

# Care Quality Commission

## Inspection Evidence Table

**biddulphdoctors (1-1162793071)**

Inspection date: 20 January 2020

Date of data download: 07 January 2020

## Overall rating: Good

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

### Safe

**Rating: Good**

#### Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	No
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>There were safeguarding policies in place at the practice however the safeguarding policy for children did not include categories of abuse. The safeguarding policies did not take account of patients accessing any online services.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>There were systems to identify vulnerable patients however, they were not always effective. For example, we saw that an alert had not been added to the records of a parent of a child with a child protection plan in place.</li> <li>Due to changes in the health visiting and school nursing services, the practice no longer held formal meetings with these services. However, they had arranged meetings with a local social worker to discuss children at risk. They were working with the local authority to validate their children's safeguarding list.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was an employee immunisation programme in place which included a review and monitoring of employee immunisation needs.</li> </ul>	

<b>Safety systems and records</b>	<b>Y/N/Partial</b>
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: June 2019	Yes
There was a record of equipment calibration. Date of last calibration: June 2019	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Yes
There was a record of fire extinguisher checks. Date of last check: March 2019	Yes
There was a log of fire drills. Date of last drill: October 2019	Yes
There was a record of fire alarm checks. Date of last check: 15 January 2020	Yes
There was a record of fire training for staff. Date of last training: Various	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 30 July 2019	Yes
Actions from fire risk assessment were identified and completed.	Yes

<b>Health and safety</b>	<b>Y/N/Partial</b>
Premises/security risk assessment had been carried out. Date of last assessment: 19 November 2018	Yes
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 2013	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>In 2013 a combined health and safety risk assessment had been completed for the practice. The recommendation was that the risk assessment was reviewed annually. We found that parts of the risk assessment had been completed however some parts had not been reviewed since 2013.</li> </ul> <p>Various risk assessments and premises checks had been completed at the practice. For example:</p> <ul style="list-style-type: none"> <li>May 2017: Legionella risk assessment.</li> <li>12 May 2018: Five-year electrical testing of fixed wires.</li> <li>August 2019: Emergency lighting checks.</li> <li>17 December 2019: Maintenance of the lift.</li> </ul>	

## Infection prevention and control

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

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 19 December 2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The infection prevention and control audit highlighted that staff were not closing the lids on sharps containers between use. There was no formal evidence that this had been shared with staff however, on the day of the inspection we saw that the lids were closed.</li></ul>	

## Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There was a process in the practice for urgent clinical review of such patients.	Yes
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Receptionists had been provided with flow charts to support them in the actions to take when they encountered an acutely unwell patient. For example, sepsis, chest pain and anaphylaxis.</li></ul>	

## Information to deliver safe care and treatment

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

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

## Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	1.06	0.98	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)	6.0%	8.7%	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)	5.49	5.22	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) (NHSBSA)	1.89	2.18	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about	Yes

Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Controlled drugs were not kept at the practice.
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• There was a system in place for tracking prescription stationery throughout the practice. A risk assessment had been completed to mitigate identified, potential risks.</li> <li>• There was a system in place to review and monitor the prescribing of non-clinical prescribers. We found that regular peer reviews of consultations and prescribing completed by non-clinical prescribers had been completed and training was provided by the GPs to support them in this role.</li> <li>• At our previous inspection in August 2015 we made a best practice recommendation to ensure that prescribing of disease-modifying antirheumatic drugs (DMARDs) included documentation that patients' blood results had been checked and that any risks identified were mitigated. At this inspection we found that a very effective system had been put in place. We found that systems for monitoring other high-risk medicines were effective and comprehensive.</li> </ul>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	26
Number of events that required action:	10
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was a system in place for reporting, investigating and sharing learning from significant events. However, an overall system for reviewing trends in significant events was not in place. The practice informed us they would review their systems to include a trend analysis.</li> </ul>	

### Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A GP had not followed guidance from the the Driver and Vehicle Licensing Agency (DVLA) when assessing a patient's fitness to drive.	The practice changed their procedures to reflect DVLA advice. This was shared with all clinical staff.
A two week wait referral for a patient with potential cancer had not been sent by the practice at the correct time.	The referral was sent when identified that it had been missed. GPs were reminded to follow the referral protocol and to send and print off a task to the medical secretaries to monitor that referrals were sent within the correct timeframe.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts for example, oxycodone and amitriptyline.	

## Effective

## Rating: Good

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Clinicians followed The National Institute for Health and Care Excellence (NICE) guidelines to keep up to date with current evidence-based practice. For example, we saw that the practice's protocol for managing hypertension had been updated in line with NICE guidance.</li> </ul>	

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)	0.45	0.78	0.74	No statistical variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. The practice matron provided a full assessment of their physical, mental and social needs either within the practice or in the patient's home.</li> <li>The practice followed up older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> </ul>

- The practice carried out structured annual medication reviews for older patients.
- The practice matron had run a search of patients aged 90 years and above who had not recently been seen by the practice. She offered them a review of their health and made referrals to other services that provided additional care and support.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice held bimonthly meetings with the Integrated Local Care Team (ILCT), a team that included health and social care professionals, to discuss older patients.
- Prior to our inspection, we spoke with the managers of three care homes where the practice provided care and treatment. Two managers were overwhelmingly positive about the service provided by the practice describing it as perfect and amazing. They told us that the practice treated all their residents as individuals and with great kindness and respect. That they provided annual medication reviews and frailty assessments. All three managers told us that the GPs were very responsive to requests for home visits. The GPs carried out a weekly ward round at the larger of the three homes to review the patients.
- The practice was a veteran friendly practice.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with asthma were offered an asthma management plan.
- The practice's clinical pharmacist carried out priority medication reviews for patients prescribed over 10 different medicines.
- The practice was a diabetes trailblazer practice working to reduce the conversion of pre-diabetic patients through inhouse management and referrals to education programmes. To date none of the pre-diabetic patients referred to the programme have gone on to develop diabetes.

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) <small>(QOF)</small>	84.9%	81.3%	79.3%	No statistical variation
Exception rate (number of exceptions).	16.9% (135)	14.5%	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) <small>(QOF)</small>	82.3%	81.3%	78.1%	No statistical variation
Exception rate (number of exceptions).	3.9% (31)	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) <small>(QOF)</small>	85.0%	84.5%	81.3%	No statistical variation
Exception rate (number of exceptions).	6.3% (50)	13.1%	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) <small>(QOF)</small>	79.8%	77.6%	75.9%	No statistical variation
Exception rate (number of exceptions).	18.6% (138)	10.4%	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) <small>(QOF)</small>	90.7%	90.4%	89.6%	No statistical variation
Exception rate (number of exceptions).	18.6% (59)	11.6%	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 measured in the preceding 12 months is 150/90mmHg or less (01/04/2018 to 31/03/2019) (QOF)	82.3%	84.9%	83.0%	No statistical variation
Exception rate (number of exceptions).	2.1% (47)	4.9%	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)	85.9%	91.1%	91.1%	No statistical variation
Exception rate (number of exceptions).	1.6% (4)	4.5%	5.9%	N/A

#### Any additional evidence or comments

- Exception reporting for patients with asthma or COPD were above the local and national averages. We discussed this with the management team. They told us that the practice nurse who carried out these reviews had left the practice during the time of this data collection. They had put interim measures in place until they recruited a replacement practice nurse.

## Families, children and young people

## Population group rating: Good

### Findings

- The practice had met the minimum 90% target for all of the four childhood immunisation uptake indicators. They had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of four childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception. The practice provided coil and implant insertions.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice worked with the 'Hospital at Home' community team to support the care of children.

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)	102	103	99.0%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	110	117	94.0%	Met 90% minimum
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)	111	117	94.9%	Met 90% minimum
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)	111	117	94.9%	Met 90% minimum

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

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

Population group rating: Good

### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including new patient checks. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients who could not attend appointments in the week were offered evening and weekend appointments at local hubs through the primary care extended access service.

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)	79.4%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	74.1%	76.0%	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)	61.1%	62.5%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	63.6%	69.9%	68.1%	N/A
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)	60.7%	58.9%	53.8%	No statistical variation

#### Any additional evidence or comments

- The practice had effective systems in place to recall and follow up patients that failed to attend for cervical screening. They used a text messaging service to remind patients about their appointments.

#### People whose circumstances make them vulnerable

#### Population group rating: Good

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice had participated in sending Christmas present boxes to local homeless people.
- The practice worked with the primary care network's social prescriber to provide additional support to patients. For example, debt management and support back into work.

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

**Population group rating: Good**

**Findings**

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- 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.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- A community psychiatric nurse provided support within the practice for patients over 65 years old experiencing poor mental health.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)	92.7%	89.6%	89.4%	No statistical variation
Exception rate (number of exceptions).	10.9% (5)	15.4%	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)	91.1%	91.6%	90.2%	No statistical variation
Exception rate (number of exceptions).	2.2% (1)	11.4%	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)	74.8%	82.5%	83.6%	No statistical variation
Exception rate (number of exceptions).	5.9% (7)	9.4%	6.7%	N/A

## Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	549.2	548.1	539.2
Overall QOF score (as a percentage of maximum)	98.2%	98.0%	96.7%
Overall QOF exception reporting (all domains)	4.9%	6.2%	5.9%

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

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

- The practice had carried out an audit of patients under 85 years old with high blood pressure to ensure that patients were offered the most appropriate treatment in line with NICE guidance. They identified 278 patients and included a sample of 30 patients in the audit. They found that only six per cent of the sample size were on the recommended triple medicine combination and there was a low patient response to medication review recalls and hypertension monitoring. In response to this the hypertension protocol was updated, blood pressure monitoring was incorporated into the monitoring of other long-term condition reviews and text messaging was used to remind patients to attend their reviews. The audit has not been repeated yet to determine the effectiveness of the changes made.
- The practice had carried out an audit of their cancer detection rate following a two week wait referral for suspected cancer. It showed an 80% cancer detection rate compared with the national average of 53.8% demonstrating they were making necessary and appropriate referrals.

## 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.	Yes
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Not applicable.
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• There were systems in place to review and monitor the prescribing of non-clinical prescribers and additional training was provided when required.</li> <li>• Regular clinical and staff role specific meetings were held within the practice.</li> <li>• At our previous inspection in August 2015 we made a best practice recommendation to ensure that copies of certificates of staff qualifications are retained within the practice. At this inspection we found that these were kept appropriately.</li> </ul>	

## 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)	Yes
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.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or	Yes

organisations were involved.	
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Prior to our inspection, we spoke with the managers of three care homes where the practice provided care and treatment. They told us that the practice provided person-centred care and worked effectively with the homes and the palliative care team to ensure that the needs of patients were met.</li> <li>• The practice had developed a broad multi-disciplinary team to ensure patients were seen by the most appropriate professional. For example, a practice matron, clinical pharmacist, advanced nurse practitioner (ANP) and a paramedic. We saw that information was readily available to patients informing them of the role of the ANP and the type of consultations they were able to provide.</li> </ul>	

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, flu immunisation, tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice used innovative ways to encourage staff to be proactive in helping patients to live healthier lives. For example, to increase the uptake of flu immunisations the practice ran a 'flu raffle'. Staff that booked a patient in or opportunistically administered a flu immunisation entered a ticket into the raffle and prizes were won by staff. Unverified data showed an increase in flu vaccine uptake from 717 patients in 2018/19 to 866 patients in 2019/20.</li> <li>The practice ran a 'flu, poo and do' clinic. The practice proactively used the flu immunisation clinics to offer additional health promotion advice. For example, patients were prompted to complete their bowel cancer screening, offered blood pressure monitoring and smoking advice where appropriate.</li> <li>The practice offered exercise on prescription at a local leisure centre.</li> </ul>	

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)	95.2%	96.4%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (21)	1.2%	0.8%	N/A

## Consent to care and treatment

**The practice always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	Yes
Policies for any online services offered were in line with national guidance.	Yes

## Well-led

**Rating: Good**

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>Leaders were aware of the challenges to the practice and had taken action to address them. For example, the practice had expanded their multi-disciplinary team to include a clinical pharmacist, practice matron and paramedic (to start working at the practice in February 2020) to support the delivery of their service and support the work of the GPs.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Partial
Explanation of any answers and additional evidence: <p>The practice had developed a mission statement which was underpinned by their core values:</p> <ul style="list-style-type: none"><li>E – Everybody matters</li><li>N – Never forgetting sustainability</li><li>I – Innovation</li><li>D – Development and training.</li></ul> <p>They told us they aspired to deliver individualized patient-centred care that aligned to national priorities. The practice had planned an away day to update their strategy to achieve their priorities.</p>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>The practice used innovative ways to support staff well-being and motivation in delivering a high-quality service. For example, to increase the uptake of flu immunisations the practice ran a 'flu raffle'. Staff that booked a patient in or opportunistically administered a flu immunisation entered a ticket into the raffle and prizes were won by staff.</li> </ul>	

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

Source	Feedback
Staff interviews	Staff we spoke with told us there was an open, supportive and transparent culture within the practice. They told us that staff worked together well as a team and they felt comfortable raising any concerns with the management team.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>An organisation structure was in place which contained clearly defined roles and responsibilities for clinical staff. Staff we spoke with were aware of who held which lead roles. For example, safeguarding and education and training.</li></ul>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We saw that the practice had carried out clinical audits to improve outcomes for patients. However, some of the audits lacked detail and had not been written up in full to demonstrate the improvements made.</li><li>At our previous inspection in August 2015, we made a best practice recommendation that the practice considered improvements to the practice business continuity plan. At this inspection we found that the plan had been updated, discussed at governance meetings and a copy was held offsite by appropriate members of the management team. However, it was not clear from the plan where the practice would relocate too if the building was not adversely affected.</li></ul>	

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Any unusual access was identified and followed up.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>The practice was in the process of reviewing and updating their online access policies and procedures. We saw minutes from staff meetings that confirmed this.</li></ul>	

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

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group (PPG).	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>We found that the practice had gathered staff views and used them to improve the service.</li> <li>We found that suggestions made by the PPG had been acted on by the practice matron to improve services for older patients. For example, the PPG had asked the practice what services they specifically offered for patients aged 90 years and above. In response to this, the practice matron ran a search of patients in this population group who had not recently been seen by the practice. She offered these patients a review of their health and made referrals to other services that provided additional care and support.</li> <li>The practice used the Friends and Family Test to assess patient satisfaction with the service. For example, in December 2019 the practice received 75 responses of which 85% of patients were likely or extremely likely to recommend the practice, 11% did not know and 4% would not recommend the practice to friends or family.</li> </ul>	

## Feedback from Patient Participation Group.

Feedback
<p>Prior to our inspection we spoke with a member of the PPG. They told us that their ideas and suggestions to improve the service were listened to and acted on by the practice. For example, the PPG had identified that the furniture in the practice was unclean. In response to this, the practice arranged for the furniture to be cleaned. The PPG member told us that there was good communication between the practice and the PPG and the practice supported them to engage with community outreach groups such as The Biddulph Youth and Community Zone and local churches to promote awareness of the PPG and how local services could work together for the community they served.</p>

CQC comments cards	
Total comments cards received.	40
Number of CQC comments received which were positive about the service.	38
Number of comments cards received which were mixed about the service.	2
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC comment cards	Patients told us that staff were caring, polite, helpful and respectful. Patients described the service as excellent, perfect and amazing. The two mixed comment cards raised concerns about access to appointments.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes

## Examples of continuous learning and improvement

- The practice used patient feedback, complaints, audits and significant events to drive improvements within the practice.
- The practice contributed to research projects run by a local university and was part of the National Institute for Health Research clinical research network. It contributed to a number of research databases for example, a back-pain checklist for use in primary care to identify older women with back pain due to un-diagnosed broken bones in the back.
- The practice was a training practice for GP trainees and recently qualified doctors.
- The practice had developed a broad multi-disciplinary team to ensure patients were seen by the most appropriate professional.
- The practice was a diabetes trailblazer practice working to reduce the conversion of pre-diabetic patients.

## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

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

## Glossary of terms used in the data.

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