The practice told they had a high number of Travellers registered with the practice who moved around, and informed us that this potentially impacted on their uptake rates. The provider told us that they had a planned cervical screening clinic on Saturday 19 August 2023 to enable working age women to access cervical screening outside of normal working hours. They told us that appointments were also available at the Tuesday evening clinics when the practice was open until 8pm as part of the extended access service provided by the Primary Care Network.

Monitoring care and treatment

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

| | Y/N/Partial |
|---|-------------|
| Clinicians took part in national and local quality improvement initiatives. | Yes |
| The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements. | Partial |
| The practice regularly reviewed unplanned admissions and readmissions and took appropriate action. | Yes |
| <ul style="list-style-type: none"> One of the GP partners was the clinical lead for end of life care for East Midlands. They led a regional quality improvement to drive changes to end of life care in the Midlands region through the development of the Midlands One Care Plan. This end of life care plan will be a unified plan across the whole of the Midlands and available on the NHS app for patients to download and share with care staff. The practice's community matron followed up older patients discharged from hospital. As part of a hospital avoidance strategy the matron made referrals to other services, for example district nurses and social prescribers, or signposted patients to support services. This group of patients were discussed at weekly multiple-disciplinary meetings if they required additional support. <p>However:</p> <ul style="list-style-type: none"> The effectiveness of recommendations made in clinical audits had not always been reviewed to promote quality improvement. | |

Any additional evidence or comments

The practice provided us with 3 clinical audits undertaken in the last 12 months. These identified recommendations to address the shortfalls identified in adhering to quality standards. For example:

- An audit had been completed of patients prescribed medicines for depression that had received follow up consultations. The audit identified that 13 out of 46 patients (28%) were followed up within the recommended 2 weeks after starting the medicines and 1 patient was referred for a psychiatric assessment. Four of the patients were less than 25 years old and had not received the recommended

follow up of 1 week after commencement of the medicine. Of the 46 patients, 22 had no documentation of suicide risk as recommended in National Institute for Health and Care Excellence guidance. Recommendations were made. For example, the use of an IT system to send text reminders to patients to book their follow up appointments and the use of a template to ensure that patients were asked the appropriate questions. However, a second cycle had not been completed to demonstrate that suggested changes had positively impacted on patient care.

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. | Partial |
| The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates. | Yes |
| There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable. | Yes |
| <ul style="list-style-type: none"> Staff told us they had protected time to complete their mandatory training and if they completed it at home in their own time they were given time off in lieu. Most staff were up to date with the practice's mandatory training schedule. Not all staff had received a recent appraisal. We reviewed the files of 4 members of staff and found that 3 members of staff had not received a formal appraisal. The provider showed us an email to demonstrate that 1 of the staff had received a review of their role and responsibilities however, it was not recorded in line with their appraisal system. We reviewed the 10 staff questionnaires we had received as part of our inspection process. Eight of the members of staff told us they had regular appraisals and 2 told us they had not had a recent appraisal. However, 1 member of staff had only recently started to work at the practice and the other member of staff was unclear what the question meant. | |

Coordinating care and treatment

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

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

| | |
|--|-----|
| Patients received consistent, coordinated, person-centred care when they moved between services. | Yes |
|--|-----|

Helping patients to live healthier lives

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

| | Y/N/Partial |
|---|-------------|
| The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. | Yes |
| Staff encouraged and supported patients to be involved in monitoring and managing their own health. | Yes |
| Patients had access to appropriate health assessments and checks. | Yes |
| Staff discussed changes to care or treatment with patients and their carers as necessary. | Yes |
| The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity. | Yes |
| <ul style="list-style-type: none"> Patient feedback to the CQC and feedback from 2 out of 3 care homes, where the practice provided care and treatment, was extremely positive about the end of life care provided to this group of patients. Feedback demonstrated that the practice went over and above to provide this care. For example, providing regular telephone support and support to family members following the death of a patient. One care home was less satisfied with the service provided stating they needed more input from the GPs at the practice. | |

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 |

- We spoke with representatives from 3 care homes where the practice provided care and treatment. They told us that DNACPR decisions and care plans were updated as required.
- From our clinical review of notes where a DNACPR decision had been recorded, we found that where possible the patients' views had been sought and respected and that information had been shared with relevant agencies.

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 | There was 1 positive comment on the website regarding the care provided by the advanced nurse practitioner. |
| Four complaints were received by the CQC prior to our inspection | One complaint related to the failure to provide appropriate care to a patient in a care home. One complaint related to lack of respect to older patients and rude non-clinical staff. Two complaints related to poor care provided by 2 clinicians. |
| One positive comment was received by the CQC prior to our inspection | The compliment related to the exemplary end of life care provided to a patient. The patient described how caring the 2 GP partners had been to the deceased family describing how the support they had received went over and above what they had expected. They described all the staff as kind, professional, compassionate and committed to giving the best care |
| As part of our inspection, we asked the provider to encourage patients to share their experience of the practice with the CQC via an electronic link on their website. We received 12 replies regarding care and treatment. | We received 11 positive comments from patients regarding care and treatment. Patients told us that staff were very supportive, approachable, professional, caring and amazing. Patients gave us examples of when the practice went over and above to support them. For example, regular phone calls to patients following road traffic accidents to support patients with both their physical and mental well-being. Patients described the service as excellent and outstanding and told us they would definitely recommend the practice to others. We received 1 negative comment regarding lack of care in managing the pain of an older patient. |
| Representatives of 3 care | The representatives described the clinicians that attended the care home as |

| | |
|---|--|
| homes where the practice provided care and treatment. | supportive, caring and knowledgeable. They told us they were highly respectful and sensitive to the needs of patients and there was good liaison with relatives as and when required. One representative told us the practice was very person-centred and described the care provided as excellent, kind and thoughtful. |
|---|--|

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022) | 90.9% | 86.2% | 85% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022) | 90.5% | 85.3% | 83.8% | No statistical variation |
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022) | 95.5% | 93.7% | 93.0% | No statistical variation |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022) | 77.0% | 71.4% | 71.3% | No statistical variation |

Any additional evidence or comments

The 4 national GP patient survey indicators for patient satisfaction with care were in line with local and national averages.

| | Y/N |
|---|---------|
| The practice carries out its own patient survey/patient feedback exercises. | Partial |

Any additional evidence

The practice had not carried out a recent patient survey however, the provider had reviewed the responses from the National GP Patient Survey and identified where they were performing well and where they needed to make improvements. They had reviewed the trends in complaints from the previous year and identified that the most common complaint related to their telephone system. After further investigation they identified the problem and purchased a new telephone system to improve telephone access for patients.

Involvement in decisions about care and treatment

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

| | Y/N/Partial |
|--|-------------|
| Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given. | Yes |
| Staff helped patients and their carers find further information and access community and advocacy services. | Yes |
| <ul style="list-style-type: none"> • Easy read and pictorial materials were available for patients with a learning disability who attended the practice for cervical screening. • One of the GPs at the practice was involved with a local charity called Jigsaw which offered support through food banks, debt management and clothing. Details were displayed in the waiting room which signposted patients to this service. | |

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|-------------|---------------|---------|--------------------------------------|
| The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023) | 96.4% | 91.3% | 90.3% | Tending towards variation (positive) |
| Any additional evidence or comments | | | | |
| The national GP patient survey indicator regarding involvement in decisions about care and treatment was above local and national averages. | | | | |
| | Y/N/Partial | | | |
| Interpretation services were available for patients who did not have English as a first language. | Yes | | | |
| Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations. | Yes | | | |
| Information leaflets were available in other languages and in easy read format. | Yes | | | |
| Information about support groups was available on the practice website. | Yes | | | |
| <ul style="list-style-type: none"> • Staff had access to a translation service for patients whose first language was not English. • There was information in the waiting room which signposted patients and their carers to support for people with dementia. | | | | |

| Carers | Narrative |
|--------|-----------|
|--------|-----------|

| | |
|---|---|
| Percentage and number of carers identified. | The practice had identified 487 carers (5.5% of the practice population) of which 468 (5.3%) were informal carers and 83 (0.9%) were occupational carers. |
| How the practice supported carers (including young carers). | The practice's website signposted carers to support available within Derbyshire. The practice was in the process of reinstating their carer's café to provide support and information to carers. They had also recruited a health and wellbeing coach and were working with the Alzheimer's Society to come into the surgery a day a week to undertake reviews and support. One of the GPs provided carers with their personal mobile number when their relative was very near to the end of their life to provide support at this difficult time. |
| How the practice supported recently bereaved patients. | The practice sent bereavement cards expressing their condolences, which contained details of what to do, when someone died. The GPs also called relatives to express their condolences and support. We received several comments from patients regarding the follow up care they had received following the death of a loved one. They described it as over and beyond the care they had expected to receive. |

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 previous inspection in February 2020, we rated the practice as outstanding for providing responsive services because:

- The practice could demonstrate how the needs of families, children and younger people, and those
- whose circumstances made them vulnerable, were paramount to how they adapted service delivery
- and fulfilled the needs of these population groups.

At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. Whilst the provider had maintained this good practice, the threshold to achieve an outstanding rating had not been reached. The practice is now rated good for providing a responsive service.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

| | Y/N/Partial |
|--|-------------|
| | |

| | |
|---|-----|
| The practice understood the needs of its local population and had developed services in response to those needs. | Yes |
| The importance of flexibility, informed choice and continuity of care was reflected in the services provided. | Yes |
| The facilities and premises were appropriate for the services being delivered. | Yes |
| The practice made reasonable adjustments when patients found it hard to access services. | Yes |
| There were arrangements in place for people who need translation services. | Yes |
| The practice complied with the Accessible Information Standard. | Yes |
| <ul style="list-style-type: none"> • The practice had identified that their practice population had a higher percentage of older patients when compared to local and national averages. In response to this they had recruited a well-being worker to review and support patients with dementia. The first clinic was arranged for 22 August 2023. • The practice worked with Citizens Advice Derbyshire to provide support such as benefits and tax credits advise, debt and employment support. The service had supported 165 patients throughout 2022 -2023. • The practice was in the process of establishing a drop in clinic to support young adults going through the process of gender transition. • One of the GP partners was the clinical lead for end of life care for East Midlands. They had used their experiences of providing end of life care within the practice to drive changes in the Midlands region by leading on the development of the Midlands One Care Plan. This end of life care plan would be a unified plan across the whole of the Midlands and available on the NHS app for patients to download and share with care staff. | |

| Practice Opening Times | |
|---|---------------|
| Day | Time |
| Opening times at Bakewell Medical Centre | |
| Monday | 8am - 6.30 pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am – 6.30pm |
| Appointments available at Tideswell Surgery | |
| Monday | 8am – 6.30pm |
| Tuesday | 8am – 6.30pm |
| Wednesday | 8am – 6.30pm |
| Thursday | 8am – 6.30pm |
| Friday | 8am – 6.30pm |

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.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary. We received feedback from parents which confirmed this.
- The Bakewell Practice was open until 8pm on Tuesdays and every fifth Saturday between 9am – 5pm as part of the extended access service. One of the GPs provided a long-acting reversible contraception clinic on Saturday mornings.
- 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 supported to register with the practice, including those with no fixed abode such as homeless people and Travellers. One of the GP partners was a trustee of a charity which supported people who required housing.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

| | Y/N/Partial |
|---|-------------|
| Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice. | Yes |
| The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online). | Yes |
| Patients were able to make appointments in a way which met their needs. | Yes |
| There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded). | Yes |
| Patients with most urgent needs had their care and treatment prioritised. | Yes |
| There was information available for patients to support them to understand how to access services (including on websites and telephone messages). | Yes |
| <ul style="list-style-type: none"> • The practice worked with other practices with the Primary Care Network to provide an extended access service. • The provider had discussed their response to the NHS Delivery Plan for Recovering Access to Primary Care with call handlers and appointment types were re-allocated to meet the requirements of the plan. Staff were aware that patients could not be asked to call back another day and the action they needed take to meet this. | |

National GP Patient Survey results

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

| Indicator | Practice | SICBL average | England | England comparison |
|---|----------|---------------|---------|--------------------------|
| The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2023 to 30/04/2023) | 70.2% | N/A | 49.6% | Variation (positive) |
| The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023) | 63.8% | 52.4% | 54.4% | No statistical variation |
| The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023) | 59.1% | 51.5% | 52.8% | No statistical variation |
| The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023) | 79.9% | 72.9% | 72.0% | No statistical variation |

Any additional evidence or comments

- Indicators from the national patient survey demonstrated that patient satisfaction with access to appointments was in line with or above local and national averages.
- Unverified data received from the Integrated Care Board (ICB) showed that patient attendance to the A&E department and the Minor Injuries Unit (MIU) was higher than average with the practice having 12th and 4th highest attendance respectively. However, this has been an historic trend due to the close proximity of the patient population to the A&E and MIU.
- Unverified data received from the ICB showed that appointment indicators for the practice in February 2023 were mostly in line with national and local indicators. However, we found that the percentage of appointments offered within 14 days of booking was 97% which was above the local average of 79% and the national average of 85%.
- We reviewed the practice's appointment system and found that the next available appointment with an advanced nurse practitioner was the following day. The next pre-bookable appointment with a GP was in 2 weeks' time however, urgent on the day appointments were available the following day. Appointments were also available through the extended access service.
- The practice had recently installed a new telephone system to support patient telephone access to the practice.

| Source | Feedback |
|---------------------------------------|--|
| NHS.uk website (formerly NHS Choices) | There were 2 negative comments regarding poor access to appointments on the website. |

| | |
|---|--|
| As part of our inspection, we asked the provider to encourage patients to share their experience of the practice with the CQC via an electronic link on their website. We received 11 replies regarding access to appointments. | We received 9 positive comments and 2 negative comments about access to appointments. Most patients told us there was very good access to appointments especially for children and prompt action was taken when required. Patients told us that if they had a problem they were seen in a timely fashion, dependent upon the severity of the concern. Several patients told us that they had received follow up calls from the GPs to check on their ongoing needs. Patients valued information links that were sent to them to understand their condition and information self-refer links to access other services for support. One negative comment related to poor telephone access and the other to the lack of continuity in seeing the same GP. |
| Representatives of 3 care homes where the practice provided care and treatment. | Representatives from 2 out of the 3 care homes we spoke with were very positive about how the practice responded to the needs of their patients through weekly ward rounds and home visits. However, another representative expressed concern regarding the timeliness of the issuing of medicines for their patients. The care home had attended a meeting with the practice to discuss their concerns however issues with obtaining medicines within a timely manner had continued. They also told us that there was a bypass telephone number the care home could call to gain quicker access to the practice and a visiting community geriatrician service at the practice. However, this information had not been shared in a timely manner with the care home. |

Listening and learning from concerns and complaints

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

| Complaints | |
|--|----|
| Number of complaints received in the last year. | 34 |
| Number of complaints we examined. | 8 |
| Number of complaints we examined that were satisfactorily handled in a timely way. | 6 |
| 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>At our previous inspection on 7 February 2020, we made the best practice recommendation:</p> <ul style="list-style-type: none"> The practice should improve the process for responding to official complaints. This included revising some of the content in both acknowledging the complaint initially, and within the final response letter. <p>At this inspection we found that:</p> <ul style="list-style-type: none"> There was a process in place for receiving and responding to complaints however, the practice's complaint policy was not always adhered to. We examined 8 complaints and found that 6 had been satisfactorily handled in a timely manner. However, 2 complaints had not received a response and we found that complainants had to contact the practice a second time before they received a response. Acknowledgement letters were not always sent to complainants and some did not | |

| | |
|---|--|
| have a final response letter following an investigation of their complaint. | |
|---|--|

Example of learning from complaints.

| Complaint | Specific action taken |
|--|---|
| A patient had not been informed of an abnormal blood result. | An apology was given to the patient and staff were advised where to look for bloods on the practice's IT system. It was decided to develop a flow chart to support staff in this process. |

Well-led

Rating: Requires Improvement

At our previous inspection in February 2020, we rated the practice as outstanding for providing a well-led service because:

- There was evidence of proactive, effective and strong leadership. There were systems in place to drive internal improvements, quality initiatives, innovation and a commitment to engage with others and share best practice.

At this inspection, we found that those areas previously regarded as outstanding practice were now embedded throughout the majority of GP practices. The threshold to achieve an outstanding rating had not been reached. The practice is now rated as requires improvement for providing a well-led service because:

- There were governance systems in place however, they did not always work effectively. Policies were not always updated in a timely manner. Policies were not always adhered to in particular, responding to complaints, cold chain management and recruitment of staff.
- Opportunities to complete risk assessments had been missed.
- It was not always clearly documented what the learning from significant events and complaints was or how it was shared with staff to drive improvements. Opportunities to raise significant events had been missed.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at most levels.

| | Y/N/Partial |
|---|-------------|
| Leaders demonstrated that they understood the challenges to quality and sustainability. | Yes |
| They had identified the actions necessary to address these challenges. | Yes |
| Staff reported that leaders were visible and approachable. | Yes |
| There was a leadership development programme, including a succession plan. | Yes |
| <ul style="list-style-type: none"> • Leaders told us that due to 2 GP partners leaving, a high staff turnover and changes made to their IT system that this had presented as a significant challenge to the practice. We found that systems had been put in place to recruit new staff to fill the vacant roles and some staff told us they had received | |

training on the new IT systems at a nearby GP practice.

- Since our previous inspection in early 2020, the practice had formally taken over Tideswell Surgery which had previously been registered as a separate location with the CQC. This had created some difficulties due to different systems and ways of working which had to be unified, and this had taken some time to resolve. Tideswell Surgery was now a branch site.
- Leaders had identified that there was a high number of older patients registered with the practice in comparison to local and national averages. There was also a high number of patients from the farming community and travelling community.
- Most staff told us that managers and the GPs were approachable, and they had an open-door policy. Staff told us that they felt confident they could approach leaders without fear of retribution and that their concerns would be listened to and acted on.

Vision and strategy

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

| | Y/N/Partial |
|---|-------------|
| The vision, values and strategy were developed in collaboration with staff, patients and external partners. | Partial |
| 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 |
| <ul style="list-style-type: none"> • From staff interviews and feedback we received from staff questionnaires we found that most staff were aware of the practice's vision however, they had not been involved in the development of the vision or strategy. | |

Culture

The practice had a culture which mostly 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. | Partial |
| The practice encouraged candour, openness and honesty. | Yes |
| The practice had access to a Freedom to Speak Up Guardian. | Yes |
| Staff had undertaken equality and diversity training. | Yes |
| <ul style="list-style-type: none"> • There was a Freedom to Speak Up Guardian however, some new members of staff were not aware of | |

who this was.

- Fifteen minute well-being breaks, which could be taken at any time, had been introduced to support staff well-being. Staff had access to a well-being App and counselling through a private health care company.
- The provider had carried out a staff questionnaire in August 2021, the results were mainly positive. Changes were made as a result of the feedback from the questionnaire. For example, staff were provided with clearer guidance about staff roles and leads within the practice. The provider told us they planned to repeat the staff questionnaire to monitor that the changes made had been effective.

However:

- It was not always clear what the learning from a complaint had been. Minutes of staff meetings had not been recorded so we were unable to assess if learning was shared with staff. There was a mixed response from staff about the sharing of learning from complaints. Half of the staff we received feedback from or we interviewed told us they were informed of learning from complaints and half told us they were not. The managers told us that there had been an issue with the handling of complaints because they had been going to various staff within the practice rather than a dedicated person. They told us they had recently found 2 complaints in an office drawer and they were unsure if they had been responded to or investigated. They told us staff had been made aware of who the dedicated person was and that all complaints should go to them.

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

| Source | Feedback |
|---|--|
| We interviewed 9 members of staff and received 10 staff feedback questionnaires | Most staff told us there was an open and supportive culture within the practice. They told us the work atmosphere was friendly and staff were approachable. A small number of staff told us that the work environment was stressful. |

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. | Yes |
| There were appropriate governance arrangements with third parties. | Yes |
| There are recovery plans in place to manage backlogs of activity and delays to treatment. | Yes |
| There were governance systems in place however, they did not always work effectively. The provider told us that there had been several management changes within the last few years and a high staff turnover which had sometimes impacted on the efficiency of their governance systems. <ul style="list-style-type: none"> • The overarching process for reviewing policies was not always effective. We found that policies had not always been updated or did not include the required information. For example, the policy for safeguarding children contained read codes for the practice's previous IT system, it had not been updated to include read codes for the new IT system which was introduced in January 2023; the | |

recruitment policy made no reference of the need to complete Disclosure and Barring Service (DBS) checks prior to staff starting to work at the practice or reference for the need to check for gaps in employment histories. The provider informed us they would update the policies.

- The practice had not followed their own policy for monitoring and acting on any potential breaches of the cold chain when storing and transporting vaccines. Vaccine fridge temperature checks were not always recorded in line with their cold chain policy which stated temperature checks should be recorded twice daily. We found that temperatures were recorded once daily or not at all. When transporting vaccines from one practice to another, monitoring of the temperature of the cool bag had not been recorded in line with the practice’s cold chain policy. Systems for reviewing and analysing information recorded on the data logger were not in place meaning breaches in the cold chain had not been identified, analysed, investigated or acted on.
- Overall governance systems and processes to securely maintain the required records relating to staff working in the practice were chaotic and ineffective. We reviewed 4 staff files and found that some of the required recruitment information was not available. Following our inspection, the provider informed us that they had found some of the missing information stored in other places within the practice or had obtained verbal confirmation. However, verbal information had not been documented or recorded in staff files. The managers had introduced a system to identify what information was missing and what they needed to do to address it.
- Systems to act on unsatisfactory findings in the 5 year electrical installation condition reports were not in place.
- Systems and policies to acknowledge and respond to complaints were not always adhered to. We found that complaints had not always been received by the designated complaints lead so it was unclear if they had been responded to. The provider told us they had made all staff aware of who complaints should be sent to.

Managing risks, issues and performance

There were some processes for managing risks, issues and performance however they were not always effective.

| | 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. | 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. | Yes |
| <ul style="list-style-type: none"> • There was a business continuity plan in place to manage any major disruptions to the service provided. For example, loss of domestic services, loss of IT, flood or cyber-attack. We found that the practice had instigated this plan following 2 large scale outages of their clinical system when clinicians • were unable to view the timings of patient appointments. We found that the system used to support clinicians in these exceptional circumstances had been risk assessed to ensure continuation of safe patient care. • We found that the practice maintained a risk log and that this was actively reviewed. <p>However, the provider had failed to identify or risk assess several potential risks. For example, risk</p> | |

assessments to mitigate potential risks had not been completed for:

- Staff working in the practice who did not have a DBS check in place.
- The frequency in which DBS checks should be renewed.
- Staff who had not received all of the required staff immunisations or, clinical staff who had not achieved immunity to hepatitis B.
- Suggested emergency medicines not held at the Bakewell Practice.

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 |
| <ul style="list-style-type: none"> • The provider had submitted statutory notifications to the CQC when it was appropriate to do so. | |

Governance and oversight of remote services

| | Y/N/Partial |
|--|-------------|
| The practice used digital services securely and effectively and conformed to relevant digital and information security standards. | Yes |
| The provider was registered as a data controller with the Information Commissioner’s Office. | Yes |
| Patient records were held in line with guidance and requirements. | Yes |
| Patients were informed and consent obtained if interactions were recorded. | Yes |
| The practice ensured patients were informed how their records were stored and managed. | Yes |
| Patients were made aware of the information sharing protocol before online services were delivered. | Yes |
| The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services. | Yes |
| Online consultations took place in appropriate environments to ensure confidentiality. | Yes |
| The practice advised patients on how to protect their online information. | Yes |
| Staff are supported to work remotely where applicable. | Yes |
| <ul style="list-style-type: none"> • All staff had signed confidentiality agreements and practice computers and laptops were encrypted. | |

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 (PPG). | Partial |
| 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 |
| <ul style="list-style-type: none"> The provider had not carried out a recent patient survey however, they had reviewed the findings of the latest national GP survey. They had responded to previous patient complaints regarding telephone access to the practice and purchased a new telephone system to address the concerns. The practice was in the process of re-establishing their PPG meetings. | |

Feedback from Patient Participation Group.

| Feedback |
|--|
| <p>We spoke with the nominated chair of the PPG. The PPG had disbanded during the Covid-19 pandemic. Prior to this, the PPGs from Bakewell and Tideswell had combined into a unified PPG and met with the practice management on a quarterly basis. Meetings had been attempted by the use of online video conferencing during the pandemic, but these had stopped taking place some time ago. A former chair of the PPG had been approached by the practice recently to help relaunch the group, and the practice was in the process of trying to recruit members, with information being available on the practice website.</p> <p>The former PPG had felt valued and had influenced some changes in the practice and assisted the practice with flu clinics and patient surveys. They had also agreed with the practice to display information on missed appointments in the waiting area, and this had a positive impact on the did not attend (DNA) rates.</p> <p>With the planned PPG relaunch, it was felt that there needed to be a strong focus on communication as this had been problematic recently. For example, changes to the process for repeat prescriptions could have been smoother with more effective communication to both patients and administrative staff. The demographics of the practice patient population was not always conducive to receiving messages by text, email or social media platforms. It had been suggested that communication with patients would be more effective if there was greater engagement with local community services, for example charities and the local church, and the use of the local newspaper.</p> <p>There was a strong sense of commitment from the PPG representative to re-establish the PPG and work in support of the practice as a critical friend.</p> |

Continuous improvement and innovation

There were some 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 |
| <ul style="list-style-type: none"> There were systems in place to manage significant events and complaints however it was not always clearly documented what the learning was or how it was shared with staff to drive improvements. | |

Examples of continuous learning and improvement

- The practice had completed clinical audits to drive improvements however, a second audit cycle had not always been completed to demonstrate that the improvements made had been effective.
- A GP partner from the practice was driving changes in end of life care throughout the Midlands regions through the development of the NHS One Care Plan which patients will be able to access through the NHS app.
- Throughout the Covid-19 pandemic, the provider had led the vaccination programme and Covid assessment clinics for the local Primary Care Network.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.