

# Care Quality Commission

## Inspection Evidence Table

### The Sunflower Medical Centre (1-537914202)

Inspection date: 10 May 2022

Date of data download: 28 April 2022

**Overall rating: add overall rating here**

**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
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	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
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: <ul style="list-style-type: none"><li>The practice had safeguarding policies in place for both children and vulnerable adults. Staff we spoke with were aware of the policy and knew where to locate it. They were able to tell us the types and signs of abuse and how they would respond to any concerns.</li><li>Records showed all staff had undergone safeguarding training to the appropriate level for their role. This included training around domestic violence.</li><li>Safeguarding was a standing agenda item at practice meetings. Records showed patients with safeguarding concerns were discussed and planned for. We saw that actions agreed were followed up until conclusion. Learning from safeguarding incidents was shared with all staff at practice meetings.</li></ul>	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> <li>Alerts were placed on the records of patients where there was a safeguarding concern or where the patient was vulnerable. We saw the practice maintained risk registers of these patients which were regularly reviewed. They also maintained records of child protection meetings and any actions arising as well as referrals made to the multi-agency safeguarding hub (MASH) or any other safeguarding agency. A log was also maintained of patients with a safeguarding concern who had left the practice. This was to ensure relevant information was shared with their new GP practice.</li> <li>Multi-disciplinary meetings took place monthly. Attendees included health visitors and district nurses. Safeguarding concerns were discussed at these meetings and any recommendations were shared with all staff.</li> <li>Some out of hours services were able to access patients' GP records so were appraised of any safeguarding concerns or if the patient had been flagged as being vulnerable. This information was also available in patients' medical summaries.</li> <li>All staff were required to undergo DBS checks, regardless of role under the practice's recruitment policy.</li> </ul>	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Recruitment checks for all staff included disclosure and barring service (DBS) checks, reference checks and employment history checks including references.</li> <li>Potential new recruits were given a conditional offer pending receipt of their DBS and two satisfactory references. If there were delays receiving a DBS or references a risk assessment was carried out to decide if the recruit could be allowed to commence employment under supervision.</li> <li>We saw records of staff immunisation. All staff were required to provide evidence of vaccination against specified diseases. Where there were any vaccinations missing, the practice offered to provide them or a risk assessment would be carried out to assess if employment could commence or continue, depending on the nature of their role.</li> </ul>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: March 2022	Y
There was a fire procedure. Date of fire risk assessment: February 2022	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the inspection in December 2020 the practice failed to provide evidence of up to date equipment calibration and fire risk assessment. At this inspection we saw evidence of electrical safety testing, equipment calibration and risk assessments including fire, health and safety,</li> </ul>	

storage of hazardous substances (COSHH) and premises and security. All had been undertaken within the previous year.

- The practice had two trained fire marshals who were responsible for ensuring fire procedures were in place and followed. Records showed weekly fire alarm testing took place and fire drills were held every three months.
- Fire risk assessments were carried out by NHS Property Services (NHSPS) which operated the health centre in which the practice was based. We looked at the most recent fire risk assessment, carried out in May 2020 (due November 2022). There was one action identified which NHSPS were in the process of resolving. The practice carried out its own regular fire risk assessments, most recently in February 2022. No actions had been identified for the practice.

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
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: March 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	N/A
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Records showed all staff had undergone infection control training within the last year.</li> <li>• The most recent infection control audit had taken place in March 2022. The records showed no actions had been identified.</li> <li>• There was a contract in place with an external company for waste removal.</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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Staff covered each other during staff absences and busy periods. We were told this arrangement worked and the practice did not need to rely on agency or temporary staff.</li> </ul>	

- Staff had received training around responding to medical emergencies including sepsis. We saw written guidance around this on display at reception and in consultation rooms. Records showed all staff had undergone basic life support training within the last year.
- Staff we spoke with demonstrated knowledge of how to identify people who could be seriously unwell and how to respond.
- The practice was equipped to respond to medical emergencies. They had a defibrillator, oxygen and emergency medicines on site. Records showed these were checked regularly by the practice nurse and practice manager to ensure they were in good working order and fit for use.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"><li>• During this inspection we looked at a sample of patient care records. We saw these contained the required information to support patient care. Patient records were managed and stored safely and securely.</li><li>• The practice had a policy in place for registering new patients. This provided guidance on how new patient information should be managed including patient summarising and coding in medical records.</li><li>• There was a documented referral management protocol in place. This set out the process for different types of referral such as cancer two-week wait referrals, rapid access referrals and routine referrals to community and secondary care services. This protocol also set out the information to be included in referrals and how these referrals would be monitored to ensure patients received appointments. It also set out the action to be taken where appointments were not received. Staff responsible for managing referrals understood the practice policy.</li><li>• The practice had a documented procedure for managing test results. As well as the steps to be taken on receipt of test results, this also included the responsibilities of clinicians and reception team members. During this inspection we looked at the practice's inbox where test results were received and found these had been managed accordingly and in a timely manner.</li><li>• Non-clinical staff were provided with guidance on how to manage test results. They knew what action to take depending on the type of test and result. Staff told us they always referred to a GP if they were unsure about what to do with any results.</li></ul>	

## 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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.40	0.55	0.76	Significant Variation (positive)
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). (01/01/2021 to 31/12/2021) (NHSBSA)	13.2%	9.7%	9.2%	Tending towards variation (negative)
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 (01/07/2021 to 31/12/2021) (NHSBSA)	8.24	5.51	5.28	Variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	49.2‰	58.3‰	129.2‰	Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.23	0.48	0.62	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	4.2‰	4.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y

Medicines management	Y/N/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.	Y
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• Vaccinations were stored in a locked fridge and records showed they were regularly checked to ensure they were in date and safe to use.</li> <li>• The practice held emergency medicines which were stored securely and were also monitored regularly.</li> <li>• Blank prescription forms were kept in a locked cupboard and records showed they were managed to ensure they were used appropriately.</li> <li>• We looked at a sample of patient group directives (PGDs) and found these were appropriate and valid.</li> <li>• At the inspection in December 2020 we told the provider they should review and improve practice protocols around patient specific directions (PSDs) as they were not all signed. At this inspection we found the processes around PSDs have been reviewed and changed and they were now created and stored in the clinical system only which included the GPs login details which acted as a digital signature.</li> </ul>	



Medicines management	Y/N/Partial
<ul style="list-style-type: none"> <li>The practice had a process in place for supervision of non-medical prescribers. Staff we spoke with told us they received regular supervision and were able to refer to a GP if they required advice.</li> <li>We looked at a sample of patient records and saw patients who were prescribed high risk medicines were monitored and reviewed appropriately.</li> <li>The practice was aware they needed to improve their antibiotic prescribing. They had carried out antibiotic prescribing audits to target improvement activity and ensure antibiotic prescribing was justified. No themes had been identified. The provider told us they would continue to keep this under review.</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.	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: 6	
Number of events that required action: 6	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>Staff were trained to ensure they understood what constituted a significant event and knew how to respond appropriately. Staff we spoke with gave examples of significant events and records showed significant events were discussed at practice meetings. Learning from significant events was shared with all staff.</li> <li>The practice had a policy governing how significant events were to be managed. Staff knew where the significant event reporting form was held and what to do once it had been completed.</li> <li>The practice maintained a log of significant events which they reviewed regularly to identify any trends.</li> </ul>	

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

Event	Specific action taken
Aggressive patient	Staff initially tried to manage the patient then called the police when behavior escalated. Incident was reviewed and action taken deemed appropriate. It was emphasised to staff to ensure their own safety before speaking to a patient with the potential for violence escalation. Practice liaised with neighbouring practice (shared premises) for common policy to manage such incidents in future.



Incorrect patient booked for an appointment (patients had similar names)	Incident was discussed with all staff at a team meeting. The importance of checking date of birth as well as patient name was re-emphasised.
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Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had a policy for managing safety alerts. This set out the various types of alerts, where they originated from and how they are received at the practice. It also set out how these alerts should be acted upon and named staff responsible for managing them.</li> <li>Staff we spoke with were aware of the process and we saw alerts were discussed at clinical meetings and any actions to be taken were recorded. Actions were tracked and the alert was closed only once all actions had been completed.</li> <li>We saw examples of actions taken on recent alerts, for example omeprazole and clopidogrel (Omeprazole reduces the amount of acid your stomach makes. Clopidogrel helps prevent blood clots). Patient records we looked at showed appropriate action had been taken to change affected patients' prescriptions.</li> </ul>	

## Effective

## Rating: Good

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

### Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice maintained registers of patients such as those with learning disabilities and poor mental health and those that were housebound and/or receiving palliative care. These registers were used to ensure these patients were reviewed regularly. Case reviews with members of the palliative care team were carried out for patients receiving palliative care.</li><li>• Patients who were housebound were reviewed annually to ensure their care needs were being met.</li><li>• We looked at examples of referrals and found these were made appropriately.</li><li>• Patients were advised about out of hours services and steps to take if their condition deteriorated.</li></ul>	

## Effective care for the practice population

### Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age. Integrated care pathways were followed for management of these patients via a multi-disciplinary healthcare organisation. A rapid response service was used for any immediate care needs to avoid hospital admissions.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Patients with long-term conditions were reviewed following discharge from hospital to ensure any indicated action such as medicines reconciliation took place.

## Management of people with long term conditions

### Findings

- The practice maintained registers of patients diagnosed with conditions such as diabetes. They had signed up for conducting virtual group consultations for these patients and had held clinics on Saturdays to accommodate patients.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. However we found five patients out of 140 patients diagnosed with hypothyroidism were overdue for monitoring. Following the inspection the provider confirmed three of these patients had since had their tests. The other two patients were not contactable and the practice had been informed they were abroad. We have told the provider they should review their monitoring processes for patients with long term conditions to ensure reviews were carried out on time.

- 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 COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	35	38	92.1%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	28	31	90.3%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	29	31	93.5%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	29	31	93.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR)	11	11	100.0%	Met 95% WHO based target

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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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

- At the previous inspection in December 2020 we found the provider's achievement in childhood immunisations was below target. At this inspection we found improvements had been made and the practice was now meeting all targets in childhood immunisations.
- The provider told us the practice took a team approach to childhood immunisation. This involved engaging with health visitors to communicate any queries parents might have and health visitors informing the practice where parents had expressed a reluctance to have their children vaccinated. They told us they worked to educate patients about the benefits of immunisation and worked with their families to meet the targets.
- Parents were contacted soon after their baby's birth to inform them about vaccinations. The practice also opportunistically booked patients in for vaccinations to be given.
- The practice worked with their local immunisation coordinator to find out if there was anything more they could do be doing to continue improvement.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	67.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	59.4%	48.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	52.3%	57.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	42.9%	56.0%	55.4%	No statistical variation

#### Any additional evidence or comments

- At the previous inspection in December 2020 we told the provider they should continue to review and improve the uptake of cervical screening. At this inspection we found the practice's achievement in cervical screening was slightly below the national comparison of 70%, which was similar to their achievement at the previous inspection. The practice had taken further steps such as nominating cervical smear champions who were responsible for contacting patients who were due for screening and booking them in. They also maintained a tracker which they used to ensure any recalls were followed up on.
- Patients who were reluctant to undergo screening were offered an appointment with the practice nurse to address any concerns they might have.
- More nurse appointments had been made available in order to increase their capacity to carry out cervical screening.
- The practice ran a weekend clinic for cervical screening and there was additional capacity at the local hub which operated Mondays to Fridays and some Saturdays. This is to boost uptake of immunisations and cervical screening. We have told the provider they should continue to improve their achievement in this area.

## 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 programme of targeted quality improvement and used information about care and treatment to make improvements.	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

- An audit had been carried out around controlled drug prescribing in April 2022. This involved 28 prescriptions. It was identified that six patients had not been correctly coded and four needed a review. Four prescriptions had more than 30 days' supply. Six prescriptions were acute and the rest were repeat prescriptions. As a result, changes were made including carrying out a review of identified patients to ensure their prescriptions were corrected, amending repeat prescriptions to acute where deemed appropriate and an alert put on patients' notes to alert clinicians whenever a new controlled drug was prescribed.
- Audits were also carried out of anti-biotic prescribing to assess if prescribing was in line with local guidelines, MHRA alerts to ensure appropriate action had been taken, patients with fatty liver disease to ensure they were receiving the appropriate care and cancer referrals to ensure the practice was using the referral system correctly. Actions identified by these audits were completed and some audits were repeated to assess if the changes had brought about improvement.

### Any additional evidence or comments

- The practice held monthly meetings with the diabetic specialist nurses and district nurses to improve the care they provided for these patients. Complex patients were discussed and planned for at these meetings.
- The practice used a digital platform provided by the local clinical commissioning group (CCG) to improve the referral and monitoring of cancer referrals under the "two-week wait" process.
- Patients with the onset of chest pain were referred to the Rapid Access Chest Pain Clinic (RACPC) for further investigation. The practice logged and monitored all of these referrals.
- Any unplanned admissions and re-admissions were flagged for a GP to follow up.



## Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	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
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: <ul style="list-style-type: none"><li>• We saw evidence of staff training, including mandatory training. The records were complete and up to date. Staff we spoke with told us they were given protected time to complete learning and development.</li><li>• Staff appraisals were carried out annually. Staff told us they were able to raise anything they wanted to discuss at their appraisals. Individual staff development plans were formulated based on what their career aspirations were and mandatory training. For example, the senior administrator had expressed an ambition to become a practice manager. This was discussed in their appraisal and plans were put in place for their training. Another member of staff had wanted to become a healthcare assistant and this had also been supported.</li><li>• There was an induction process in place which was tailored depending on the staff member's role.</li></ul>	

## Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	

- The practice worked collaboratively with other healthcare professionals such as community clinics, tissue viability nurses, district nurses, incontinence services, rehabilitation services and physiotherapists to meet patients' needs.
- They also followed an integrated care pathway to meet the needs of vulnerable and elderly patients. The practice made the referrals and liaised with the other services involved with that patient within the community.
- The practice worked with a social prescriber provided by the clinical commissioning group (CCG) to ensure a holistic approach was taken to patients' health and wellbeing.

## Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>• Patients were directed to services such as a social prescriber and services which provided acute-level care in patient's homes to ensure they received the enhanced level of care needed.</li> <li>• Patients were referred to specialist services, for example for education for patients newly diagnosed with diabetes or asthma or those who required additional support to control their condition.</li> <li>• Records showed any changes to patient care was discussed with them and additional guidance provided as required.</li> </ul>	

## Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
Explanation of any answers and additional evidence:	

- At the time of this inspection the practice did not have any active DNACPR decisions in place. We saw there had been five patients in the previous two years who had DNACPR decisions in place but they were all deceased. The provider described the process they followed for patients when decisions around resuscitation had to be made. They told us they would always involve the patient and their family or carers in those decisions.

## 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.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The provider told us the main challenge they had faced, aside from the Covid 19 pandemic, had been educating patients around issues such as vaccinations and cervical screening. They told us they involved health visitors, social services and community services to take a multi-disciplinary approach to patient education.</li><li>• Staff told us the practice operated as a team and they were positive about the leadership. The previous practice manager had left the practice in April 2022 to move abroad. We saw this was discussed and planned for in practice meeting minutes and staff told us the transition to the new practice manager had been smooth and well managed. They told us the new practice manager was experienced and the team was stable and competent with good communication and support from the leadership.</li><li>• We were told at the time of this inspection the practice team was stable and there were no plans to make any changes in terms of leadership or composition.</li></ul>	

### Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Staff told us the leadership shared their aims and vision with all staff. Their aim was to provide safe and compassionate care. They told us they discussed plans and goals in practice meetings and were encouraged to contribute their ideas.</li></ul>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice had two partners. Staff were advised to raise any concerns with either partner, with the practice manager or with the neighbouring practice if they felt they could not speak with staff at this practice. Staff we spoke with told us they would feel comfortable about raising any concerns with the practice and believed they would be taken seriously and supported.</li> <li>Information about the Freedom to Speak Up Guardian was displayed and staff were aware they could also contact them with any concerns.</li> <li>Staff told us their health and wellbeing were considered. They told us there was open communication amongst the team and staff could discuss anything with the leadership. For example staff had experienced bereavements and were given time off and flexibility to undertake caring responsibilities.</li> <li>Staff were aware of the duty of candour. They told us they worked in a transparent way and would admit and issue apologies where they had made an error. Any such incidents were discussed in practice meetings as was the outcome of investigations and any learning identified.</li> </ul>	

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

Source	Feedback
Administration team	Staff told us they were listened to and their needs and views were taken into account. An example was given of where administration staff needed headsets to make it easier to use a phone whilst using the computer. These were provided. They had requested an administration room and the leadership were in the process of arranging that.

## 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
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The practice used a digital platform to manage overall governance including administrative tasks, audits, quality improvement activity, human resource management, clinical support and day to day practice management. This included the organising of practice policies and procedures governing every aspect of the practice's operations. We saw these were suitable, tailored for the service and reviewed regularly.</li> <li>Staff we spoke with were clear about their role. There was guidance on display about each role's duties and responsibilities.</li> <li>The practice had a policy around how information was shared and how the practice worked with external agencies.</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.	Y
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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:	
<ul style="list-style-type: none"> <li>The practice had risk management processes in place to ensure they operated safely. These included fire, health and safety, security and infection control risk assessments and regular audits to identify areas requiring improvement.</li> <li>The provider benchmarked the practice's performance against local and national targets and guidelines to manage their performance.</li> <li>The practice had a business continuity plan in place. Staff knew where it could be located both remotely and on site. Staff were trained to respond to emergencies and major incidents.</li> </ul>	

## The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>During the pandemic most appointments had been telephone consultations. Patients had to contact the practice by phone initially and would be triaged by GPs. The practice had increased the use of text messaging to contact patients during the pandemic and patients were able to send in photographs where appropriate. GPs decided based on risk which patients would be seen in person.</li> <li>The booking of appointments online was paused during the pandemic. The provider told us this was done so as not to disadvantage patients who did not have internet access. This facility had been restarted at the time of this inspection.</li> <li>The practice had provided all necessary personal protective equipment (PPE) for staff and patients and had provided additional training for staff around infection control.</li> <li>Staff were provided with the equipment to support them to work from home where necessary.</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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	
Explanation of any answers and additional evidence:	



- Staff used sources of information such as feedback from the friends and families test, practice surveys and feedback from the patient participation group (PPG) to gather data on practice performance. They used this information to plan audits and quality improvement activity.
- The provider collected performance data to benchmark their practice's performance against local and national targets and guidelines.

## Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	N/A
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>• The practice used anti-virus software provided by the clinical commissioning group and conformed to their safeguards and guidelines to ensure they used digital services safely.</li> <li>• All staff were required to sign the practice's confidentiality statement when commencing employment.</li> <li>• The practice provided patients with information about how their information was stored and shared on the practice website.</li> <li>• Any pictures received from patients were stored onto patient records straightaway and deleted from any devices.</li> <li>• Staff were required to sign a document to confirm they understood the requirements for safety and security when logging on remotely.</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.	Y
The practice had an active Patient Participation Group.	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:

- The practice gathered views from the patient participation group (PPG) to help inform the delivery of the service. The most recent meeting with the PPG had been in December 2021. They had discussed how patients were finding access to the service following the pandemic. Feedback had been positive. They also discussed the results of the most recent patient surveys as well as practice performance around flu vaccinations, A&E attendance, cancer referrals and complaints.
- The practice carried out its own patient survey as well as analysing the results of the national GP patient survey and friends and families test. We saw through analysis the practice had identified the areas where action was required. Feedback from patients was largely positive with some comments around the need for more nurse appointments and more face to face appointments.
- The practice had responded to this feedback by increasing their provision of face to face appointments and started a Saturday morning clinic, in addition to their usual extended hours provision.
- The practice also used feedback from complaints received to make improvements. At the inspection in December 2020 we found the conclusion of some complaints received by the practice had not been logged in their records. At this inspection we were provided with a complaints log which showed all complaints were fully detailed including the outcome, any actions taken and learning identified.
- The provider told us in the wake of the pandemic they were planning to partner with more local services and increase the use of social prescribers to support patients. Plans were also in place to move to a cloud based telephone system to improve patient experience.

Feedback from Patient Participation Group.

Feedback
Feedback from members of the practice's patient participation group was that the provider involved and engaged with them in planning how the service operated, for example around the provision of appointments and which services the practice provided. They told us the provider discussed feedback from surveys with them and they contributed to the content of the practice's own surveys. They said they were able to speak freely with the leadership and felt their comments were taken on board.

## Continuous improvement and innovation

**There were 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At the previous inspection in December 2020 we found limited evidence of learning initiatives at the practice. To address this the provider targeted learning through in house learning sessions, practice meetings, clinical meetings and multi-disciplinary team meetings. This was shared with all staff through meeting minutes. Staff also had access to learning through local services such as a training hub which provided learning resources and learning through the primary care network (PCN). Individual training and development needs were identified through appraisals and we saw these were followed up on.</li> <li>Since taking over the practice in June 2020 the provider reviewed all aspects of the practice's operations and had devised an action plan to reflect the areas for ongoing learning and improvement activity. This plan was a live document which was continually reviewed and updated.</li> <li>One example of improvement activity was around coding of patients. Having identified anomalies in the coding of patients the provider had contracted with a data solutions company to support them in assessing and rectifying the patient coding issues, which improved the quality of their disease registers. This helped the practice improve chronic disease management for patients.</li> <li>The practice had taken steps to improve performance in cervical screening and childhood immunisations as highlighted in the previous report of December 2020 by starting a weekend clinic to make it more accessible to working people.</li> </ul>	

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