Care Quality Commission

Inspection Evidence Table

Dr Webb and Partners (1-550670216)

Inspection date: 13 January 2020

Date of data download: 27 December 2019

Overall rating: Requires improvement

At the previous inspection in February 2019, we rated this practice as requires improvement overall. This was because the practice was rated as requires improvement for providing safe and well-led services.

At the inspection in January 2020, the practice remains rated requires improvement because:

- We observed that some changes had been implemented to address our previous findings.
- However, we identified some concerns that had not been fully addressed to provide assurances that safe care was sufficiently robust.
- In addition, we found areas that were highlighted as lacking evidence of compliance as a result of practice systems having insufficient clinical and managerial oversight and ongoing review.

Safe Rating: Requires improvement

At the previous inspection in February 2019, we rated this practice as requires improvement for providing safe services. At the inspection in January 2020, we found that the practice had taken actions to improve most of the safety concerns we had previously identified, for example:

- Electrical equipment had been tested and a system was in place to repeat this on an annual basis.
- Staff recruitment processes including the induction of new staff had been strengthened and supported by documentation.
- Staff immunity records had been updated.
- Adherence to infection control standards had been improved with evidence of cleaning schedules, and a documented process for the cleaning of medical equipment was in place.

However we still noted some areas that needed improvement in January 2020. This included:

- The practice could still not provide their own evidence of progress against action plans further to fire and Legionella risk assessments.
- The practice could still not fully demonstrate evidence of their response to safety alerts.
- A range of medicines management issues were identified as concerns. This included out of date medicines in a doctor's bag, a single safe process to monitor blank prescription stationery, the monitoring of high-risk medicines, Patient Group Directions not being appropriately signed, the

availability of risk assessments to cover recommended emergency medicines which were not held by the practice, and documented evidence to review non-medical prescribing.

Safety systems and processes

The practice did not always have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
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
Staff who acted as chaperones were trained for their role.	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
Explanation of any answers and additional evidence: • At our previous inspection in February 2019, we were unable to find evidence of suitable DBS checks for all staff in the sample of staff files we reviewed. At this inspection in January 2020, we found that appropriate DBS clearance was in place for the staff files we reviewed. • There was a lead GP for safeguarding. All practice clinicians were invited to attended quarterly child safeguarding meetings with the health visitor to review any children deemed to be at risk. The school nurse would attend these meetings when available and if not, the health visitor would liaise with the nurse to ensure joined up working.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Explanation of any answers and additional evidence:	

At our previous inspection in February 2019, we found that:

- Some staff files did not always contain the appropriate supporting documentation to evidence safe recruitment.
- The practice was not able to produce evidence of staff immunisation status for all recommended vaccinations.
- Annual checks of professional registrations were not being undertaken in-house.

At this inspection (January 2020), we found that the practice had satisfactorily addressed all of these issues:

- Staff files were well organised and contained appropriate recruitment checks.
- The immunity status of all staff was recorded.
- Professional registrations were checked each year and staff files were updated with this information.
- In addition, the practice had instigated their own checks for locums to ensure they fulfilled all of the necessary safe recruitment criteria.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: March 2019	Y
There was a record of equipment calibration. Date of last calibration: February 2019 (with some additional items having been calibrated in September and October 2019)	Y
There were risk assessments for any storage of hazardous substances for example, storage of chemical, oxygen cylinders.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: July 2019	Y
There was a log of fire drills. Date of last drill: February 2019	Y
There was a record of fire alarm checks. Date of last check: weekly checks were recorded and an annual maintenance contract was carried out and last completed in July 2019.	Y
There was a record of fire training for staff. Date of last training: various dates	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: January 2019	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence:	

At our previous inspection in February 2019:

- The practice was unable to produce evidence of a recent portable appliance testing (PAT) certificate. There was some confusion between the practice and the building owner as to whose responsibility it was to arrange the testing until we announced the previous inspection at which point the practice discovered it was their responsibility.
- A fire risk assessment had been undertaken for the whole building (i.e. inclusive of all occupants) which had been organised by the premises owner, NHS Property Services Ltd. There was an action plan in place but it was unclear which actions related to the practice. The practice was able to get some information during the inspection to indicate that actions had been completed but no actions had been signed off as completed within the action plan.

At this inspection (January 2020), we found that:

- All electrical equipment had been PAT tested, and arrangements were in place for this to be repeated annually
- We saw a comprehensive fire risk assessment had been completed in January 2019 and this was accompanied with an action plan. The action plan contained some updates which had been completed by NHS Property Services. However, it was still unclear which components of the action plan related specifically to the practice and we did not see any evidence to support that the practice had taken ownership of the plan, for example, by following up on action points which in some cases had passed their target completion date.
- Following our inspection, the practice sent us a Building Management Policy dated January 2020. In relation to fire, the policy stated that whilst NHS Property Services were responsible for carrying out a fire risk assessment for the building, this should not detract from the practice's responsibilities as a tenant.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2019 (Legionella - June 2019)	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2019	Partial

Explanation of any answers and additional evidence:

At our previous inspection in February 2019, we found:

- Health and safety management, including asbestos surveys and the Legionella risk assessment was undertaken and held by the building owner/contractor. The practice did not keep their own record or evidence of updates in relation to any actions.
- We saw that electrical extension leads were widely used, and were not positioned safely, for example, to ensure they were not trapped under furniture.
- We found that general risk assessment processes were undeveloped. For example, there were no risk assessments for the use of extension leads, manual handling processes, the use of visual display equipment, or the care of pregnant workers.

At this inspection in January 2020, we found that:

- The practice had completed a display screen equipment work station check list with staff, and we saw a risk assessment for lone workers. However, we did not find that risk assessments were

embedded and used in response to any areas of potential or identified risk at the practice. For example, we had suggested manual handling as an area for consideration at the previous inspection, and we found that risk assessments had not been completed for some recommended emergency medicines which were not kept in stock. Following our inspection, the practice provided us with a table of risk assessments that had been produced for a range of identified risks, including a risk rating and measures to control the risk and minimise any impact.

- The practice also told us after the inspection that they planned conduct a practice health & safety risk assessment on a monthly basis or updated whenever there were any changes within the building. Any significant issues raised in respect of the health and safety in the building would be reported to NHS Property Services via an email notification with a corresponding entry made in a building record log.
- The Legionella risk assessment action plan had not been updated since being produced in June 2019, and the practice informed us that some actions had been taken but the plan was overseen by NHS Property Services. Following the inspection, the practice sent us a Building Management Policy dated January 2020. In relation to Legionella, the policy stated that whilst NHS Property Services were responsible for organising the assessment for the building, this should not detract from the practice's responsibilities as a tenant.
- Extension leads were being used safely and wires well organised and plugs were labelled to ensure safety.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: November 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2019, we found that:

- The practice was unable to evidence recent completed cleaning schedules, and could only produce schedules dated up to April 2018. These detailed daily and weekly cleaning tasks, and whilst schedules referenced monthly/six-monthly and annual checks, there was no evidence that these had been completed.
- The practice did not have a documented record to demonstrate that medical equipment was cleaned in accordance with manufacturers' recommendations.

At this inspection (January 2020), we found that the provider had satisfactorily addressed these issues.

- Cleaning schedules were in place and were completed
- Medical equipment was cleaned in accordance with manufacturers' recommendations, and this was documented.

- We saw that infection control was discussed as part of clinical staff meetings.

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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 was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

At the previous inspection in February 2019 we found that :

- There was no formal induction paperwork signed by the employee and employer to demonstrate that all relevant new starter information had been covered during their induction. Following the inspection, the practice provided us with a template they intended to use with new starters in the future.

At this inspection in January 2020:

- We saw that new staff had an induction template completed and topics were signed off when they had been completed.

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

Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

- We saw that incoming test results were managed quickly and we saw no evidence of any backlogs.
- A member of the reception team had undertaken notes summarisation training. This had helped to complete more notes summarisations and we saw that only a small number of patient paper records remained to be summarised. The staff member who undertook this task had designated time to focus on this work, and told us they received good support from managers and the GPs if they had any queries.

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.72	0.84	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	7.5%	7.4%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	4.83	5.41	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019)	1.09	2.03	2.08	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
(NHSBSA)				

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations to administer medicines including Patient Group Directions(PGDs) or Patient Specific Directions (PSDs).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured 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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
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 PHE guidance to ensure they remained safe and effective.	Partial
Explanation of any answers and additional evidence: At our previous inspection in January 2019, we found that: • There was a system to check that medicines stored within the practice were in date. However, we saw that dates of the checks were not recorded.	

Medicines management	Y/N/Partial

- The security of blank prescription stationery needed to be strengthened.

At the inspection in January 2020, we found that:

- The checks of stock and expiry dates for medicines stored on site was now recorded. However, we asked about doctor's bags and were told that two of the GPs did carry some medicines in their bag, although these were not included in the medicines checks undertaken by the nursing team. We asked to view one of the GP bags and found two medicines to be out of date, although the same medicine which was in date was also being carried in the bag. This created a potential risk of giving the out of date medicine to the patient.
- Blank prescription stationery was not always being monitored effectively to ensure that the serial numbers were recorded on delivery to individual consulting rooms, or that security measures had been considered further since our previous inspection. Prescribers did not adhere to one process, for example one clinician took blank prescriptions from a box in reception but did not record the serial numbers, whilst other clinicians took blank prescriptions form a box that had been allocated to a specific consulting room. We found that some doctors still carried a full prescription pad in their bag for visits. We were told that the bag was left in the car and not removed to a secure location at the end of home visits. Following the inspection, the practice provided us with an updated practice paper prescription policy, which provided written evidence of a much tighter and consistent approach to the safe handling of paper prescriptions (FP10s) in the premises, and when transported in cars.
- A small number of PGDs had not been signed individually as part of legal requirements. Following the inspection, the practice provided documentation to show that the PGDs had been signed appropriately.
- We found one of the recommended emergency medicines was not available with the emergency drugs kit. There was no risk assessment in place to explain its absence, or suggest an alternative way of managing a patient requiring these medicines in an emergency. Following the inspection, the provider sent us an appropriate risk assessment for emergency medicines that were not held in stock.
- We discussed the oversight of non-medical prescribers with the GP partners and whilst they told us this was done informally, there had been no formal review for assurance purposes. However, following our inspection, the practice provided us with an independent prescriber review protocol. This indicated that any independent prescribers employed by the partners would undertake a reflective review of an area of prescribing within their competency on a quarterly basis. The review would follow the guidelines in the Royal Pharmaceuticals Society's 'Prescribing Competencies Framework' which could be undertaken with the Independent Prescriber by any other prescriber with appropriate competence e.g. diabetes nurse specialist, General Practitioner, prescribing pharmacist or representative from the Medicines Management Team.
- We observed two ampules of flu vaccine which had been returned to the vaccine refrigerator in sealed packaging but were not stored back into their original box as recommended. The practice said they would ensure that medicines were always returned to their original package in the future.
- Whilst there were processes to monitor high risk medicines, the system required further strengthening. We observed that an audit showed some patients were overdue with blood test monitoring. The outcome of the audit was to review this in two years, rather than to instigate immediate action to ensure that patients were monitored appropriately. However, following our inspection, the practice provided evidence that they had undertaken a second audit in January 2020. This showed that 77.3% of patients were up to date with their monitoring whilst a further

Medicines management	Y/N/Partial
9% had been reviewed within three weeks of their allocated review date. This audit included clear actions for the ongoing monitoring of oversight of high risk medicines within the practice.	

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.	Y
Number of events recorded in last 12 months:	13
Number of events that required action:	13
Explanation of any answers and additional evidence: • All significant events were discussed at practice and clinical meetings. Each incident was reviewed in terms of impact, and actions would be taken immediately if necessary to ensure safety.	

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

Event	Specific action taken
• No follow up action or discussion was instigated further to a low blood pressure reading being recorded on a patient.	• Additional training was provided on the normal parameters of physiological recordings, and the actions that were needed when results fell outside of these. The protocol for the health care assistant to follow was updated.
• A patient was administered a vaccine without the appropriate Patient Specific Directive being in place.	• Additional awareness training was provided on the legalities of PSDs. There was an increased emphasis on forward planning to check clinics in advance and make sure the appropriate PSDs were in place before they took place. The PSD also needed to be available electronically to proceed with the vaccination and not undertaken by a verbal agreement as had happened at the initial incident.

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

Explanation of any answers and additional evidence:

At our previous inspection in January 2019:

- We saw evidence that alert information had been passed onto clinicians. However, the recording of outcomes was not clear and this needed to be strengthened to document that follow up actions had been considered and acted upon when appropriate. Following our inspection, the practice provided a safety alerts policy although this still did not give clear information on how the practice responded to alerts and maintained evidence of the outcomes for each relevant alert.

At this inspection in January 2020, we found that:

- The practice showed improvements had been made in this area and worked collaboratively with their medicines management team (MMT). A system had been put in place which included a spreadsheet to monitor how alerts were dealt with and this was undertaken by the MMT pharmacist linked to the practice. The pharmacist reviewed actions at practice meetings every two months and provided support where needed. The practice was able to provide documented evidence to demonstrate effective compliance following the inspection

- The practice provided a safety alerts policy dated April 2019 which highlighted a clear process for reviewing and acting upon alerts.
- We saw examples of actions taken on recent alerts for example, regarding sodium valproate.

Effective Rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

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 used digital services securely and effectively and conformed to relevant digital and information security standards.	N/A
Explanation of any answers and additional evidence: • Regular clinical meetings were used to discuss new or revised guidance and other clinically related issues.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHSBSA)	1.07	0.61	0.74	No statistical variation

Older people Population group rating: Good

Findings
• Community Delivery Team (a multi-disciplinary team) meetings took place every three to four weeks where vulnerable older patients with complex needs were reviewed to consider if they required any additional care or support. • The practice identified older patients who were living with moderate or severe frailty and monitored them through the care co-ordinator. These patients could be referred to a local frailty team to help

in supporting them to live independently at home. Those identified received a full assessment of their physical, mental and social needs.

- The practice followed up on older patients discharged from hospital. The care coordinator (who worked for the local community health provider) would ring patients on their return home to check their well-being following a hospital admission. The practice team ensured that care plans and prescriptions were updated to reflect any extra or changed needs, and held regular meetings with the wider health and social care teams to facilitate appropriate care and support for each patient.
- The practice team could refer to a single point of access which provided a range of support services including same-day physiotherapy, emergency respite care at a residential home, and admission to the local community hospital (subject to bed availability). There was also access to support services for patients who had experienced a fall to improve their confidence and safety.
- The care co-ordinator who worked with the practice participated in a well-being project for patients aged 80 and over. This ensured these patients were kept under review even if they were not regularly being seen within the practice.
- There was access to social prescribing schemes and a range of local voluntary services.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, the nurse practitioner had completed accredited spirometry training.
- Patients with chronic obstructive pulmonary disease (COPD) were actively encouraged to attend locally held pulmonary rehabilitation sessions
- Patients with COPD were provided with rescue packs (standby antibiotics and steroids for an exacerbation of their condition).
- Patients with asthma were offered an asthma management plan.
- Patients with diabetes were referred to support programmes, and those with signs of pre-diabetes were referred to a diabetes prevention programme. The practice provided insulin initiation to avoid patients travelling to hospital to access this service. Advice on managing patients with complex diabetes was available through the Erewash Diabetes Service. The local diabetes specialist nurse undertook joint clinics on site with the nurse practitioner.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered 24 hour ambulatory blood pressure monitoring. Patients were also able to loan an electronic sphygmomanometer from the practice to monitor their blood pressure at home.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.3%	81.4%	79.3%	No statistical variation
Exception rate (number of exceptions).	16.7% (37)	16.9%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) (QOF)	88.4%	78.5%	78.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	10.0% (22)	10.3%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) (QOF)	92.0%	83.4%	81.3%	Variation (positive)
Exception rate (number of exceptions).	10.0% (22)	15.0%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) (QOF)	76.4%	78.4%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.8% (5)	9.0%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	90.0%	90.5%	89.6%	No statistical variation
Exception rate (number of exceptions).	3.0% (4)	13.3%	11.2%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading	89.0%	84.5%	83.0%	Tending towards variation (positive)

measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	3.2% (22)	4.0%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) (QOF)	98.4%	93.3%	91.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	3.1% (2)	6.0%	5.9%	N/A

Any additional evidence or comments

- The practice achieved good outcomes for patients with long-term conditions and this was done with low level of exception reporting.

Families, children and young people Population group rating: Good

Findings

- The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for the three childhood immunisation uptake indicators we had data about.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. For example, relevant patients were provided with advice in accordance with best practice guidance following a recent medicines alert.
- The practice had arrangements for following up failed attendance of children's appointments for immunisation. The lead safeguarding GP was informed and a letter would be sent to parents regarding the importance of their attendance. Liaison with health visitors would take place when necessary. Failed appointments within secondary care were left for the hospital to follow up.
- The practice hosted safeguarding meetings every eight to ten weeks involving the GP partners and nurse practitioner with the health visitor to discuss and review any children of concern. The midwife and school nurse would attend these meetings as appropriate, and subject to their availability
- Young people could access services for sexual health and contraception. Chlamydia screening kits were provided within the practice and these were available in discreet areas.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	No Data	No Data		No Data
The percentage of children aged 2 who	34	35	97.1%	Met 95% WHO based target

have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	34	35	97.1%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	34	35	97.1%	Met 95% WHO based target

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices

Any additional evidence or comments

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- 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 had achieved the national target of 80% uptake for cervical screening in eligible female patients.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (31/03/2019 to 30/06/2019) (Public Health England)	80.1%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	74.6%	74.5%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	61.6%	61.2%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as	57.1%	66.5%	68.1%	N/A

occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)				
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	64.3%	48.8%	53.8%	No statistical variation

Any additional evidence or comments

- The practice promoted cervical cancer screening. There was a display in the waiting room during cervical cancer awareness week to help promote awareness and uptake.
- The number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) had risen from 46.2% in 2017-18 to 64.3% in 2018-19.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Patients aged 14 and over with a learning disability were encouraged to receive an annual review to ensure their health needs were being met. We saw that 25 of the 43 eligible patients on the practice's learning disability register (58%) had received an annual review in the last 12 months.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice referred people who misused substances to local services for guidance and support.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice ensured effective liaison with local community mental services and secondary care to provide holistic care for patients with mental health needs and dementia.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. The practice worked with local mental health services.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- We saw that staff had received training on the implications of the Mental Capacity Act.

Mental Health Indicators	Practice	CCG	England	England

		average	average	comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	85.7%	92.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	6.7% (1)	15.5%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.9%	92.4%	90.2%	No statistical variation
Exception rate (number of exceptions).	6.7% (1)	13.6%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	74.4%	84.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	7.1% (3)	8.4%	6.7%	N/A

Any additional evidence or comments

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	554.8	549.4	539.2
Overall QOF score (as a percentage of maximum)	99.2%	98.3%	96.7%
Overall QOF exception reporting (all domains)	4.4%	6.1%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

- The practice had completed a full cycle audit on diabetes control in older patients. This focused on patients at risk of hypoglycaemia (low blood sugar) and the risk factors involved in this, including their prescribed medicines. Patients were reviewed and the second cycle demonstrated improved outcomes and safety for patients, for example nine patients achieved stability in their condition with lower prescribing.
- A single cycle audit in November 2019 on disease-modifying anti-rheumatic drugs (DMARDs) demonstrated 64% of 22 patients were having blood tests monitoring within recommended timescales. The majority of other patients were being seen within one month after the date recommended. Recommendations were made to improve performance although the conclusion was to repeat the audit in two years' time. Due to the risks associated with these medicine we would have expected to see evidence of actions being completed and a regular programme of repeat audit cycles to ensure ongoing compliance. However, following feedback at the end of our inspection, the practice then provided evidence of a second audit which included outcomes to strengthen monitoring arrangements and to limit re-authorised repeat prescriptions for these medicines to only two issues.
- The CCG medicines management team helped the practice to complete medicine audits and respond to any patients reviews this required.

Any additional evidence or comments
• We saw minutes from clinical meetings which included an overview of current QOF performance and highlighted areas which needed more focus to ensure targets were achieved.

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. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- We reviewed training records and found them to be incomplete although the practice felt that staff were mostly up to date with their required training schedule and updates but the practice did not have access to up-to-date evidence to demonstrate this. Following our inspection, the practice had collated the training information into a training log and we observed that the team were mostly up to date with training requirements.
- Nursing staff appraisals were up to date but non-clinical staff appraisals were overdue. These were last done in April 2018, and at the time of inspection no dates were booked to complete these. Following our inspection, the practice provided information to say that these appraisals had been completed in the two days following our inspection.
- We saw examples of ongoing development, for example the practice nurse had just completed spirometry training, and was planning to commence some further training in diabetes management.
- We saw examples of how all staff had been encouraged to develop in their roles. For example, an apprentice had been appointed as a receptionist. Another receptionist had undertaken training to work as a phlebotomist and there were plans to expand the role further as a health care assistant.
- Whilst we did not see evidence that the health care assistant had completed the Care Certificate, they had completed the NVQ qualification and competencies had been assessed and signed off by the nurse practitioner. The health care assistant received ongoing support and guidance from the nurse practitioner.

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A

Explanation of any answers and additional evidence:

- Community Delivery Meetings were held every four weeks to review the care and needs of the practice's most vulnerable patients. This was a multi-disciplinary meeting attended by district nurses, a social worker, members of the community rehabilitation team such as physiotherapists and occupational therapists, and members of the practice team. This meeting incorporated discussion of patients approaching the end of life.

- The practice used a health and social care plan called Respect (Recommended Summary Plan for Emergency Care and Treatment) which targeted patients' wishes and the care they required. This incorporated an assessment of mental capacity and details of the patient's resuscitation status (i.e. if cardiopulmonary resuscitation should be given or not).

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, tackling obesity.	Y

Explanation of any answers and additional evidence:

- The main noticeboard in the waiting area was changed regularly with topical and relevant information and with patient input. At the time of our inspection the theme was 'healthy lungs', and previous subjects had included alcohol awareness and the promotion of 'dry January', and information on the cervical cancer screening programme.
- Patients were referred to the 'Live Life Better Derbyshire' scheme for ongoing support with smoking cessation, weight management and healthy lifestyles.
- There was a self-controlled blood pressure machine within the waiting area. When we asked how this was managed, we were informed that the results print-out was not operational. Patients were asked to write down the results on a piece of blank paper and bring them to reception if they had any concerns. However, there were no instructions or guidance with the machine, and the process for reviewing the results was vague. The practice had not considered any risks associated with this. However, following our inspection the practice informed us that this equipment had been removed from the waiting area.

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	94.1%	95.4%	95.0%	No statistical variation

Exception rate (number of exceptions).	0.3% (3)	0.8%	0.8%	N/A

Any additional evidence or comments
• Smoking cessation support was offered within the practice by the health care assistant

Consent to care and treatment

The practice mostly 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
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	N/A
Explanation of any answers and additional evidence: • Consent was documented, for example, when patients attended for joint injections.	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	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
Explanation of any answers and additional evidence: • Patients could access a chaplain who attended the health centre building each week. This was part of a wider scheme for local practices initiated by the previous CCG.	

CQC comments cards	
Total comments cards received.	35
Number of CQC comments received which were positive about the service.	35
Number of comments cards received which were mixed about the service.	0
Number of CQC comments received which were negative about the service.	0

Source	Feedback
Patient comment cards	• All patient comment cards praised the care and support received from the practice team. Patients said they were given appropriate information about their condition; that they were listened to and given time to discuss their concerns; that they were always treated with dignity and respect; and that staff were friendly and helpful.
NHS Choices	• Three comments had been posted on the NHS website over the last two years. Two of these were extremely positive highlighting responsive care from helpful and caring staff. One comment raised dissatisfaction about a particular consultation.
Healthwatch	• Two comments had been received by Healthwatch in the last 18 months. This included a positive comment about prompt access to care, whilst the other stated concerns about being given insufficient time during a consultation.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population

3,542	277	110	39.7%	3.11%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	95.1%	89.5%	88.9%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	93.6%	88.3%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	98.5%	96.2%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	88.5%	84.5%	82.9%	No statistical variation

Any additional evidence or comments
• Results for 'caring' indicators in the most recent national GP survey were above local and national averages. We saw that most indicators in the survey relating to caring had increased from the previous survey 12 months ago (for example, 95.1% of respondents stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them – this had increased from 89% in 2018). Feedback received on patient comment cards provided additional evidence that patients felt the practice team delivered high quality care.

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

Any additional evidence
• The practice had previously undertaken internal patient surveys but had not done any in the last 12 months. A new system was being introduced for quarterly patient questionnaires on a rotational basis with the local GP federation, Erewash Health Partnership (EHP). The plan was that EHP would run a questionnaire across all of their member practices in one quarter to provide a wider information return across all member practices which they could use as a comparison tool, whilst the next quarter would be a practice specific survey to use for their own purposes.

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: • Easy read and pictorial materials were available.	

Source	Feedback
Patient comment cards.	Patients told us that they received an explanation about treatment options, and were involved in decisions about their ongoing care.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2019 to 31/03/2019)	97.6%	93.6%	93.4%	No statistical variation

Any additional evidence or comments
• This indicator has risen from 94.4% in 2018.

	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
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified.	• There were 60 carers on the practice carers' register. This was 1.7% of registered patients.
How the practice supported carers (including young carers).	• The practice provided carers with information to support them. This included local carers' support services. • The practice website included a link to carer support information. • Information leaflets were available for young carers. • Carers were invited to receive an annual flu vaccination. • There was a display board within the practice containing information for carers on local services and information on how they could access further help and advice. A TV screen in the waiting area also displayed information on carer support. • Newly appointed social prescribers through the Primary Care Network would be an additional source of advice and support for carers, as well as for all patients who might require social support.
How the practice supported recently bereaved patients.	• GPs would contact relatives/carers following a bereavement, when appropriate to do so, to offer condolences and support. The practice was looking to send a condolence card with supporting information about bereavement as a development. • Patients were referred to bereavement counselling if this was required. • The practice website contained a link to information on what to do in times of bereavement. • There was access to a weekly visiting chaplaincy service.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
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
Explanation of any answers and additional evidence:	

If the practice offered online services:

	Y/N/Partial
Patients were informed and consent obtained if interactions were recorded.	n/a
The practice ensured patients were informed how their records were stored and managed.	n/a
Patients were made aware of the information sharing protocol before online services were	n/a

delivered.	
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	n/a
Online consultations took place in appropriate environments to ensure confidentiality.	n/a
The practice advised patients on how to protect their online information.	n/a
Explanation of any answers and additional evidence:	

Responsive Rating: Good

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:

- The practice was co-located in a health centre that hosted some community health services and another GP practice. An independent pharmacy was situated next to the practice with easy access between the two. This helped patients to access services at one location.
- All services were located at ground level and there was good access for wheelchairs and mobility scooters. There were automatic entrance doors and there were designated disabled parking spaces available.
- Alerts were used on the computer to identify any individual patient needs.
- A hearing loop was available for patients with a hearing impairment.
- Information could be provided in different formats (e.g. larger and different font types, colour, etc) on request for people who required it.

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8.00am – 6.30pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm
Appointments available:	
Monday	8.30am – 10.50am, 2.50pm – 5.40pm
Tuesday	8.30am – 10.50am; 4.00pm – 5.30pm

Wednesday	8.30am – 10.50am; No routine GP surgery is held on a Wednesday afternoon, but urgent cases are seen *
Thursday	9.00am – 10.50am; 4.00pm – 5.30pm
Friday	8.30am – 10.50am; 4.00pm – 5.30pm

- Although the last allocated appointment times were 10.50am in the morning and 5.30pm in the evenings, additional patients would be seen after these times if necessary. This reflected the practice ethos of trying to accommodate patients who needed to be seen on the same day.
- The practice worked collaboratively with other local practices on a Wednesday afternoon to allow GPs more capacity to catch up with administrative and other duties. They worked with the practice situated in the same premises to see any urgent cases from both practices between 1.30pm and 5pm on a Wednesday afternoon in a reciprocal arrangement. In addition, a similar scheme was in operation with three other local practices between 5pm and 6.30pm on a Wednesday so that each practice covered for the others every fourth week.
- Two additional GP telephone consultations were offered between 6.30pm – 7.00pm on Mondays and Fridays, and phlebotomy appointments were available on a Monday morning from 7.15am.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3,542	277	110	39.7%	3.11%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2019 to 31/03/2019)	98.5%	95.2%	94.5%	No statistical variation

Any additional evidence or comments

There were a range of options open to patients which created good access.

- When all appointments had been booked for the day, patients requiring an urgent appointment could access an 'on-the-day' service with a nurse practitioner. This service had been initiated by the former NHS Erewash CCG and was provided at a nearby GP practice. The practice was allocated five appointments on this service each Monday, and two from Tuesday to Friday.
- Patients could be seen as part of a local extended access scheme from Monday to Friday between 6pm and 8pm provided by the Erewash Extended Hours Hub at one of two locations locally. The Hub also provided extended access appointments at weekends and on bank holidays.
- A new practice telephone system had been introduced in September 2019. This offered more functionality such as increased waiting capacity, less options to select from in order to speak to someone, caller identification, complete call recording, and links to input into the practice IT system.

- The introduction of the iPlato system in July 2019 also offered improved communication for patients. The system allowed patients to receive text appointment reminders, the ability to decline appointments via text, and also to cancel booked appointments via the service. It had been used to good effect during the flu campaign when patients could respond to say they had received the vaccination elsewhere, or decline to have the flu jab. The service linked to the records for coding purposes. It was hoped that iPlato would be developed to work with the NHS application to enable patient annual recalls to be managed by this system later in the year.
- Patients had access to a local walk in centre at Ilkeston.
- The practice could book appropriate patients directly for a physiotherapy assessment at the local community hospital

Older people — Population group rating: Good

Findings

- As the practice had higher number of older patients compared to local and national averages, the practice team provided continuity of care, and worked with health care professionals and social services to deliver holistic care.
- Reception and administrative staff had offered computer training during annual flu clinics to encourage patients to register for online access.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The CCG had developed an acute home visiting service undertaken by advanced nurse practitioners (and overseen by a named community GP) for a defined range of conditions. This delivered a more responsive service for patients (for example, visits could be done earlier in the day), whilst also reducing the number of home visits required to be done by GPs.
- The practice also had access to a CCG initiated care home support service which involved advanced nurse practitioners visiting care home patients. This scheme had also helped to reduce the number of home visits undertaken by GPs.

People with long-term conditions — Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one or two appointments whenever possible. The review would be undertaken in the patient's home if they were not able to attend the practice.
- The practice liaised regularly with the local district nursing team and community healthcare team to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people — Population group rating: Good

Findings

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment

when necessary.

- The midwife attended the practice once a fortnight and held a session at the other GP practice within the health centre on the week in-between. Patients could attend either session to receive care and support both during and after pregnancy.
- This was a children's play area in the waiting room.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided telephone consultations, and there was access to a medicines order line for patients to request repeat medicines via telephone.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.
- The practice offered an extended hours service for phlebotomy appointments from 7.15am on a Monday morning, and pre-bookable telephone consultations with a GP on a Monday and Thursday evening which were often used to discuss blood results or health concerns and sometimes to discuss relatives they cared for.
- Additional pre-bookable appointments were available to all patients via the local Hub extended access scheme. Appointments were offered until 8pm during the week, and were also available on Saturday and Sunday mornings. The practice also had some access to an 'on-the-day' service at a nearby GP practice where patients could see an advanced nurse practitioner.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- There was an emphasis on continuity of care by trying to book vulnerable patients in with the same doctor for their consultations.
- The practice held a register of patients living in vulnerable circumstances, for example, patients with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings
• Priority appointments were allocated when necessary to those experiencing poor mental health. Patients could arrange to have a longer appointment if this was required. • Staff had a good understanding of how to support patients with mental health needs and those patients living with dementia. Practice staff had received 'dementia friends' training. • The practice was aware of support groups within the area and signposted their patients to these accordingly, for example we observed leaflets on monthly easy dementia friendly walks which took place in Ilkeston. • The practice liaised with pharmacies to ensure safe prescribing and medicines management, for example, the use of compliance aids, for those patients with dementia. • Patients could self-refer to talking therapies and a range of local support services.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence: • The practice had access to an acute home visiting service provided through the Erewash Health Partnership. The home visits were undertaken by advanced nurse practitioners although they did not see patients at the end of life, patients with obstetric or gynaecological problems, or patients with mental health difficulties. A named community-based GP provided oversight of this scheme. The scheme's nurses had access to the same computer system so that the practice team had instant access to their consultation notes. GPs within the practice undertook home visits for patients who did not met the scheme's criteria, or when capacity on the scheme was full. GPs would opt to see some of their patients for continuity rather than refer to the scheme. • The practice also had access to a local CCG initiated nursing home visiting service led by advanced nurse practitioners.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	85.7%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP	88.1%	67.2%	67.4%	Tending

Indicator	Practice	CCG average	England average	England comparison
patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)				towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	73.2%	64.8%	64.7%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	84.6%	75.1%	73.6%	No statistical variation

Any additional evidence or comments
• The practice scored higher than local and national averages for indicators related to access. We saw that the practice survey results had improved in some areas and lowered in others in comparison to the previous year, for example: ➢ 88.1% of patients responded positively to the overall experience of making an appointment in the 2019 survey, compared to 80.2% in 2018. ➢ 85.7% of patients responded positively to how easy it was to get through to someone at their GP practice on the phone, compared to 88.8% in 2018.

Source	Feedback
Patient comment cards	Feedback was positive in relation to the ease of getting an appointment and being responded to in a prompt and effective manner. One person said that they would like more details regarding their appointment times to be explained, although they told us that they were always received excellent care. Another patient said they felt that waiting times for appointments was too long but also acknowledged that this was a wider issue for all GP practices.

Listening and learning from concerns and complaints

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

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

	Y/N/Partial

Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence: • The practice complaints procedure required some minor updates to reflect guidance. This was completed by the practice on the day of our inspection.	

Example(s) of learning from complaints.

Complaint	Specific action taken
• Whilst there were no formal complaints we discussed an issue raised by a patient on the NHS website and also with the CQC regarding a consultation at the practice.	• The practice had made efforts to engage with the patient to discuss their concerns. The GP had used the case for personal reflection in their annual appraisal.

Well-led Rating: Requires improvement

We previously rated the provider as requires improvement for providing well-led services in 2019 because:

- The practice did not have effective systems to identify, manage and mitigate risk.
- We found that the oversight of some systems required additional assurances to ensure they were working effectively. For example, we identified issues that required stronger managerial and clinical oversight relating to systems and processes within the practice.

At our inspection in 2020, we again rated the practice as requires improvement for providing well-led services because:

Some areas which had been identified for action at our previous inspection had not been fully addressed. This included:

- Site management responsibilities indicated a lack of ownership for site-related matters following assessment – for example, oversight of action plans relating to fire, Legionella and health and safety.
- The oversight of systems such as checks for medicines stored on site, the internal distribution of prescription stationery, actions taken in response to the findings of clinical audits, and risk assessment processes, were not always sufficiently robust.
- In addition, we found that leaders were not always receptive to the requirements needed to provide assurance as part of their registration with the CQC.

Leadership capacity and capability

Leaders could not consistently demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	N
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y

Explanation of any answers and additional evidence:

- The practice was a member of the Erewash Health Partnership (EHP), covering approximately 70,000 patients. This was a federation of 10 local GP practices who worked collaboratively to ensure standardisation and efficiency, to strengthen resilience, and to derive benefits from economies of scale. Each practice was still autonomous in how they worked. Initiatives such as the EHP's extended access scheme offered greater opportunities for patient consultations.
- The practice was also part of the local Primary Care Network (PCN) which was composed of 13 local GP practices and encompassed a population of approximately 1000,000. A GP partner and the business manager attended PCN meetings and the practice was committed to the PCN agenda.
- The partners attended external meetings, and they engaged with their CCG. There was participation in local practice manager meetings and nurse forums.

- Clinicians had identified lead roles to act as a point of reference and expertise, for example, contraception and sexual health, undergraduate training, QOF, and joint injections.
- A business manager had started working at the practice from May 2019. This brought additional expertise and a wider strategic approach to the management of the practice.
- We did not find that sufficient improvements had been made following the previous inspection in February 2019. Some issues which had been previously highlighted remained as concerns, alongside some additional matters which we observed on the day of the inspection. This was a result of a lack of leadership and oversight meaning that systems were not always robust.
- The partners did not fully acknowledge the importance of demonstrating their compliance with regulations supported by documented evidence.

Vision and strategy

The practice had a clear vision but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Partial

Explanation of any answers and additional evidence:

- The strategy was integrated with Erewash Health Partnership's plans to address the NHS Five Year Forward View.
- The practice had a mission statement and it had developed service aims, which incorporated their values. The practice told us that they took pride in offering an accessible and approachable service. They were patient-orientated and as a small practice who knew their patients well, they strove to deliver continuity of care.
- There was no formal practice business plan but the business manager informed us that the practice intended to develop this in the near future in order to give some structure to their future plans and aspirations.

Culture

The practice culture did not effectively support 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's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	N
The practice had access to a Freedom to Speak Up Guardian.	N
Staff had undertaken equality and diversity training.	Y

Explanation of any answers and additional evidence:

- All the staff we spoke with during the inspection gave a very positive account of their interactions with managers and the GP partners.
- Staff turnover was low. The only change in personnel since our inspection 12 months ago, had been the appointment of a business manager. Staff informed us that they felt valued by the partners and managers.
- The partners valued their team. We were informed that the partners took staff out for a Christmas meal each year, and thanked staff for their work and commitment.
- The practice whistleblowing policy had some gaps (for example, reference to the CQC), and there was no mention of a Freedom to Speak Up Guardian. The practice took steps to address this on the day of the inspection. Following our inspection, the provider sent us an appropriate updated policy.

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

Source	Feedback
Staff interviews	Staff told us they were happy working at the practice. They received support on a personal level when necessary, and they were also encouraged to develop within their roles. They told us that the team worked together and that they were always able to access support when this was needed. Staff also said they would be confident to raise any concerns and would be supported to do so. The salaried GP told us that he was well supported by the partners, particularly in terms of support for study leave and continuing professional development.

Governance arrangements

The responsibilities, roles and systems of accountability to support good governance and management were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial

Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	N

Explanation of any answers and additional evidence:

- The responsibilities around health and safety management, and the assurances for site management issues were not always working effectively. This issue had been raised at the previous inspection in February 2019, but we found there was still a requirement for more concerted action on this matter. Evidence of compliance was not always readily available, and there was a reliance on the building owner/contractor to manage these issues.

- Although there were a comprehensive range of policies and procedures we reviewed two policies and found both of these required some updates.

- There was a network of internal meetings to support good governance. When practice representatives attended external meetings, feedback was shared with the team to promote best practice.

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Y
There was a programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

- Due to the issues relating to the oversight of site related issues, the arrangements for identifying, managing and mitigating risks were not adequate. Whilst we saw that some of the concerns raised at the previous inspection had been addressed, other areas such as the managerial oversight to ensure risk assessments (for example, fire and Legionella) were completed in a timely fashion with documented evidence were not sufficient.
- In addition, some assurance systems were not working effectively. For example, the nursing team reviewed stocks of medicines for quantities and expiry dates, but the doctors' bags were not included. We subsequently found that expired medicines were being kept in one doctor's bag.
- The risk assessment process was not being used to minimise where risks were in place or identified, for example, the security of doctor's bags, emergency medicines that were not routinely stocked, and the control of prescription stationery.
- Following our inspection, the practice provided us with documentation to show that they had acted

upon our feedback and revised processes to demonstrate their compliance with regulations. The practice informed us the new ways of working were to be introduced immediately.

Appropriate and accurate information

There was a commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	n/a
Patient records were held in line with guidance and requirements.	n/a
Any unusual access was identified and followed up.	n/a
Explanation of any answers and additional evidence:	

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 (PPG).	N
Staff views were reflected in the planning and delivery of services.	Y
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: • A staff 'away day' was held annually at a local venue. This provided an opportunity for team	

building and learning. External speakers would attend the event to provide staff training and updates. The most recent event in October 2019 included topics such as adult safeguarding, dementia, and paediatric occupational therapy.

- The PPG was established in 2011 but was not active at the time of our inspection due to unforeseen personal circumstances and as a small group, it was not viable to continue. The practice told us they were considering the potential to develop a virtual PPG in the future.

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.	Y

Explanation of any answers and additional evidence:

- We saw that the business manager had implemented some changes to improve efficiency and free capacity for staff to focus on core duties. For example, an external company had been commissioned to shred confidential documentation and this helped to free up additional capacity for administrative duties.
- The practice utilised the GP TeamNet system which was an effective system for document management and staff access to information. The practice knew there was scope to increase the functionality of this system for the future.

Examples of continuous learning and improvement

- As a member practice of the Erewash Health Partnership (EHP), there was a drive towards collaborative working and standardisation locally. Initiatives such as a nurse-led home visiting service and extended access were in operation at the time of our inspection, offering greater flexibility and alternative choices for patients. In the longer term, developments such as one call centre for all telephone calls and one secretarial pool were potential areas to benefit all member practices.
- EHP had developed specific workstreams with a manager being identified as the lead for each. For example, the business manager at the practice was leading the enhanced services working group, but also contributed to other working groups. The intention was to look at how things could be improved and how any outcomes could be shared collectively with other practices.
- The practice was also engaged to developments being introduced through the Primary Care Network (PCN). There were plans for a PCN pharmacist to provide one clinic a week on site in the near future. In addition, a new role of social prescriber had been introduced through the PCN. The social prescriber had arranged two practice visits with the first scheduled for 20 January 2020. The plan was to engage with patients in the waiting area to talk about their role and to suggest how they might support patients and carers. These sessions were displayed in the waiting area to ensure patients were aware that they could access this support if needed.
- New computers had been purchased for the practice to ensure the framework was in place for further IT developments.
- The iPlato system offered more options to communicate with patients for efficiency. The practice

were looking to expand its use to give greater functionality, for example, family and friends returns and in the longer term, annual patient recalls.
- The nurse practitioner undertook a part-time role for the CCG looking at the development of practice nurse services as part of the wider local CCG strategy.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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