

# Care Quality Commission

## Inspection Evidence Table

### Saltdean and Rottingdean Medical Practice (1-554574721)

Inspection date: 8 to 14 November 2022

Date of data download: 26 October 2022

## Overall rating: Requires improvement

At our last inspection in June 2019 we rated the practice as requires improvement overall. This was because systems were not in place to monitor the overall governance arrangements of the practice. At this inspection in November 2022, we saw evidence that the practice had taken action to improve the areas that were identified as a concern at our previous inspection. The provider was engaged throughout the inspection process and demonstrated their commitment to improvements. However, there were still areas that required improvement. This was because:

- The practice did not always have clear systems, practices and processes that were consistently followed.
- There were some concerns around the management of medicines and review of patients with long-term conditions.
- The practice did not always have clear and effective processes for managing risks, issues and performance.

## Safe

## Rating: Requires improvement

At our last inspection in June 2019 we rated the practice as requires improvement for providing safe services. This was because; the practice was not always prescribing patients a certain medicine safely, systems for responding to incidents and safety alerts were not always effective, emergency medicines and equipment were not properly monitored.

At this inspection in November 2022, the practice demonstrated that they had taken action to address our concerns. However, there were areas that needed further review and improvement. The practice remains rated as requires improvement because:

- The systems and processes to safeguard children and vulnerable adults from abuse were not always operating effectively.
- Practice nurses did not always have appropriate authorisation to administer medicines.
- There were some concerns around the monitoring and prescribing of medicines, including high risk medicines and for patients with long term conditions.

- The practice learned and made improvements when things went wrong, but the recording of events and completion of actions were not consistently documented.
- The practice did not have an effective system for recording safety alerts and ensuring affected patients had been followed up.

## Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Partners and staff were trained to appropriate levels for their role.	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.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in June 2019 we found that clinical staff had not received safeguarding training appropriate to their role.</p> <p>At this inspection in November 2022 we found the practice had allocated a member of staff to oversee training. The practice had a training matrix, which was reviewed monthly and staff were notified when a module was due. We saw that all staff had completed safeguarding training appropriate to their role. The safeguarding lead had also recently delivered a face to face update to all staff.</p> <p>Additionally, on this inspection, we found there was a safeguarding lead GP, and staff were aware of who to speak with if they had concerns about a patient. There was also a dedicated safeguarding administrator. We were told that regular practice meetings were conducted, and that safeguarding was a standing agenda item for discussion. The practice invited other health and social care professionals, but they were not usually able to attend. Staff told us they were always able to speak with other professionals on an ad hoc basis and these conversations were documented.</p> <p>Although alerts were placed on the practice clinical system for patients at risk, we found they were not routinely linked with other family records.</p> <p>We also found the practice had safeguarding registers, to maintain oversight of concerns and actions. It was not clear whether these were reconciled regularly with the local authority.</p> <p>There was a system to follow up on children who were not brought to their appointment, including an appointment at the practice, for immunisation, or at secondary care. However, we found staff were not always sure about what this process was.</p> <p>Therefore, this meant concerns about a child or other family members could be missed.</p>	

Safeguarding	Y/N/Partial
<p>All clinical staff received an enhanced disclosure and barring scheme check (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw the practice carried out a risk assessment for each non-clinical staff member to determine whether a DBS was necessary. The practice told us they were reviewing their DBS policy and were reconsidering whether any non-clinical staff should be checked. For example, they had decided to carry out a DBS check for the reception managers and administrative staff dealing with safeguarding information.</p>	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 5 staff files and found the majority of appropriate recruitment checks had been completed. However, 2 staff files did not contain complete evidence of satisfactory conduct in previous employment, as per the practice recruitment policy. However, we saw these had been requested. The practice took immediate action and promptly sent us evidence that they had received the information.</p> <p>We found staff immunisation was monitored by the lead nurse. Each staff member had completed a checklist to confirm the vaccinations they had received. We saw that not all staff had been able to obtain evidence of vaccinations, as their records were not always available, for example staff who had received their immunisations in another country. The lead nurse had carried out a risk assessment for those staff members to determine the level of risk to the staff member and patients, and any mitigating actions. The practice was considering using an occupational health provider to carry out immunity testing as necessary.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: July 2022	Yes
There was a fire procedure. Date of fire risk assessment: October 2022	Yes
Actions from fire risk assessment were identified and completed.	Yes

## 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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: January 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence:	
At our last inspection in June 2019 we found the practice could not evidence that two clinical staff had received training on infection prevention and control (IPC).	
At this inspection in November 2022 we found all staff had completed IPC training. The lead nurse also delivered hand hygiene training. The health care assistant carried out annual hand hygiene audits with all staff.	

## 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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence:	
The practice staff told us they had been coping with a high staff turnover and a high number of staff absences due to COVID-19. Staff told us this was being managed with a mix of overtime, new staff or bank /locum staff. Staff told us the workload was high but that everyone was supporting each other. They were aware that management were recruiting.	
The practice management staff described the staffing issues they had dealt with over the past year and they continued to take action to address workforce concerns. They told us they carried out regular workforce audits to ensure staffing levels remained safe.	
Reception staff demonstrated an understanding of signs and symptoms of serious illness. Staff had received face to face training delivered by one of the practice GPs. Guidance was also available.	

## 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. <sup>1</sup>	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
Referrals to specialist services were documented, contained the required information 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
Explanation of any answers and additional evidence:	
We found the practice had implemented a workflow optimisation system for dealing with incoming correspondence and were processing appropriately. We were told that GPs provided opportunistic feedback to staff if issues were identified, however there was no routine audit activity. The practice told us they planned to bring in a formalised programme of audit and review activity carried out by the lead GP, to ensure compliance and provide assurance of safe decision making.	

## Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.79	0.68	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	15.1%	9.7%	8.5%	Variation (negative)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and	5.43	5.39	5.31	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	176.5‰	156.0‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.70	0.94	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	8.6‰	10.2‰	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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes <sup>1</sup>
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial <sup>2</sup>
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. <sup>1</sup>	Yes
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.	Yes
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. <sup>2</sup>	Partial <sup>3</sup>
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 and Improvement 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.	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.	Yes

Medicines management	Y/N/Partial
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 <sup>4</sup>
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 UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <ol style="list-style-type: none"> <li>At this inspection we found the practice had systems to ensure blank pre-printed prescription stationery for computers was being monitored throughout the practice. However, we found the documentation to record this could be improved. Staff took immediate action and implemented improvements during our inspection.</li> <li>We also reviewed patient group directions (PGDs), which allow specified health professionals to supply and/or administer medicine without a prescription or an instruction from a prescriber. We saw PGDs that had been signed by nurses, after being signed by the authorising GP. This meant that the nurse had not been authorised to administer medicines under PGDs. Following our inspection, the practice told us they had reviewed all PGDs and ensured they were now correctly authorised.</li> <li>At our last inspection in June 2019, we found GPs did not always check patients' monitoring results before prescribing a blood thinning medicine. At this inspection in November 2022, we found that a pharmacy continued to carry out blood tests for the practice. The practice had reviewed and updated their processes to ensure that test results were now obtained from a shared clinical system prior to prescribing.</li> </ol> <p>Additionally, at this inspection, we found some concerns around the monitoring and prescribing of medicines, including those that are high risk and for patients with long term conditions. However, this was for a small number of patients and there was no evidence of potential patient harm.</p> <p>We took into consideration that the practice had recently merged with another practice and their patient list size had increased by approximately 3000 patients. It was recognised that a high number of these had outstanding health monitoring, some of which appeared in our search results. The practice explained they had received clinical assistance from a local GP and a pharmacist, who was attached to the integrated care system NHS Sussex (commissioners of healthcare). They had also carried out additional phlebotomy clinics to catch up on patients requiring blood tests. Staff we spoke with explained they had all been working hard to deal with the backlog of patients requiring monitoring.</p> <p>With the consent of the practice, a CQC GP Specialist Advisor (GP SpA) accessed the practice's systems to undertake remote searches on 9 November 2022. These searches indicated the number of patients potentially at risk due to a lack of monitoring. A further investigation of patient records was undertaken to assess the potential risks. The CQC GP Specialist Advisor sampled a select number of service user records, where any risks were potentially identified, to assess the risks for these individual patients.</p>	

- We identified 47 patients in our search who were prescribed an immunosuppressant, and our search suggested that one patient was overdue monitoring. We reviewed the records for 5 patients and found they were up to date with their six monthly health monitoring. We found one patient, prescribed by secondary care, was overdue three monthly health monitoring. We also found one patient that required a supplement to help prevent a folate deficiency, which can be caused by this medicine.
- We identified 11 patients who were prescribed anti-coagulant medicines, used to treat and prevent blood clots and stroke. Our search suggested that all of these patients were overdue monitoring. We reviewed the records for 5 patients. We saw that all of these patients had been identified as overdue and we noted input from the pharmacist to task and organise follow up appointments. We found one patient that was overdue three monthly health monitoring. However, based on their last results, our GP SpA determined the patient was likely on the correct dose for their medicine. We also found one patient who had not ordered their medicine and had not responded to requests to attend a follow up appointment, and therefore required review.
- We also identified that the protocol to follow up when patients prescribed high risk medicines did not attend for monitoring appointments could be improved. We found examples of tasks being sent to staff to contact patients for a follow up appointment, or patients failing to respond or attend an appointment, with no action documented by the practice to evidence this was followed up.

Following our inspection, the practice took immediate action in response to our concerns. They told us they had reviewed the records for patients that we were concerned about and recalled them for health monitoring. They also told us they were reviewing all patients from the search results and were working closely with a medicines management lead from the integrated care system NHS Sussex.

4. At our last inspection in June 2019, we found the practice had not carried out a risk assessment to determine the range of emergency medicines held. We also found there were no systems to ensure the defibrillator was regularly checked and fit for use.

At this inspection in November 2022, we found the nursing team carried out a monthly check of emergency equipment and medicines. During our visit we saw there were appropriate emergency medicines and equipment available that were safe for use. The practice had undertaken appropriate risk assessments to determine the range of medicines held. Although we found one adult mask beyond its expiry date within the oxygen grab bag, there were spares available. Staff took immediate action and removed this mask.

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

The practice learned and made improvements when things went wrong, however the recording of actions could be improved.

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.	Partial
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 6 months:	9
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in June 2019, we found the systems for recording and acting on significant events were not comprehensive. There were inconsistencies in recording and no evidence that significant events were discussed in meetings.</p> <p>At this inspection in November 2022, we found the practice had improved the systems and processes to record and act on significant events. Staff we spoke with knew how to report incidents and significant events and were able to share examples of learning from them. According to the “significant event process”, staff were expected to complete a significant event reporting form, however this was not consistently used.</p> <p>We saw from the minutes of practice meetings that incidents were a standing agenda item. We saw examples of incidents that had been discussed with staff to support learning and improvement.</p> <p>Staff told us they took part in quarterly learning events, which were used to disseminate learning from significant events and encourage further ideas for improvement.</p> <p>There was a log of significant events, however further improvements were required. For example, the completion of actions was not always clearly or consistently documented. We also identified incidents that were documented on a recording form, but not on the log. This meant the significant event log was not up to date. Therefore, the practice was unable to demonstrate that actions had always been taken to improve safety.</p> <p>Following our inspection, the practice told us they would review and improve their significant event process, and develop their log to further improve record keeping and oversight.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p data-bbox="57 371 810 412">Explanation of any answers and additional evidence:</p> <p data-bbox="57 443 1513 519">At our last inspection in June 2019, we found there was no record of action taken in relation to safety alerts and not all staff were aware of all of the alerts.</p> <p data-bbox="57 555 1513 703">At this inspection in November 2022 we found there were systems to receive and respond to medicine and safety alerts. All safety alerts had oversight by a GP for clinical decision making, to determine whether it was necessary for the practice to take action. We saw from the minutes of practice meetings that safety alerts were a standing agenda item.</p> <p data-bbox="57 703 1513 815">The practice had a safety alert log, which included information about whether there were any actions as a result. We found the log could be improved to record the completion of those identified actions, including lead responsibilities and timescales.</p> <p data-bbox="57 851 1513 963">The practice explained they were in the process of reviewing their safety alert process and planned to make further improvements. For example, the pharmacist was setting up a simpler structure within the clinical computer system to record alerts and search for affected patients.</p> <p data-bbox="57 999 1513 1070">As part of our clinical searches, we identified patients who may have been affected by safety alerts or medicines alerts published in the past.</p> <p data-bbox="57 1070 1513 1142">Our search identified 23 patients who were taking medicines that could have implications for women of childbearing age, as the medicine could affect the development of an unborn child.</p> <ul data-bbox="105 1178 1513 1554" style="list-style-type: none"> <li data-bbox="105 1178 1513 1366">• We looked at 3 records for patients prescribed a medicine for pain relief or to treat epilepsy. There was no evidence in their records that the patients had been informed of the risks associated with this medicine, as alerted by the Medicines and Healthcare Products Regulatory Agency (MHRA) in April 2022. One of these patients had a medication review within the last 3 months but there was no evidence that the safety alert had been considered.</li> <li data-bbox="105 1366 1513 1554">• We looked at 2 records for patients prescribed a medicine used to treat epilepsy and bipolar disorder. There was evidence that the risks had been discussed with the patient, as alerted by the MHRA in April 2017 and updated in January 2020. However, we could not locate their pregnancy prevention programme letter (the PPP ensures all female patients are fully informed of the risks and the need to avoid exposure to this medicine in pregnancy).</li> </ul> <p data-bbox="57 1590 1513 1702">Following our inspection, the practice told us they would act immediately in response to our concerns. They told us they would fully review their safety alerts process and discuss further improvements with the pharmacist. They were also adding safety alerts as a standing agenda item to clinical meetings.</p>	

## Effective

## Rating: Requires improvement

At our last inspection in June 2019 we rated the practice as requires improvement for providing effective services. This was because we found gaps in training for some of the clinical staff.

At this inspection in November 2022 the practice demonstrated that they had taken action to address this. However, there were additional areas that needed review and improvement. The practice remains rated as requires improvement because:

- Not all patients with a long-term condition had received appropriate monitoring and clinical review
- The practice had not always identified patients who may need extra support and directed them to relevant services.

*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 not always assessed, and care and treatment was not always 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.	Partial
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.	Partial
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 prioritised care for their most clinically vulnerable patients.	Yes
Explanation of any answers and additional evidence:  Our clinical review of patient records identified that patients' immediate and ongoing needs were not always fully assessed. We identified patients with a long-term condition that had not received regular review in line with national guidance.	

Clinical staff we spoke with described how they kept up to date with evidence-based practice. Clinical issues were regularly discussed between members of the team at practice meetings. This was supported by the practice lead GP who ensured updates were circulated to staff.

## 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.
- 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. The practice worked closely with the specialist community disability service. Dedicated practice nurses attended care homes in the local area. The attending practice nurses were forming relationships with patients to build trust and enable them to deliver care and treatment.
- 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. The practice offered a serious mental illness enhanced service, with specially trained GPs and health care assistants.
- Patients with poor mental health, including dementia, were referred to appropriate services. There was a dedicated administrator who contacted patients from the mental health register and arranged a health assessment with the health care assistant. The patients were then invited to a follow up consultation with a GP and medication review to discuss ongoing care. Patients also had access to a mental health practitioner who provided regular sessions in the practice.

## Management of people with long term conditions

### Findings

With the consent of the practice, a CQC GP Specialist Advisor accessed the practice's systems to undertake remote searches. These searches indicated the number of patients potentially at risk due to a lack of monitoring. A further investigation of patient records was undertaken to assess the potential risks. The CQC GP Specialist Advisor sampled a select number of patient records, where any risks were potentially identified, to assess the risks for these individual patients.

We took into consideration the practice had recently merged with another practice and their patient list size had increased by approximately 3000 patients. It was recognised that a high number of these had outstanding health monitoring, some of which appeared in our search results.

We found the clinical records did not always evidence appropriate monitoring and clinical review for patients with a long term condition.

- Our search identified 49 patients who were diagnosed with asthma and who had been prescribed two or more courses of rescue steroids. We viewed 5 patient records and found 2 of these patients were overdue an asthma review. Three patients required a steroid emergency treatment card. We saw that the practice had inconsistently reviewed patients following an issue of a steroid prescription in line with national guidance. However, records documented that each patient had been provided with appropriate information regarding exacerbation of symptoms.
- Our search identified 32 patients diagnosed with hypothyroidism who had not received monitoring for 18 months. We viewed 5 patient records and saw all were overdue health monitoring and 3 patients that were overdue their annual medication review. However, we noted the practice had identified that each patient required monitoring and there was evidence those patients had been contacted to prompt them to arrange an appointment.  
We saw that some of the patients had been contacted on more than one occasion and had failed to respond. However, it was not clear what action the practice had taken as a result.
- Our search identified 56 patients with diabetic retinopathy whose latest blood test result were outside the normal range. We viewed 5 patient records. We saw 1 patient that was overdue their diabetes annual review. We also saw 1 patient who was overdue their health monitoring, diabetes annual review and medication review. However, we saw that patients' conditions were generally controlled and were being well managed under secondary care. We also saw good communication with the practice.
- Our search identified 15 patients identified as having a potential missed diagnosis of diabetes. We viewed 5 patient records. Of these, 1 patient was potentially diabetic and had not been identified as requiring review, and therefore had not received health monitoring or appropriate screening referrals. We found 1 patient had been identified as pre-diabetic, but their blood tests were not within the recommended timescales to determine this.

Following our inspection, the practice told us they took immediate action in response to our concerns. They reviewed the records for patients that we were concerned about and recalled them for health monitoring. They also told us they were reviewing all patients from the search results and were working closely with a medicines management lead from the integrated care system NHS Sussex.

Examples of other findings included:

- Patients with long-term conditions were not always 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 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)	81	83	97.6%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	71	93.0%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	71	93.0%	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)	66	71	93.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	84	85	98.8%	Met 95% WHO based target

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

Cancer Indicators	Practice	SICBL 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: 30/06/2022) (UK Health and Security Agency)	72.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	69.6%	56.3%	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)	72.6%	63.4%	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)	59.7%	53.4%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

### Any additional evidence or comments

The practice performance for cervical screening was below the 80% coverage target. They were aware that their performance was below the national target, and staff told us there was proactive action being taken to improve uptake. For example, the practice had administrative staff who followed up with patients who had not attended their appointment, and encouraged them to book a new appointment.

### Monitoring care and treatment

**The practice had a 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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	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

We found there was a programme of clinical audit that included full cycle audits. This included audits of prescribing and medicines management audits. We were provided with evidence of audits including; an audit of patients prescribed hormone replacement therapy (HRT) and breast screening uptake, and an audit of the insertion or removal of subcutaneous contraception.

## 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.	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
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:	
<p>The practice had identified mandatory training requirements for staff. Staff we spoke with told us the practice was supportive of training and their development, as they were given opportunities to meet the needs of the service.</p> <p>The practice had a spreadsheet to maintain oversight of training. We asked whether staff had received training on how to support people with a learning disability and autistic people, at a level appropriate to their role. Staff we spoke with had not yet completed this training, including nursing staff attending care homes to provide care and treatment for patients with a learning disability. This new legal requirement was introduced by the Health and Care Act 2022 from 1 July 2022. The practice told us they would arrange for staff to complete the government's preferred training.</p> <p>All staff had received an appraisal this year. Staff we spoke with told us they felt able to raise any issues, suggestions for improvements or to discuss their development.</p> <p>We saw evidence that non-medical staff received regular clinical supervision. This included discussion about recent cases, any issues, and training completed or planned. However, this did not yet include prescribing decisions. This was because 1 staff member had recently qualified as a prescriber and was not yet recorded as such on the clinical system. This meant they were not issuing prescriptions. However, the staff member had recently started to authorise patient specific directions (a PSD is an instruction to supply and/or administer a medicine written and signed by the prescriber). We spoke with the practice who told us they would discuss this with the supervising clinician. They would ensure prescribing decisions were added to the supervision notes, as well as regular prescribing audits.</p>	

## 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.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

## 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.	Partial
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, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence:  We were not assured that the practice was consistently identifying patients at risk of developing a long-term condition, for example diabetes.	

## 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

## Caring

**Rating: Good**

### Kindness, respect and compassion

**Staff treated patients with kindness, respect and compassion. Feedback from patients was positive.**

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence:	
Throughout our inspection, we observed staff at the reception desk that were engaging with patients in a professional and supportive manner.	

Patient feedback	
Source	Feedback
Complaints and feedback to CQC	We received 2 complaints in the last 12 months. This were about access to appointments, the triage system and complaints handling. We received positive feedback from 5 patients who were happy with the care and treatment they received. The main themes were about the friendly, polite and helpful staff, care and treatment from GPs, continuity of care, and feeling listened to.
Friends and family test	No data for October 2022.
NHS Choices	There were 8 reviews in the last 12 months, which were rated 5* except for 1 review. Comments included positive feedback about the care and treatment received, a flexible service, and friendly and professional staff including clinicians. One review contained negative feedback about the telephone system.

## National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	83.5%	87.5%	84.7%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2022 to 30/04/2022)	82.1%	86.7%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	92.9%	94.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	78.3%	77.9%	72.4%	No statistical variation

### Any additional evidence or comments

At our last inspection in June 2019, we told the provider they should improve on areas of patient satisfaction, including for patients feeling listened to and treated with care and concern.

At this inspection in November 2022, we found the practice had improved their patient satisfaction results and were now in line with local and England averages. For example, the practice result for patients who said the healthcare professional was good or very good at listening to them had improved from 68% (01/01/2018 to 31/03/2018) to 84% (01/01/2022 to 30/04/2022).

We found the practice had arrangements in place to encourage patients to provide feedback about their experience. The practice told us that overall the feedback was positive. They had a suggestion box in the waiting room, used the results from the national GP Patient Survey. They had an active patient participation group.

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

### Any additional evidence

The practice was intending to conduct a patient survey in January 2023 to understand the impact on patients following their merge with another practice.

### Involvement in decisions about care and treatment

#### Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
Feedback from patients to CQC	We received feedback from a carer who was positive about the attitude of staff and their management of medicines.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	91.5%	91.9%	89.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 359 patients who are also carers. This was approximately 3% of the practice population.
How the practice supported carers (including young carers).	The practice computer system alerted GPs and nurses if a patient was also a carer. There was written information available for carers to ensure they understood the various avenues of support available to them. The practice told us they felt carers were under reported, either as the patient had not recognised themselves as carers did not wish to be recorded as such. They had plans to promote care for carers through the primary care network with other local practices.
How the practice supported recently bereaved patients.	Staff told us that if families had suffered bereavement, the practice contacted them. This could be followed by a patient consultation and/or by giving them advice on how to find a support service.

## Privacy and dignity

### The practice respected patients' privacy and dignity.

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

## Responsive

## Rating: Good

At our previous inspection in June 2019 the provider was rated as requires improvement for providing responsive services. This was because we found complaints were not always recorded so that trends, issues and concerns could be appropriately identified.

At this inspection in November 2022 we found the practice had taken action and made improvements. Therefore, the practice is now rated good for providing responsive services.

### Responding to and meeting people's needs

#### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

#### Practice Opening Times

Day	Time
Opening times:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30

#### Further information about how the practice is responding to the needs of their population

- Evening and weekend appointments were offered through the local GP federation. These were held at the practice or other practices in the local area. These included remote and face to face GP appointments as well as appointments with a nurse, pharmacist or health care assistant. Specialist clinics were also being planned, for example menopause.
- Telephone and video appointments were offered through a remote primary care provider from 9am to 8:30pm weekdays and 9am to 12:30pm on weekends.
- Patients could register for online services through the practice website, to book appointments and order medication.
- A physiotherapist worked at the practice one day per week, through the primary care network of local GPs.
- The practice worked closely with the specialist community disability service. Dedicated practice nurses attended care homes in the local area to encourage patients to have their learning

disability annual review, and this was co-ordinated with flu clinics to increase uptake. The attending practice nurses formed relationships with patients to build trust and enable them to deliver care and treatment.

- Patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence:	
<p>In response to patient feedback and following their merger with another local GP practice, the practice had recently brought in a new telephone system. They aimed to increase capacity and improve efficiency. They planned to further improve access by opening telephone lines at 8am.</p> <p>Patients could book appointments in person, by telephone, or online via the practice website. The practice also arranged appointments via email for a specific list of patients, for example those with certain communication needs.</p> <p>Information about how to book appointments was included on the practice website and displayed on posters.</p>	

The practice managed the number of appointments so that patients who rang on the day could be seen on the day, if required. Patients were triaged by a GP and telephoned first in case the problem could be dealt with over the phone. A certain number of appointments were secured for patients with urgent needs. The practice offered both telephone appointments or face to face depending on patient preference and clinical appropriateness. Video appointments were also available through a digital provider.

On the day of our inspection we found patients could get an appointment on the same day or within two to three weeks for a pre booked appointment.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	76.8%	N/A	52.7%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	52.4%	61.7%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	48.1%	61.2%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	61.3%	76.7%	71.9%	No statistical variation

Patient feedback	
Source	Feedback
Complaints and feedback to CQC	We received 2 complaints in the last 12 months. These were about access to appointments, the triage system and complaints handling. We received positive feedback from 5 patients who were happy with the care and treatment they received.
Friends and family test	No data for October 2022.
NHS Choices	There were 8 reviews in the last 12 months, which were rated 5* with the exception of 1 review. Comments included positive feedback about the care and treatment received, a flexible service, and friendly and professional staff including clinicians. One review contained negative feedback about the telephone system.

## 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.	70
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection in June 2019, we found complaints were not recorded sufficiently so that trends, issues and concerns could be appropriately identified. We also told the provider they should include details of how to contact the ombudsman in complaints communication with patients.</p> <p>At this inspection in November 2022 we found the practice had improved their complaints processes. We saw evidence that complaints were fully investigated, with transparency and openness. Responses from the practice showed that patients were signposted to the parliamentary and health service ombudsman, in case they were not satisfied with the resolution of their complaint within the practice.</p> <p>The practice included verbal complaints in their recording systems. We saw the practice also recorded and disseminated compliments from patients made about staff.</p> <p>The practice learned lessons from individual concerns or complaints, and from analysis of trends. They acted as a result to improve the quality of care. We saw complaints that had been appropriately identified as significant events, however this was not always consistent.</p> <p>The practice discussed complaints within staff meetings and cascaded learning points to staff within individual team meetings. The practice also discussed complaints with all staff during quarterly learning events, to disseminate learning and encourage further ideas for improvement. We saw evidence of this within the 3 complaints we examined. However, we found the practice complaints log was not always updated with this information. We noted there were opportunities to further strengthen the complaints process by consistently linking with the significant event process, to identify additional trends and learning. The practice told us they would implement these changes immediately.</p>	

#### Example(s) of learning from complaints.

Complaint	Specific action taken
Complaint about the care and treatment received.	The practice investigated the complaint. The GP responded with an apology and a full explanation of events. The practice offered to meet with the patient to discuss further. The patient was provided with details of the ombudsman if they were not satisfied with the response.

## Well-led

## Rating: Requires improvement

At our last inspection in June 2019 we rated the practice as requires improvement for providing well led services. This was because systems were not in place to monitor the overall governance arrangements of the practice.

At this inspection in November 2022 the practice demonstrated that although they had taken action to address our concerns, there were areas that needed further review and improvement. Therefore, the practice remains rated as requires improvement because:

- The practice did not always have clear and effective processes for managing risks, issues and performance.
- The practice could not always demonstrate that learning was shared effectively and used to make improvements.

### 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:	
<p>The practice demonstrated there had been improvements since our last inspection in June 2019. The leaders at the practice were focused on addressing our concerns. The practice was also addressing challenges that had arisen from their recent merger with another local practice, which increased their patient list size by approximately 3000 patients. Their main focus was to continue to improve access to appointments and to catch up with a backlog of those patients requiring health monitoring and/or clinical review. The practice explained they had received clinical assistance from a local GP and a pharmacist, who was attached to the integrated care system NHS Sussex (commissioners of healthcare). They had also carried out additional phlebotomy clinics to catch up on patients requiring blood tests.</p> <p>The merger had also presented the practice with increased workload and significant staffing challenges. To address this, the practice had recruited new clinical and administrative staff and continued to as well as upskilling existing staff.</p> <p>The practice leaders described long term succession planning and future ambitions, such as plans to review the staffing structure to increase capacity and managerial oversight of key areas. They also aspired to become a training practice and veteran friendly practice.</p> <p>We received feedback from staff that the leaders were visible and approachable, particularly the practice manager, who we were told was supportive with both work and personal issues.</p>	

## 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.	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.	Yes

## 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 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:  Through staff interviews and questionnaires, staff provided several examples where the practice had made changes following staff feedback. For example, the practice brought in a lunchtime closure to allow staff to have a break, socialise and to boost morale. Telephone lines remained open for patient calls.	

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

Source	Feedback
Staff questionnaires & interviews	<p>Through staff interviews and questionnaires, comments showed that staff were happy with the level of support provided. We received numerous examples of staff being supported professionally and personally. Staff told us that it was a friendly environment, and everyone was hardworking and motivated to provide patient focused care.</p> <p>Staff told us the workload was extremely high and this had increased dramatically following the merge with another practice. They felt there was not</p>

	<p>always enough clinical and non clinical staff to keep up with demand, however all staff were aware of plans to deal with the staffing issues.</p> <p>We received positive comments from staff that the practice looked after them during the height of the COVID-19 pandemic. They were grateful for the protective and supportive measures put in place.</p> <p>Staff felt they were encouraged to provide their views and suggestions for improvements. They felt the leaders at the practice were approachable and always listened to their concerns. However, not all staff felt confident that the practice would take action in response.</p> <p>Staff told us communication was generally good at the practice. There were social events and staff told us they enjoyed getting together, especially because there was not enough time to do this on a normal working day. We received feedback from staff who felt the relationships between staff groups could be improved, for example some clinical and non clinical staff rarely saw each other, and they felt this hampered understanding of roles.</p>
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## 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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Yes

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
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:

At our last inspection in June 2019 we found that although assurance systems were in place, these were not always regularly reviewed and improved. We found staff meetings were ad hoc and clinical meetings were not regular or sustained. Systems for managing significant events, complaints and safety alerts needed to be improved.

At this inspection in November 2022, the practice demonstrated they had taken action to address our concerns. We saw evidence of processes and protocols that had been brought in or improved, to mitigate or manage risk. Regular meetings took place, including for individual teams, clinical, non-clinical and leadership.

However, there were areas that needed further review and improvement. The practice was aware of some issues and described the actions they were carrying out to overcome these challenges. Particularly for; medicines management, safety alerts and significant events processes. During our inspection we also identified some processes that had not operated as intended, for example safeguarding procedures.

Throughout the inspection we found all staff and leaders were responsive to our concerns, keen to learn and eager to make improvements. Following our inspection, the practice told us they would address the areas we had concerns about. They told us they would seek advice and guidance from lead members of the integrated care system, NHS Sussex to ensure they had effective governance arrangements.

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

Explanation of any answers and additional evidence:

The practice told us they monitored patient outcomes, including using the Quality Outcomes Framework (QOF). They used this information to identify and address performance issues, including an action plan for QOF and plans to recover from the backlog of patients requiring health monitoring. There were two administrative staff allocated to facilitate this. For example, they had doubled phlebotomy clinics so that all aspects of health monitoring for the patient could be obtained in one appointment. They regularly reviewed their action plan and were on track to complete by March 2023.

## 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.	Yes
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
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes
Staff are supported to work remotely where applicable.	Yes

## 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.	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:	
<p>The practice told us they usually sought staff views through meetings and individual conversations. Staff told us they felt encouraged to provide their suggestions and challenges. We were given examples of changes to the delivery of services following staff feedback, such as an improvement to the appointment booking system and a change to the emergency duty system.</p> <p>The practice used feedback from patients through their patient participation group, the GP national patient survey, complaints and compliments. The practice told us they used this information to improve service delivery. For example, following patient feedback, the practice now has 2 staff at the reception desk each morning, so that queries could be dealt with efficiently. They also brought in a new telephone system to improve the automated queuing information and time waiting.</p>	

## Feedback from Patient Participation Group.

### Feedback

There was an active patient participation group (PPG).

The chair of the PPG told us the group was formed 6 years ago and they had approximately 50 members. The PPG's aims were to be a critical friend to the practice, encourage patients, and assist patients with improving their health.

They had quarterly evening meetings that were attended by 8 to 12 members and they had regular speakers or events, for example Tai Chi and gardening social events. The PPG had worked with the practice to initiate improvements, such as with the new telephone system.

The PPG told us the main themes of patient feedback were regarding access to appointments. Patients told them they were waiting for approximately 20 minutes in the telephone queue and they were concerned with availability of doctors. However, recent feedback suggested an increase of doctors had helped but demand was still high.

Additionally, they were positive about the care and treatment they received personally. They told us the doctors showed care and concern, and they were very satisfied with the service overall.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
Staff told us leaders supported them in their development and encouraged them to take up learning opportunities. Staff were given allocated time to complete mandatory training.	
Although we found learning was cascaded to staff, this was not consistently recorded and therefore presented a risk for future opportunities for improvement to be recognised.	

#### 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 SICBL 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 SICBL 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.