

Inspection Evidence Table

Old Station Surgery

(1-548015749)

Inspection Date: 14 November 2023

Date of data download: 31/10/2023

Overall rating: Requires improvement

At our previous comprehensive inspection in October 2015, we rated the practice as good in the effective, caring, responsive and well-led questions, and as good overall. However, we rated the practice as requires improvement in safe due to the absence of Legionella risk assessments. A desk top review was completed in July 2016, when we determined that the risk assessments had been completed and were being acted upon, so we therefore rated the practice as good in safe.

At this inspection in November 2023, the practice was rated as requires improvement overall. The key questions of safe, effective, responsive and well-led were rated as requires improvement which led to an overall rating of requires improvement. The practice was rated as good for providing caring services.

Context

The provider is registered with the Care Quality Commission (CQC) as a partnership to deliver the regulated activities, diagnostic and screening procedures, maternity and midwifery services, family planning, surgical procedures, and treatment of disease, disorder or injury.

Old Station Surgery delivers primary care services from a practice located near to Ilkeston town centre. There are 2 branch sites situated in Kirk Hallam and Cotmanhay. The practice is part of the Erewash Primary Care Network (PCN), a wider network of 10 GP practices that work collaboratively to deliver primary care services.

The practice is situated within the Joined-Up Care Derbyshire Integrated Care System (ICS) and delivers primary care services to a patient population of approximately 15,150 people.

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the 4th decile (4 out of 10). The lower the decile, the more deprived the practice population is relative to others. However, Cotmanhay is listed as the most deprived area in Derbyshire.

According to the latest available data, the ethnic make-up of the practice area is predominantly white at 98.2% of the registered patients, with estimates of 0.6% Asian, 0.2% Black, 0.9% mixed, and 0.1% other.

The clinical team consists of 5 GP partners and 1 senior clinical pharmacist partner, 3 salaried GPs, a clinical pharmacist and pharmacy technician, 3 advanced nurse practitioners, 5 practice nurses (1 of whom is a nurse prescriber), a nurse associate, 2 GP assistants, 1 healthcare assistant and 2 phlebotomists.

The clinical staff are supported by a business practice manager, an operations manager, a finance officer, and a team of 22 reception and administration staff.

At the time of our inspection, the practice was experiencing pressures in line with many other GP surgeries and recognised that telephone access was a significant issue for them. There had been a recent focus on recruitment and a management restructure, and this had impacted on a number of processes which the practice was aware would need greater emphasis to improve and become fully productive. They were also aware of the challenges of working across 3 sites and the need to re-establish a functional patient participation group to help champion the patient voice. Their active engagement within NHS England's GP Improvement Programme was helping the practice to plan for future sustainable improvements.

Safe

Rating: Requires improvement

At our initial comprehensive inspection in 2015, we rated the practices as requires improvement for providing safe services due to the absence of Legionella risk assessments previous focused inspection in July 2016, we rated the practice as good for providing safe services. However, the rating was changed to good further to a follow up review undertaken in 2016.

At this inspection in November 2023, we rated the practice as requires improvement for providing safe services. This was because:

- Some minor amendments were required to safeguarding policies.
- Evidence of safe recruitment information was not available for a regular GP locum. Staff immunisation status was incomplete.
- Infection prevention and control audits did not demonstrate that all issues had been acted upon, or that this was done in a timely fashion.
- Not all staff had evidence of having completed mandatory training modules.
- We identified some issues relating to safe medicines management including the use of Patient Group Directions (PGDs) and the monitoring of vaccine refrigerators.
- Some significant events required more analysis to determine root causes. Learning points needed to be shared more widely with the team and followed-up to ensure they had been effectively addressed.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y

Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Further to a proposal from the practice's GP child safeguarding lead, the Primary Care Network (PCN) had developed an initiative to appoint 2 safeguarding children care co-ordinators working across their practices. The role was introduced in November 2023 and the coordinators would offer administrative support, for example, in taking meeting minutes and cleansing registers, and also to liaise with other providers and agencies, such as social care, to monitor cases on an ongoing basis. • The child safeguarding lead GP met with the health visitor to review safeguarding concerns. Others were invited including the midwife, the local council's early help advisor, and school nurses. However, it was difficult to engage others due to their work commitments and as such the meetings mostly focused on the GP and health visitor. The GP was able to discuss any safeguarding concerns on an ongoing basis with other health professionals by using the messaging system on the practice computer. • Adult safeguarding meetings took place approximately every 6 weeks. The practice adult safeguarding lead GP met with external representatives including district nursing, social work, mental health and the care coordinator. • We reviewed the practice's safeguarding policies. The child safeguarding policy did not specify the levels of training required for clinical and non-clinical staff. Issues such as county lines and forced marriage were not identified within safeguarding policies. There was a reference to a Female Genital Mutilation (FGM) flowchart in the child safeguarding policy. • Training records indicated that 2 members of the practice team were not up to date with adult safeguarding training. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We reviewed a random sample of staff records and found that evidence of a process in place to ensure safe recruitment. However, we reviewed documentation for 2 regular locum GPs whose input had been arranged directly by the practice, rather than through an agency. We saw that there was limited evidence of safe recruitment for 1 of these GPs. • We undertook a random sample of records to review staff vaccination status. These were not available in 2 of the 6 records we reviewed. Following the inspection, the provider sent us a risk assessment which they had put in place for 1 clinical staff member immediately after our inspection, identifying which duties could continue safely supported by control measures, and other duties which were temporarily suspended pending the immunisation results being received from occupational health. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 10 April 2023 (Old Station Surgery and Cotmanhay); 12 June 2023 (Kirk Hallam branch)	Y
There was a fire procedure.	Y
Date of fire risk assessment: 7 September 2023 (main site and both branches)	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We reviewed the fire risk assessments undertaken across the main and branch sites in September 2023. This included a number of significant findings and high-risk issues which needs urgent (immediate action) or prompt action (within 1 month). On the day of our inspection, we saw that remedial work and actions were in place, or had already been completed, to address these findings. The provider carried out its own health and safety checks (including fire checks) every 6 months. Electrical and clinical equipment was regularly checked to ensure it was safe and worked accurately. Portable Appliance Testing (PAT) to ensure electrical equipment was safe was last completed in January 2023. Clinical equipment was last calibrated to ensure it worked correctly and gave accurate readings in January 2023. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were mostly met.

		Y/N/Partial
Staff had received effective training on infection prevention and control.		Partial
Infection prevention and control audits were carried out.		Y
Date of last infection prevention and control audit: August 2023 - Old Station Surgery (August 2023); Kirk Hallam (16 June 2023); Cotmanhay (14 June 2023)		N/A
The practice had acted on any issues identified in infection prevention and control audits.		N
The arrangements for managing waste and clinical specimens kept people safe.		Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Training records showed that 5 staff had not completed, or were overdue, infection prevention and control training. 		

	<ul style="list-style-type: none"> • We saw that infection control audits were completed. The main site had most recently received a thorough audit by the local area infection prevention and control team, whilst the branch sites had been completed by the GP assistants with oversight from the practice infection prevention and control lead. We saw that some sections of the audit had not been completed. • We saw limited evidence of action plans for 2 of these audits which addressed all the findings and specified leads and timescales for actions to be completed. The audit for the Cotmanhay branch which was undertaken in June 2023 was still in draft form and had been passed to the practice manager for review in November 2023. • There was a practice infection prevention and control policy. Some minor updates were required which the practice rectified after our inspection. • We identified a small number of infection prevention and control issues during our inspection. <ul style="list-style-type: none"> ➤ In the clinical waste area, we checked 4 sharp boxes which were awaiting collection by the waste contractor, 3 of which were not closed or signed. This was corrected at the time by a member of staff. ➤ Mops were stored incorrectly in the cleaning cupboard with mop stored with the head on the floor. Additionally, we saw some used single gloves that had not been disposed of. • A new lead for infection prevention and control had been appointed recently and we observed that this was helping to improve the overall approach to the management of infection and prevention control. • Legionella risk assessments were completed every 5 years, and the last reports available were for 2019. The previous assessment had highlighted a number of issues which led to the practice implementing a regular monitoring regime with an external contractor across all 3 sites.
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Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
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.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours.	Y

Explanation of any answers and additional evidence:

- Rotas were arranged to usually ensure a minimum of 3 GPs on duty at the main site, and 1 at each branch site Monday to Friday. The advanced nurse practitioners also provided on-the-day appointments.
- As most staff rotated across all 3 sites, individuals could be moved from one site to another subject to need, and the practice also utilised locum advanced nurse practitioners and GPs when needed.
- Regular GP locums were used. The practice told us that on average 2 locums were used each week. A new salaried GP was due to start in January 2024 and the practice were trying to recruit an additional advanced nurse practitioner. This would help reduce locum cover and provide a more stable workforce in the future.
- Feedback from staff questionnaires indicated that staff felt there were sufficient staff numbers to provide for staff absences and busy periods.
- Not all staff had completed sepsis training appropriate to their roles.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results, and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y

Explanation of any answers and additional evidence:

- Our review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.
- There was a backlog of just over 1,000 patients notes that required summarising. However, the patients' notes were stored alphabetically and were easily accessible in the rare event that they were required. The practice had staff appropriately trained in coding and summarising and a plan had been put in place to address the backlog.
- As part of our remote searches, we observed that the oversight of incoming pathology results was effectively managed with no results dating back more than 1 working day. There was a failsafe process in place to ensure all cervical cytology samples sent for analysis were checked to make sure that results were received.

- We saw that incoming correspondence was mostly dealt with in a timely manner. We saw that there had been a slight backlog recently, but this was explained as being a consequence of GP sickness.

Appropriate and safe use of medicines

The practice did not always 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) (01/07/2022 to 30/06/2023) (NHSBSA)	0.83	0.88	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). (01/07/2022 to 30/06/2023) (NHSBSA)	10.4%	7.6%	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 uncomplicated urinary tract infection (01/01/2023 to 30/06/2023) (NHSBSA)	4.57	5.07	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	176.4‰	157.6‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.61	0.48	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	10.8‰	7.4‰	6.8‰	Tending towards variation (negative)

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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y

Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	N
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.	N
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Y
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.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (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).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ul style="list-style-type: none"> • Our remote review of patients' clinical records undertaken by our GP specialist advisor showed that patients' prescribed medicines that required monitoring were mostly managed safely. However, we identified 2 issues where medicines management needed strengthening. For example: <ul style="list-style-type: none"> ➤ The remote searches identified 106 potential missed diagnosis of chronic kidney disease (CKD) stage 3, 4 or 5 and we selected 5 patients to review in more depth. We found that 2 of these patients did have a diagnosis of CKD 3 that had not been recorded and coded in their record. We asked the practice to look into these 2 patients, who confirmed these would be coded as having CKD 3. In addition, we asked the practice to consider the relatively high number of 106 potentially missed CKD diagnoses identified by the search. The practice responded and told us that the partners had reviewed all 106 patients following our search results, and that 61 of these patients had now been coded as having CKD. A further 45 patients remained subject to ongoing monitoring to see if a CKD diagnosis might be confirmed after their next blood test (the diagnosis is subject to 2 consecutive blood results to demonstrate the kidney is not working effectively at least 3 months apart). The practice assured us that the 61 patients who had not been diagnosed had still received the correct treatment (for example, the prescribing of statins) and follow up, but they had not been coded on the system and this had now been addressed. 	

➤ The searches also identified 115 of 347 patients prescribed gabapentoids which are medicines used to treat neuropathic (nerve) pain. We reviewed 5 randomly selected patient records from the 115 identified by the search. This showed that 1 patient had not been coded as having received a review, whilst 1 other patient was slightly overdue the annual monitoring by 2 months. We asked the practice to review those patients who were showing as outstanding an annual review as this was approximately one third of all patients being prescribed gabapentoids. The practice investigated this issue further by reviewing 25 patients identified by our searches as overdue an annual medicines review. Approximately half of these patients had received the annual review, but it had not been coded on their medical record; the remaining patients were slightly overdue (mostly within 3 months) and would be contacted to arrange review. The practice also told us that they acknowledged that they were high prescribers of this type of medicine and were able to explain the rationale for this. They were committed to reduce the prescribing of this type of medicine due to potential dependency issues and had considered alternatives such as pain clinic referrals.

- All other search parameters for medicines that required monitoring showed no concerns, for example, patients prescribed disease-modifying antirheumatic drugs, and patients being prescribed direct oral anticoagulants (DOACs), which are medicines used to help prevent blood clots.
- The clinical pharmacist had set up an effective process for patients prescribed direct oral anticoagulants (DOACs). This enhanced the recommended monitoring levels of six-monthly checks by ensuring that every time a patient prescribed DOACs had a blood test for any reason, the results were checked to ensure that the dosage was checked as being safe.
- We reviewed the quality of medication reviews in the last 3 months by looking into 5 records of the 1131 patients who had been coded as having received a review. We found that all 5 reviews were completed effectively and supported with details of the review undertaken, rather than just being simply coded.
- The practice was proactive in running their own searches to check medicines were being prescribed safely. New searches would be added as and when required, for example, further to a safety alert, or an issue identified through the significant event reporting process. This was led by a pharmacy technician and this work had been shared with other practices to promote best practice.
- We reviewed some Patient Group Directions (PGDs) in paper form and also reviewed some that were stored on the practice's software package. We found that 2 PGDs had expired in the last 3 months with no updated PGD in place. PGDs provide the legal framework to allow registered health care professionals to administer prescription only medicines. Staff were not able to locate the PGDs easily on the computer. Following our inspection, the practice reverted to signed paper copies of PGDs and we received evidence that this was fully in place within 2 days of our visit.
- During the inspection, we saw that Patient Specific Directions (PSDs) were used appropriately and safely in line with guidance. However, we observed that this had been an issue recently with some vaccine clinics being set up without the necessary PSDs. This was addressed by ensuring sufficient administration time was allocated to a prescribing clinician to organise this.
- We observed that vaccine fridge temperatures were mostly recorded to evidence that vaccines were being stored safely. However, we identified some discrepancies with missed dates, including some dates when a nurse-led clinic was not held at a branch site. However, the practice should have contingencies to ensure that vaccine fridge temperatures were monitored on all the days they

opened. The temperatures needed to be logged contemporaneously as evidence that checks had been completed, and any deviations outside of the recommended ranges required a reasonable explanation why a breach may have occurred. However, on the day of the inspection, we identified that this system required strengthening to provide full assurance of the practice's compliance in this area.

- Prescribing data (01/01/2023 to 30/06/2023) indicated a tending-to-negative variation with respect to the number of patients being prescribed multiple psychotropics, in comparison to local and national averages. When we asked the practice about this, they reviewed the prescribing of psychotropic medicines, with particular emphasis on the prescribing of benzodiazepines and z drugs. These are medicines which can be used to treat conditions such as anxiety and sleeping disorders but can present longer-term usage issues. The practice told us they had started to look at this as part of a quality improvement programme with the aim to reduce opioid prescribing, and to not initiate new prescribing of these medications. The practice catchment area included areas of higher-level deprivation which contributed to the higher prescribing levels. The practice provided us with unverified data which demonstrated an overall downward trend in this prescribing.

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in 12-month period: (April 2022 to March 2023)	33
Number of events that required action:	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw that incidents were included as a standing agenda item for practice meetings, and we viewed minutes of these meetings which evidenced examples of this. • During staff interviews and in returned staff questionnaires, very few staff indicated they had reported a significant event, and most were unable to provide any examples of learning that had been shared following an incident. There were clear processes in place to support the reporting of significant events, but we were not fully assured that the process was used to proactively share wider learning. • We observed that incidents were logged on a form and risk rated with follow up actions documented. However, we saw that some incidents required more information to demonstrate a thorough investigation and follow-up of the learning points identified. 	

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

Event	Specific action taken
Further to a patient collapse, they were moved into a room for monitoring, but battery-operated blood pressure monitoring equipment was found to be not working.	A system to undertake regular equipment checks was instigated. A blood pressure monitor with a cuff attached was placed on the resuscitation trolley.
A patient was issued with medicines that had been stopped by secondary care after a hospital admission. The patient and pharmacy were contacted to inform them about the error.	The learning applied was that staff should always check the patient record for discharge summaries. It was reinforced that staff needed to allocate sufficient time when doing tasks to ensure they are done correctly.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice had a highly effective process to manage alerts including those issued by the Medicines and Healthcare products Regulatory Agency (MHRA). There was a system to check for new alerts each day and to have these reviewed by clinician, who then ensured these were cascaded to other clinical staff as and when appropriate. This was supported by a system to record that the clinicians had received and acknowledged the information. All alerts were logged on the practice electronic system which detailed any follow up actions undertaken. A practice policy and protocol were in place to describe the procedure followed. The pharmacy technician ran a suite of searches monthly to check that medicines were prescribed safely. This included running historic reports for MHRA alerts to ensure any newly registered patients, or those new to a certain medicine, would be identified as needing a review in line with MHRA recommendations. As part of our remote searches, we selected a MHRA safety alert relating to the risk of the combined use of 2 particular medicines. Evidence showed that the combination of these medicines may cause higher than normal potassium levels in the bloods, and consequent potential serious harm to the patient. Our searches identified that 4 out of 83 patients prescribed this combination may have had an issue with their blood monitoring. We reviewed the records of the 4 patients and found that 3 of these patients had received their last prescription within 6 months of the last blood test in line with guidance. The remaining patient was overdue monitoring by approximately 6 weeks, although we saw they had been booked in for a review 2 weeks after our inspection. 	

Effective

Rating: Requires improvement

At our previous comprehensive inspection in October 2015, we rated the practice as good for effective services. At this inspection in November 2023, we rated the practice as requires improvement for providing effective services. This was because:

- Our remote clinical searches identified that patients prescribed high dose steroid treatment for severe asthma episodes were not always followed up after 1 week in line with guidance.
- There was limited evidence to demonstrate that clinical audit was driving improvement in patient outcomes.
- Some staff appraisals were overdue, including 4 that had not been done for over 3 years.
- There were gaps in the mandatory training programme for staff.
- There was no formal audit to provide assurance on the quality of non-medical prescribing, although we saw that mechanisms were in place to support non-medical prescribers.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a schedule of weekly practice meetings which rotated in content, and the first meeting of the month focused on clinical matters. The agenda included clinical incidents, sharing best practice, safeguarding issues and end of life. 	

Effective care for the practice population

Findings

- Those identified received a full assessment of their physical, mental and social needs.
- Flu, shingles and pneumonia vaccinations were offered where relevant to older patients.
- 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. The practice also had the option to send to their Primary Care Network (PCN) hub for these health checks.
- All patients with a learning disability were offered an annual health check. We saw that 67% of the 103 eligible patients with a learning disability had been reviewed in the 12-month period April 2022 to March 2023.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. There were good links with the community palliative care nurse who met with clinicians at the practice.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice had taken part in 2 projects/pilots in response to 2 areas where some improvement had been identified as necessary; this was for dementia reviews and reviews of people with severe mental illness. This incorporated mental health practitioners and dementia nurses providing in-house review clinics and home visits to increase the number of reviews. No data was available at the time of our inspection, but this was expected imminently.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice previously had 4 allocated care homes. In the past 2 years, a Primary Care Network (PCN) Frailty Team had taken over the routine management of these care homes and had a programme of regular visits. The practice retained little input, other than an occasional visit. This was an advanced nurse practitioner-led scheme which included medicines management input, overseen by a named GP.
- GPs provided some input at a local community hospital twice a week.

Management of people with long term conditions

Findings

- The remote clinical searches identified that patients prescribed high dose steroid treatment for severe asthma episodes were not always followed up after 1 week in line with guidance to ensure they received appropriate care. Our remote clinical review of patient records identified that 81 of 1630 patients with a diagnosis of asthma had received 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 randomly selected patients of the 81 and saw that all 5 patients had received an adequate assessment at the time of prescribing rescue steroids. However, we found that the majority of patients had not been followed up to check on their response to treatment within a week of the acute asthma exacerbation in line with guidance. In addition, 1 of these 5 patients was overdue an annual review. The partners told us that in response, a notification had been issued to all prescribers to raise awareness and to ensure that a follow-up review was arranged with one of the advanced nurse practitioners.
- Our searches identified that all 67 patients with chronic kidney disease stages 4 or 5 who had received the recommended blood monitoring within the last 9 months.
- Only 2 of 621 patients with hypothyroidism had not had thyroid function test monitoring for 18 months. When reviewing the records, 1 of these patients had been short scripted from 100 tablets to 14 to try and engage them with the monitoring process. The other patient was slightly overdue a blood test and had not had an annual medicines review. The provider informed us they would follow up this case.

- We saw that the monitoring of patients with diabetic retinopathy (a complication of diabetes causing eye damage) with raised blood glucose levels was effective, with just 1 patient observed as being slightly overdue an annual review, but we saw that they had an appointment booked to address this.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the practice team worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. Clinical staff had lead roles including diabetes and respiratory conditions.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae 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)	156	160	97.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	143	148	96.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	143	148	96.6%	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)	143	148	96.6%	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)	171	181	94.5%	Met 90% minimum

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

- There was a proactive approach to the management of childhood immunisations. Parents were contacted when immunisations were due for their child and if they did not attend, they were contacted by telephone, usually at the time of their missed appointment. They were usually given another appointment on this call, sometimes at very short notice if an appointment slot was available.

- If parents did not engage with the immunisation programme, the practice child safeguarding lead was informed to follow this up.

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)	65.9%	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)	74.1%	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). (3/31/2023 to 3/31/2023) (UKHSA)	78.8%	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) (4/1/2021 to 3/31/2022) (UKHSA)	60.0%	51.6%	54.9%	No statistical variation

Any additional evidence or comments

- The practice was marginally below the national target for cervical screening uptake. Updated data available after our inspection took place showed that the uptake had increased to 79.6% (30/06/2023). This demonstrated a very slight increase, although remaining just below the national target.
- If patients did not respond following a second invite for cervical cancer screening, the lead nurse for smears would contact the patient by telephone, after checking that they had not already booked an appointment. An appointment was then agreed with the patient on the call at a time to meet their needs unless they declined to engage with the screening process. If unsuccessful at making telephone contact, the patient's previous smear test result was checked, and if the previous result had been abnormal the patient would be called a second time and an appointment arranged.

Monitoring care and treatment

The practice had a programme of quality improvement activity but did not routinely review the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <ul style="list-style-type: none"> • There was limited evidence of an embedded regular programme of clinical audit. • An audit of patients with newly diagnosed type 2 diabetes was completed in July 2023. The audit was undertaken to see if NICE guidance was being followed with regards to reinforcing dietary and lifestyle advice when initiating or changing medicines for patients with type 2 diabetes. A total of 10 patients were identified as being newly diagnosed with type 2 diabetes between January and March 2023 to see if they had been given the appropriate dietary and lifestyle advice. The audit identified that only 2 of the 10 patients had received both dietary and lifestyle advice; 3 more patients had received only dietary advice, and a further 2 had only received lifestyle advice. There were 3 of the 10 patients who had not been given either dietary or lifestyle advice. The outcome was to reinforce to all clinicians that all type 2 diabetic patients should be given dietary and lifestyle advice at the point of initiating or reviewing treatment and when changing medications, in line with NICE guidance, and this should be documented in their record. The practice planned a second cycle audit in 6 months to review improvements. • The practice undertook an annual audit of newly diagnosed patients with cancer. This reviewed how many patients had been identified via the 2-week referral route. It also identified some patients which were used for potential learning where a 2-week wait referral may have been considered, where further monitoring may have been indicated, and to ensure clear safety netting had been applied. 	
Any additional evidence or comments	
<ul style="list-style-type: none"> • As part of quality improvement, the practice was participating in NHS England's National General Practice Improvement Programme to improve patient experience on telephone access. This is described in the responsive section of the report. 	

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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y

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.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The practice proactively championed staff development and there was a strong commitment to nurture talent and support people to progress. This could be demonstrated in several members of the team progressing within the practice from both non-clinical (either moving to different roles within a similar area, for example, from reception to administration roles; or reception staff moving to health care assistant roles) and clinical teams, for example, supporting non-medical staff in prescribing training, or mentoring staff to complete the nurse associate training. The pharmacy technician had been supported to complete a level 4 diploma in clinical pharmacy services. • We saw that some staff annual appraisals were overdue. Information provided by the service showed that 4 staff had not had an appraisal for over 3 years, but we saw that a meeting had been arranged with their line manager in November 2023 to do this. Two other staff were overdue by over 18 months, whilst a further 8 staff were due appraisals as it had been just over a year since their previous one. The practice recognised that some had been delayed due to a restructure of the management team and training to support their development to become appraisers. Staff who had appraisals recently told us that these had been useful, and they were supported to achieve any learning opportunities that were identified. We reviewed 7 appraisals, some of which were very brief and did not always indicate clear objectives and did not always include acknowledgement of the issues raised within the staff member's own self-assessment. Most were unsigned by either the appraiser or appraisee. The appraisals we reviewed did not link into any wider practice objectives or align with the practice values. • A process of performance review had been introduced for the reception team which was additional to the appraisal process. The performance review took place between appraisals and was linked to a banding for each staff member enabling progression. Each of the 3 bands was underpinned by duties and length of service linked to pay. It was planned to expand the programme to include the administrative team. • Staff accessed an online training platform and were also encouraged to attend face-to-face training at external venues. Most staff said they had time to complete mandatory training, but some said they needed to do this in their own time due to work commitments, however, they said the practice reimbursed them for this. • We reviewed the practice's staff training records. Whilst we saw that the majority of training was up to date, there were some gaps. For example, 15 staff were overdue mental capacity act training, 11 staff required an infection prevention and control update, and 4 staff required a fire update training session. There had been a good uptake of tier 1 (general awareness) learning disability and autism training which is now mandatory training for all healthcare staff; however not many staff had completed the tier 2 training (for those who may provide care and support directly). • Whilst non-medical prescribers told us that they received support, advice and informal supervision, there was no evidence of any formal audits of non-medical or locum prescribing. 	

- Nurse meetings took place either monthly or bi-monthly. This acted as a forum to support supervision, although there was no formal clinical supervision process. Advanced nurse practitioners had time for a debrief to discuss any concerns with GPs, but there was no formal documented 1-1 process. The clinical pharmacist had weekly mentoring session with the senior clinical pharmacist.
- The pharmacy technician told us that they were given time to be part of the Joined-up Care Derbyshire Senior Pharmacy Technician group that had representatives from all sectors and met monthly to discuss issues relating to pharmacy in the local area.

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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Monthly multi-disciplinary meetings were held to review the practice’s most vulnerable patients. These were attended by practice representatives and others including the community palliative care nurse, district nurses, and the care coordinator. 	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population’s health, for example, stop smoking campaigns and tackling obesity.	Y

Any additional evidence or comments

All new patients registering at the practice were offered a full health check including a blood test, and a review of any prescribed medicines. This ensured that all repeat medicines remained appropriate for their individual needs, and any necessary monitoring and recall arrangements could be set up. In some cases, patients were offered further treatment, for example, some patients with enhanced cardiovascular risk may have no previous evidence of statin prescribing. The new patient check also offered an opportunity to identify any new issues, enabling the practice to address these promptly.

The practice were awarded for coming 2nd in Derbyshire for the number of referrals to the National Diabetes Prevention Programme in 2022. They also won an award for the best diabetes prevention patient information board in September 2022.

The practice had promoted a walking group prior to the pandemic and hoped to re-establish this in the future.

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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence	
<ul style="list-style-type: none">We reviewed 3 randomly selected patient records where our remote searches had shown a DNACPR decision was in place. The DNACPR forms were completed in line with guidance including an assessment of mental capacity and they were signed by the clinician who had completed it. The practice told us that the DNACPR decision was reviewed when necessary, for example, after a significant change further to hospital admission, a change in the individual's capacity to consent, or if the patient's condition and prognosis improved.	

Caring

Rating: Good

At our previous comprehensive inspection in October 2015, we rated the practice as good for caring services. At this inspection in November 2023, the practice retained its rating of good in caring.

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

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 (01/01/2023 to 30/04/2023)	74.6%	86.2%	85.0%	Tending towards variation (negative)
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 (01/01/2023 to 30/04/2023)	72.9%	85.3%	83.8%	Tending towards variation (negative)
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 (01/01/2023 to 30/04/2023)	88.9%	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 (01/01/2023 to 30/04/2023)	62.8%	71.4%	71.3%	No statistical variation

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

Any additional evidence

- Formal patient surveys had been ceased during the pandemic, but the practice was keen to re-establish them. Patient feedback was being sought as part of an ongoing telephone access improvement project.

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.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Easy read and pictorial materials were available. 	

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)	87.0%	91.3%	90.3%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> 510 patients were identified as carers (3.4%). However, the practice told us that they were aware that a cleansing exercise needed to be undertaken to ensure those included on the list were still active carers.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> A member of the practice team was identified as the carers lead. Carer support information was available on the practice website. A carers information board was displayed at the main site, and posters were on display at all 3 sites. Patients were offered flu and covid vaccinations.

How the practice supported recently bereaved patients.	<ul style="list-style-type: none"> A GP contacted relatives/carers by telephone to offer support and talk through the process to be followed. Individuals could be signposted to services to provide additional bereavement support if this was required. The practice website contained contact details for the National Bereavement Service.
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Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires improvement

At our previous inspection in October 2015, the practice was rated as good for providing responsive services. At this inspection in November 2023, the practice was rated as requires improvement for providing responsive services. This was because:

- Patient experience in accessing appointments by telephoning the practice was poor. The latest national GP patient survey showed that only 14% of respondents were positive in terms of how easy it was to get through to someone at their GP practice on the phone. This also reflected on the overall patient experience of making an appointment.
- The practice did not display information on the complaints procedure in a patient area and some minor updates were required to their complaints policy and procedure.

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.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

- Services were provided on the ground level. The sites had automatic doors accessed via a ramp providing good wheelchair access. Designated disabled parking spaces and toilets were available. Hearing loops were available for patients. Information could be printed for patients in larger font sizes on request.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. It sent easy-read information with pictorial prompts for health review appointments and flu vaccinations to patients with a learning disability. The practice offered these appointments at times and venues to create a calmer environment for patients to attend, so these would often be offered in the branch sites around midday. The practice also worked with local learning disability team to maximise the care and support offered to these patients.

Practice Opening Times

Day	Time
Opening times (Old Station Surgery):	
Monday	8am – 6.30pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

- The branch sites at Kirk Hallam and Cotmanhay opened Monday to Friday from 8am to 6pm.
- Appointments were available at the Old Station Surgery site from 7.30am Monday to Friday for bloods. Reception opened to patients at 8am on these days.
- There was 1 central appointment line for the main site and 2 branches. There was some flexibility at the branch sites, for example, in that elderly patients could ring the branch surgery directly to obtain an appointment. Patients could also attend in person at all 3 sites to request a consultation.
- The practice had access to an on-the-day service provided through their PCN, staffed by advanced nurse practitioners. When capacity for appointments was reached at the practice, there was some limited capacity to refer to this service held at the local community hospital and at a neighbouring practice.
- Patients could also access appointments at an extended hours hub locally 6.30-8pm on weekdays, plus Saturday and Sunday mornings and bank holidays.
- Home visits could be requested via a separate option on the appointment line up until 11am. Requests were triaged by an advanced nurse practitioner or the on-call GP. The practice could allocate some appropriate visits to a Primary Care Network acute home visiting ANP-led service. This had limited capacity and when full, the practice GPs would pick up any remaining visits. The practice informed us that they were in the process of reviewing their home visit protocol and the housebound patient list at the time of our inspection.

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 offered urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Early morning and late afternoon nurse appointments were available for school age children so that they did not need to miss school.
- Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pre-bookable appointments were also available to all patients at additional locations within the area.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people. Homeless people could use the practice address and agree a method for contact, for example, to attend the surgery once a week to check if any communications had been received for them, or they would nominate a friend as a point of contact.
- The practice periodically produced a patient newsletter. We reviewed the most recent newsletter from September 2023. This included details of the local flu and covid vaccination programmes, information on the Stoptober programme to help people to quit smoking, and a section to respond to frequently asked questions. This included why receptionists have to ask patients questions about their health problem, explaining that receptionists are trained in care navigation in order to direct the patient to see the most appropriate person or service.

Access to the service

People were not always 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.	N
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	N
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y

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
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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)	14.4%	N/A	49.6%	Significant variation (negative)
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)	32.9%	52.4%	54.4%	Tending towards variation (negative)
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)	48.8%	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)	63.0%	72.9%	72.0%	No statistical variation

Any additional evidence or comments

- We observed that patient experience of telephone access had decreased significantly over the last 2 years. Prior to this, results from the national GP patient survey mostly aligned with local and national averages. However, results in the 2022 GP patient survey showed a decrease from 62% in 2021 to 29%. Whilst the most recent results for 2023 showed a further decrease to 14% of patients responding positively to how easy it was to get through to someone at their GP practice on the phone.
- The practice was aware that telephone access was a significant concern for their patients which had resulted in a poor outcome in the most recent national GP patient survey. The practice was trying to address this as part of the National General Practice Improvement Programme. This NHS England programme provided tailored support for practices to make changes and improvements to how they worked. The practice had signed up to this 13-week project and had chosen to extend this by an additional 6 weeks to maximise its benefits. We saw evidence that the practice was fully committed and actively engaged in this project, and we observed how the practice was undertaking a full analysis of call data.
- As part of this programme, the practice had reintroduced an online clinical triage enabling patients to contact the practice regarding a medical issue via their website or the NHS app. This system had been in place previously, but it had not worked effectively, and this created frustration and a poor experience for patients. Therefore, this programme was being reintroduced in a controlled way to address any potential difficulties before it was fully relaunched. The online triage, overseen by an advanced nurse practitioner, was reintroduced as a trial for 4 weeks from 6 November 2023, operating from 6am to 9am Monday to Friday (or until a maximum of 20 requests had been received on any day). The trial was being closely monitored to allow for any adaptations to be made and for the service to be fully audited to determine its value and impact. Once the practice had achieved this, they planned to fully relaunch the online triage programme from February 2024.
- Whilst the practice had identified other measures to improve telephone access, such as including a call-back facility for those who join a queue on the telephone, these had been parked to allow focus on achieving specific tasks rather than trying to do everything all at the same time.

- The practice had a cloud-based telephony system which gave them the ability to check demand and flex capacity for call handling in response.
- The practice had undertaken an exercise to look at the number of appointments provided, and this seemed to indicate that there were sufficient slots available for the number of registered patients, however, the demand for appointments continued to increase.

Source	Feedback
NHS.uk website (formerly NHS Choices)	<p>There had been 5 comments posted in the last 12 months, 2 were positive, 1 was mixed and 2 were negative.</p> <p>Positive comments included caring and professional staff who were understanding and supportive, compassionate care, and excellent follow up care.</p> <p>Negative comments related to issues with prescriptions, poor access to appointments, unsympathetic staff, and difficulties accessing online triage</p>
Healthwatch	<p>There had been 2 patients contacts with Healthwatch over the last 12 months:</p> <p>The first patient reported disappointment in support for maternal mental health, particularly in respect of a more holistic approach rather than a focus on medication.</p> <p>The second patient expressed difficulty in booking a GP appointment with long waits on the telephone. They reported that they did not want an on-the-day appointment but were unable to book a non-urgent appointment for a future date and were told to ring back the next day.</p>
'Share Your Experience' feedback to the CQC	<p>The CQC received 4 concerns that were reported by patients over the last 12 months. Of these, 2 related to the difficulties in accessing an appointment at the practice. The other 2 concerns related to delay in obtaining prescriptions. We reviewed these concerns with the practice but found that the issues were not attributable to practice systems.</p>

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in 12-month period April 2022 – March 2023	71
Number of complaints we examined.	5
Number of complaints we examined that were satisfactorily handled in a timely way.	5
Number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO).	0

	Y/N/Partial
Information about how to complain was readily available.	Partial

There was evidence that complaints were used to drive continuous improvement.	Y
<ul style="list-style-type: none"> The service logged and reviewed all complaints received, this included written (including emails and web forms) and verbal complaints. There was no information regarding how to make a complaint displayed in the reception on the day of our inspection, although we were informed that patients would be provided with complaint form by a member of the reception team if this was indicated or requested. The practice website included a copy of the complaints policy and also provided the facility to make a complaint online. The complaints policy needing updating to provide patients with the option of making their complaint either directly to the practice, or to raise this via their local integrated care board. When final complaints responses were sent, these did not always include details of the option to take the complaint to the PHSO if the complainant was dissatisfied with the reply. The practice told us this was within the complaints leaflet sent to the patient, but the practice should reference this clearly within their final response letter. We saw that complaints were a quarterly agenda time at practice meetings. 	

Examples of learning from complaints.

Complaint	Specific action taken
Difficulty in obtaining an appointment for a dressing.	The practice team had a discussion and added urgent slots throughout the week to accommodate more appointments for dressings.
Delays in obtaining medicines recommended following a hospital appointment	There was contradictory information received from the hospital which should have been investigated. Staff did not follow the correct procedure with regards to dealing with incoming letters containing actions for GP, and so further training was provided to staff.

Well-led

Rating: Requires improvement

At our previous comprehensive inspection in October 2015, we rated the practice as good for well-led services. At this inspection in November 2023, we rated the practice as requires improvement in well-led because:

- The practice did not always have clear and effective processes for identifying, managing and responding to risks.
- Governance processes did not always provide assurance that systems and processes worked effectively.
- Staff and patient involvement did not always influence change or drive improvement although we saw that steps were being taken to improve this.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice was situated in the Erewash area of Derbyshire where the majority of the 11 GP practices were part of a 'super-partnership', Erewash Health Partnership (EHP) which comprised of 8 GP practices working in partnership to improve resilience and extend the range and quality of services available locally. However, Old Station Surgery strove to maintain its independence and prided itself as being described as somewhat maverick by others and was happy to do things their way, including new ways of working. There were 3 GP practices in Erewash which were not part of EHP. The practice was however part of the Erewash Primary Care Network (PCN) to ensure there was locally joined up work and collaboration, including access to staff employed through the Additional Roles Reimbursement Scheme (ARRS) such as first contact physiotherapy and social prescribing. The PCN included 10 of the 11 Erewash practices. The management team had restructured in April 2023 to create posts for an operations manager and finance officer to support the business practice manager. This had been done in recognition of the workload of a large practice covering 3 sites, and the need to have effective management capacity available at all times. At the time of our inspection, the new management structure had been in place a few months and the new managers were being given the support and training required to work productively and effectively in the new roles. Managers and partners had defined lead roles and staff knew what these were. The practice was aware of succession planning and were in the process of adding another GP to the partnership. 	

Vision and strategy

The practice had a clear vision and strategy to provide high quality sustainable care, but this did not clearly reflect staff involvement and engagement in developing future plans.

	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.	Y
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The provider displayed their vision and values on the homepage of the practice website. These stated working cohesively in a caring and supporting environment and supporting people to achieve their full potential through personal development. With regards to patients, the values were based around '5Ps' – promise to do our best for patients; providing the highest standard of care; promoting patient participation and patient wellbeing; practising highest standards of hygiene; and protecting patient confidentiality and integrity. 	

- 13 respondents to our staff questionnaire did not feel engaged with the future planning and development of the practice such as the mission statement/vision or values.
- Whilst staff responses indicated that they were not involved in developing values, our interviews and observations indicated that staff adhered to the practice values in all aspects of their work.

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • A whistleblowing/freedom to speak up policy was in place. The practice had identified a named individual to act as a Freedom to Speak Up Guardian who was independent of the practice. • Some staff had not completed equality and diversity training. 	

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

Source	Feedback
Staff questionnaires	<p>We received 34 staff responses to our questionnaire, 20 from non-clinical staff members and 14 from clinical or clinical support staff.</p> <p>Overall, feedback was positive, particularly with regards to:</p> <ul style="list-style-type: none"> • There being sufficient staffing levels, apart from episodes of unplanned leave such as sickness. • Being provided with a comprehensive induction suitable to each role when starting at the practice. • Participation in meetings. • Awareness of processes to support vulnerable patients. • Feeling able to raise concerns, and confidence that these would be considered by partners and managers

	<p>Most staff who responded to the questionnaire said that they had access to specific training to support their role; that they were encouraged to identify their training and development needs; and were given protected time to undertake their training. However, 2 employees said they had not been given opportunities for developments and 2 clinical and 1 non-clinical staff felt that did not have time to do the required training due to work pressures.</p> <p>Staff felt that line managers were supportive, gave them encouragement, asked individuals for their opinions, took an interest in their well-being and made them feel valued. The responses to the same questions in relation to the provider were slightly less positive although only 2 issues were highlighted as being negative – 5 staff who responded felt that the provider did not ask staff about their opinions on decisions affecting their work, whilst 3 said that the provider did not communicate effectively about changes that affected their work. 1 member of staff said they received no encouragement to do their work.</p> <p>Most staff said they had received an appraisal, although some stated that it had been over a year since their last appraisal and 2 staff saying that it was more than 2 years.</p> <p>The areas that were highlighted by staff as requiring more focus were:</p> <ul style="list-style-type: none"> • Communications could be improved. • Feedback on learning from incidents was not always cascaded to promote wider learning. • Staff did not feel involved in developing or understanding the practice values, objectives and mission statement.
Staff interviews	<p>We undertook 10 staff interviews remotely before undertaking the inspection site visit. We also talked with other staff on the day of our inspection.</p> <p>Feedback was positive and team members said there was a good rapport amongst staff, and that colleagues pulled together to help out and support each other. Managers and partners were said to be visible and approachable, and operated an open-door policy.</p> <p>Communication was highlighted to be difficult on occasions, but it was acknowledged that this was enhanced due to the service operating across 3 sites.</p> <p>Some clinical staff found it difficult to complete mandatory training modules in work time but told us they were paid when these had to be done in their own time.</p> <p>There were no meetings for the whole practice team to come together and some non-clinical staff felt that they were a little isolated at times. However, the rotation of reception staff across the 3 sites helped to address this.</p>

Governance arrangements

There were some gaps regarding responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found that governance processes were not always working effectively. For example, some staff appraisals were overdue, some of which had been significantly delayed. There were gaps in the practice mandatory training programme. PGDs, vaccine fridge management and infection control audits required more oversight to ensure these were effective. A range of policies and procedures supported how the practice operated but we observed that some, for example, safeguarding, infection prevention and control and complaints required some updates. 	

Managing risks, issues and performance

The practice did not always have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We observed areas where risks had not been mitigated, such as for those staff who had not provided evidence of their immunisation status. Evidence of comprehensive assurance systems required strengthening as described in the above section on governance. 	

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

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.	Y
The provider was registered as a data controller with the Information Commissioner’s Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

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.	Y
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	

- The practice had undertaken their own staff survey and had received 24 responses from members of the practice team. This had identified strengths and weaknesses as well as feedback on individual experience of working at the practice. The practice told us they were working on a response to the feedback received as part of their involvement in the GP Improvement Programme.
- Responses to the CQC staff questionnaire indicated that staff did not always feel their views were considered in future planning and some staff felt that they did not receive effective communication on decisions that affected their role. However, we did see an example in the ongoing GP Improvement Programme that the practice telephone message was being updated and staff were being asked to vote for a preferred option.

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> • The Patient Participation Group (PPG) had disbanded during the COVID-19 pandemic. The practice had approached a previous member who had taken on the role of PPG chair, and they were in the process of trying to re-establish the group. • We spoke with this PPG representative who informed us that the practice was keen to relaunch the group. • Previously the PPG had worked well with the practice, and they felt that their views were respected, listened to, and acted upon. The practice was open with the PPG and shared information with them appropriately. • The PPG had previously raised an issue regarding telephone access, and this had been reviewed at the time and some technical problems were addressed. The PPG had also championed the need to provide higher chairs for patients who had difficulty getting into and out of low seats, and the practice responded by purchasing some higher seats for the reception area.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The GP Improvement Programme was helping to drive improvement across a number of areas. At the time of our inspections, the project was ongoing, and we were therefore unable to see the outcomes this would achieve. However, we saw that there was a passion to deliver improvements. 	

- A digital practice project practice was undertaken in 2021 as part of continuous development and service improvement. Outcomes included the implementation of a new improved and accessible website and cloud-based telephony.
- The senior leadership team had undertaken a Triumvirate Leadership Programme which was promoted and supported by NHS England as part of continuous improvement.
- We found that learning from significant events and complaints was in place, but this was not always cascaded across the whole team in order to make a significant impact.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

Glossary of terms used in the data.

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