Care Quality Commission

Inspection Evidence Table

Sunnyhill Healthcare C.I.C (1-520153601)

Inspection date: 12 December 2019

Date of data download: 09 December 2019

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

Safe

Safety systems and processes

Recruitment systems	Y/N/Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice had commenced work on collecting staff vaccination and immunisation history however, this work was incomplete. There was no evidence of self-certification of staff. This information was not held in a shared file and not in recruitment records.

At the December 2019 inspection we found:

- The practice had a full record of staff immunisations. We saw evidence that new staff induction included gathering this information. The practice offered blood testing and vaccination where necessary.
- Policies had been developed that contained relevant information regarding each vaccine. A risk assessment had been completed that included staff declaration should there be refusal to receive vaccination.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 10/10/2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 10/10/2019	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice had not completed a premises or security risk assessment.
- The practice had not completed a health and safety risk assessment at the time of inspection. This was received shortly following the inspection.

At the December 2019 inspection we found:

- The practice had used an external agency to conduct a health and safety and security risk assessment. An associated action plan had been developed and we saw that remedial work had taken place. For example, signage had been placed above hot water taps and display screen assessments had been completed for all staff.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: October 2019	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- Actions arising from the practice infection prevention and control (IPC) audit had been completed, such as adjustments to the flooring, however the audit had not identified all the IPC concerns within the practice. For example, the lack of pedal bins and the lack of single use linings for baby change facilities. We also saw evidence of disrepair in the building, including cracked tiling, peeling paintwork and holes in ceiling tiles. These had not been reported in the IPC audit. Shortly after the inspection, the practice provided evidence that they had purchased pedal bins and colour coded mop heads.
- The practice used an external cleaning company. A cleaning audit had not been completed by the practice and we saw areas that required a deep clean. The practice was unable to provide evidence that the appropriate cleaning had been completed or that the cleaning agency was compliant with the IPC policy. Shortly after the inspection, we received evidence that a cleaning schedule had been devised with the cleaning company.
- The practice was unable to give evidence of cleaning of non-single use equipment such as ear syringing machines or blood pressure monitors. The schedule for cleaning these items was in the IPC policy however, this had not been completed.
- At the time of inspection, the practice was unable to provide evidence of a completed legionella risk assessment.

At the December 2019 inspection we found:

- The practice had completed a further IPC audit and had sought support from the clinical commissioning group who had also completed an audit. Action plans had been developed and we saw evidence that these were being completed. For example, replacement flooring had been laid and decorative work to peeling paintwork had been completed. The practice had also responded to issues found at the September 2019 inspection and had purchased pedal bins and single-use liners for baby changing facilities. The practice had plans to replace the ceiling in the coming months.
- The practice had employed a new external cleaning agency and we saw that cleaning was completed to an adequate level. The practice had developed a cleaning schedule for the building and sign sheets were in place to ensure this was completed. Weekly audits of the cleaning were completed by the cleaning agency and the practice to maintain the standard of cleaning.
- The practice had developed cleaning schedules for non-single use equipment that was kept in each consultation room. We saw that this was completed on a daily basis.

- A legionella risk assessment had been completed in September 2019 and recommendations had been made to monitor water temperatures regularly. We saw that this was being completed. The practice had also requested documents from the council for the areas of the building that they did not manage, that included the boiler, to ensure the appropriate maintenance was being completed.

Appropriate and safe use of medicines

Medicines management	Y/N/Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
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.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- We reviewed Patient Group Directions (PGD's) that allowed non-prescribers to give vaccinations to groups of patients. These PGDs had not been signed by an appropriate person. Shortly after the inspection, the practice told us this had been rectified however, we did not receive evidence to verify this.

- There were ineffective systems in place to audit prescribing, including that of non-medical prescribers. Records of ad-hoc conversations were not detailed and there was no evidence of actions or learning taken.

- The practice did not hold all recommended emergency medicines and they were not held in an accessible area.

At the December 2019 inspection we found:

- The practice had reviewed all PGD's and these had been signed by the lead clinician. The nursing team had signed to confirm these had been read and understood. All old PGD's had been archived.
- We saw that audits and performance reviews of non-medical prescribers had been completed where consultations and prescriptions had been scrutinised. This had been completed by the lead clinician. Feedback had been given to the clinicians and the practice had plans to repeat the audit on an annual basis.
- The practice held all recommended emergency medicines. We saw that these were all in date and held in an accessible area.

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
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

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The process for monitoring significant events was lacking. Some staff were comfortable in raising concerns and these events were recorded however, there was limited evidence that learning was taken from these.
- There was no mechanism in place to review actions needed. We saw evidence that some significant events were discussed at practice meetings however, it was not a standing agenda item.

At the December 2019 inspection we found:

- Staff we spoke with told us they were happy with raising concerns and felt these would be acted on.
- The process for managing significant events had been reviewed. We saw that learning was taken from significant events and this was shared with the staff team. Meeting minutes that we reviewed confirmed this.

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

Event	Specific action taken
A verbal complaint had been received regarding a prescribing error.	This had been discussed with the clinician who had reflected on the situation. We saw this had also been discussed at a clinical meeting.
During building renovations, the fridge plug had been knocked causing the fridge to be switched off.	The practice had used the electronic thermometer to determine how long the fridge had been disconnected for. Manufacturers of the affected vaccines were contacted, and their advice was followed. All patients who received affected medicines were

	informed of this. Public Health England was also contacted. This was discussed at a practice meeting and fridge plugs were fitted with signage to remind people to be vigilant.

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 the September 2019 inspection we found:

- There was limited oversight of safety alerts. The practice maintained a log of safety alerts received however was unable to provide evidence of what actions had been taken in response to these. Records we reviewed showed action had been taken for recent safety alerts.

At the December 2019 inspection we found:

- The practice maintained oversight of patient safety alerts using a log that included actions taken and searches of the patient computer records system that had been completed. We saw evidence of recent searches that had been undertaken in response to safety alerts. Clinical records we looked at showed appropriate actions had been taken in response to recent alerts. However, not all patient contacts, such as letters, had been recorded in patient records.
- Meeting minutes we looked at showed that safety alerts were discussed regularly at clinical meetings and at weekly meetings between the lead clinician and salaried GPs.

Effective

Families, children and young people

Findings

At the September 2019 inspection we found:

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets. However, the process for managing children who had not attended for vaccination was unstructured. There were no fail-safe systems in place to ensure all children had been recognised.
- The practice had some 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 however, the system for this was unstructured with no fail-safe systems in place.

At the December 2019 inspection we found:

- The process for following up failed attendances had been reviewed and the practice had implemented a log of children who had not attended. This was a new process and we saw that some children had been followed up. The practice planned to use this list to track patients and highlight them to safeguarding teams or health visitors as necessary. The practice was aware that this new system required embedding.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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

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

Any additional evidence or comments
At the September 2019 inspection we found: • The practice had completed patient searches that were requested from the clinical commissioning group. • The practice had completed a single cycle audit of patients using high levels of pain relief and had reduced dosages as appropriate. • The practice had not completed any two-cycle audits. They were unable to provide evidence of quality improvement using clinical audits. At the December 2019 inspection we found: • A second cycle of the audit of patients using high levels of pain relief had been completed and dosages had been further reduced. The focused review of these patients had reduced the number of patients that were on high levels of multiple pain relief medicines. • A two-cycle audit had been completed regarding the blood testing of patients on thyroid medicines. We saw that the practice planned to repeat searches annually. • The practice was in the process of developing audit schedules with planned quality improvement activity regarding antibiotic use and cervical screening.

Effective staffing

The practice was able demonstrate that staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
The learning and development needs of staff were assessed.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
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

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice had a system of regular appraisals however, documentation of these was lacking. The process was informal and there was limited discussion of learning needs of staff or action plans for developments.
- The non-medical prescribers had three monthly meetings with the lead GP however, there was no audit of their practice or competency.

At the December 2019 inspection we found:

- We saw that appraisals had been completed and included career discussions and highlighted staff members learning needs. We saw that objectives had been set and the practice had plans to repeat this process annually. Staff we spoke with told us they had opportunity to discuss their learning needs.
- We spoke with staff who were within their induction period and were told this was supportive and they felt they had been trained to complete tasks needed.
- The competency and performance of non-medical prescribers had been audited and feedback had been given to the clinicians.

Responsive

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.	Three complaints received since previous inspection
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	None

	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:

At the September 2019 inspection we found:

- The process for managing complaints was lacking. The practice was unable to evidence what action had been taken in response to complaints received and what learning had been taken. Not all complaints had received a formal written response however, the practice told us that these complaints had been resolved verbally.
- The practice did not have oversight of these complaints and there had been no analysis of trends or themes to improve systems or patient safety. We saw evidence of themes within the complaints, including missed diagnosis, care of pregnant woman and compassion of staff however, these had not been identified by the practice.
- The complaint policy, patient leaflet and response letters did not contain information of how to escalate concerns to the Parliamentary and Health Service Ombudsman (PHSO).
- Other methods of patient feedback were not analysed for themes or used to drive practice improvement.

At the December 2019 inspection we found:

- The process to manage complaints had been reviewed. We saw that oversight of complaints had improved and a log had been commenced.

- The practice had received three complaints since the September 2019 inspection. We saw the practice had responded to these appropriately. We saw that learning had been taken and this was shared with staff at clinical meetings. A meeting had been scheduled in January 2020 to review trends of complaints.
- Response letters and the complaints leaflet included details of how to escalate concerns to the PHSO.
- Patient feedback had been collected and analysis had commenced. The practice had plans to share this feedback with the staff team at a meeting in January 2020.

Example(s) of learning from complaints.

Complaint	Specific action taken
A blood form was not available for a patient.	The process for managing correspondence was reviewed with staff members involved in the process.
GP care of a patient with a form of dementia.	The clinician reflected on the situation and it was discussed at a clinical meeting where all staff were reminded to give more time to patients with dementia and their carers.

Well-led

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice had not formally assessed the challenges to offering good quality care. They were aware that areas of the premises required repair and updating and told us they had been in discussions with the local authority and clinical commissioning groups regarding this however, we were not provided any evidence to support this.
- Some staff told us they did not feel supported by management teams and did not feel able to raise concerns. Due to limited space at the practice, the practice manager was not always able to be on site.

At the December 2019 inspection we found:

- The practice had completed risk assessments and highlighted areas of challenge and improvement. We saw that actions had been taken in response to risk assessments. Areas of the building that they were responsible for had been repaired and updated. Some areas that had not been improved, such as the ceiling, were booked for repair in the coming months.
- Staff we spoke with told us that the management teams were approachable, and they felt comfortable in raising concerns. They felt these concerns would be responded to.

Culture

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

	Y/N/Partial
Staff reported that they felt able to raise concerns without fear of retribution.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- Some staff told us they did not feel able to raise concerns and felt there was no actions when concerns were raised. The practice had a whistleblowing policy in place and advertised the contact details of the freedom to speak up guardian however, some staff told us that they were unable to raise concerns about the management team.

- We saw examples of where patients had been informed of things that had gone wrong and given an apology. However, we saw that there was no associated actions, review or evidence of learning shared with the wide practice team.

At the December 2019 inspection we found:

- Staff told us that management teams were approachable and gave us examples of when they had received support.
- The practice ensured that all complaints were responded to and patients were given apologies and explanation where appropriate. Complaints were discussed at practice meetings where learning was shared.

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

Source	Feedback
Staff Interviews	Staff told us that they enjoyed working at the practice and felt that they had the tools needed to complete their work. They were comfortable with raising concerns and felt this would be listened to.

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.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice lacked a strong governance system and had limited oversight of complaints and significant events. Some systems, for example, the following up of children who may be at risk, were disjointed and relied on individual clinicians following up patients as they felt appropriate.
- There was limited risk assessments or audit of practice systems and a lack of formal action planning for required practice improvements.

At the December 2019 inspection we found:

- The practice had reviewed the governance systems and had increased oversight of complaints, patient feedback and significant events. We saw that this was shared with teams at regular practice meetings. These meetings had standing agenda items including safeguarding, safety alerts, infection prevention and control and significant events and the minutes were clear and thorough.
- The practice had completed both organisational risk assessments and clinical audits. Action plans had been developed and mitigating actions had been commenced. We saw this was used to drive practice improvements.

Managing risks, issues and performance

There were processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

At the September 2019 inspection we found:

- The practice did not have a process of clinical audit or other quality improvement methods to highlight areas that needed improvement. There were limited organisation risk assessments and action planning in place.
- The practice did not have appropriate infection prevention and control measures in place, including records of cleaning or comprehensive audits.
- The practice did not maintain a complete record of staff immunisation and vaccination history.
- The practice did not hold all recommended emergency medicines and there was no risk assessment in place to mitigate this. At the time of inspection, the emergency medicines were not in an accessible area.

At the December 2019 inspection we found:

- The practice had created a schedule for risk assessments and audits. We saw this had highlighted areas of improvement that were being progressed. The practice had plans to present the findings of clinical audits at a full practice meeting in January 2020.
- The practice had improved infection prevention and control systems and held cleaning schedules and completed audits.
- The practice maintained a record of staff vaccinations.
- The practice held all emergency medicines in an accessible area.

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
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:

At the September 2019 inspection we found:

- Patient feedback was reviewed individually, however not analysed for themes to make practice improvement and shape the service.
- We reviewed minutes from the Patient Participation Group (PPG) meetings and these lacked detail as to what was discussed and there were no standing agenda items.

At the December 2019 inspection we found:

- Patient feedback had been reviewed and analysed for themes. The practice had plans to share this with staff at a practice meeting in January 2020.
- We looked at minutes from the recent PPG meeting and saw that minutes were detailed and standing agenda items had been put in place, such as appointments and premises.

Any additional evidence

At the September 2019 inspection we found:

- Clinical policies, such as the mental capacity act policy, were not detailed and thorough. They did not fully explain processes or what safety netting was in place for patients.
- Staff had access to these policies however, these were disorganised.

At the December 2019 inspection we found:

- Clinical policies had been reviewed. We looked at the mental capacity act policy and this now included details of capacity assessments, best interest decisions and advocacy services.
- The practice had reviewed the way policies and procedures were stored and presented to staff. There was now an organised system in place where staff could access policies in hard copy or electronically.

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.