

Care Quality Commission

Inspection Evidence Table

Dr C M Marsh & Partners (1-552757739)

Inspection date: 24 June 2022

Date of data download: 30 May 2022

Overall rating: Good

Safe

Rating: Requires Improvement

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.	No
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: The practice had a Disclosure and Barring Service check policy and procedure (DBS – a check which enables employers to check the criminal records of current and potential employees in order to ascertain whether they are suitable to work). We looked at the records of staff employed and found that all clinical staff had the most appropriate check undertaken. However, we saw that administrative and reception staff had not been checked, nor had they been risk assessed as not requiring checking. We raised this with the practice manager at the time. Following the inspection, we received documentary evidence to show that an appropriate and comprehensive risk assessment had been implemented, which detailed the reason why a DBS check was not required for this staff group.	

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
Explanation of any answers and additional evidence: The practice maintained records of up to date information relating to staff indemnity insurance and proof of registration with professional bodies. For example, the General Medical Council and the Nursing and Midwifery Council. The practice had effective policies and processes for recruiting staff.	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: November 2021	Y
There was a fire procedure. Date of fire risk assessment: January 2022	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: We saw records to confirm that staff who were designated fire marshals had received training. The fire risk assessment clearly identified risks, the level of risk and actions taken to address these. Records showed that portable appliance testing (PAT) and calibration testing of equipment had been carried out within the last 12 months. Legionella (a bacterium found in water supplies which can cause severe respiratory illness) testing and routine systems and processes for monitoring of this were being maintained. Records viewed confirmed this.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were 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: November 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

The general practice assistant was the lead for infection prevention and control (IPC). We saw from records that they had the required level of training to undertake this role.

We saw that hand hygiene audits and annual IPC statements were being routinely conducted.

We saw that the most recent IPC check had identified areas that the cleaner had not been deep cleaning all specified areas. Further records viewed that the IPC lead had met with the cleaner and practice clinicians, to work out a scheme of delegation and responsibilities, as it had been identified that the cleaner had extensive cleaning to do. We saw that following these discussions, cleaning schedules had been updated to reflect the new system implemented, whereby clinicians had undertaken responsibility for certain aspects of cleaning clinical areas.

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

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

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.94	0.83	0.79	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). (01/04/2021 to 31/03/2022) (NHSBSA)	15.0%	9.2%	8.8%	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 (01/10/2021 to 31/03/2022) (NHSBSA)	6.07	5.75	5.29	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	187.1‰	132.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.57	0.62	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	8.0‰	6.9‰	6.8‰	No statistical variation

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

Any additional evidence or comments

The practice was aware of their results for the number of prescription items for co-amoxiclav, cephalosporins and quinolones. They had completed a two-cycle audit had the results showed that all those prescribed these high-risk antibiotics were for appropriate medical reasons. For example, where alternative medicines had been prescribed previously and were ineffective. The results of which identified that they were routinely reviewing and assessing patients in a care home setting who were being offered alternatives and/or showed previous ineffectiveness. The second cycle of the audit identified that reviews and assessments were continuing to be effective.

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
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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (For example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England 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.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	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> <p>The practice had taken appropriate action to address the issues we identified during our clinical searches. At the time of our inspection visit, we found that best practice guidance and safe management of high-risk medicines was not always applied. For example, we looked at the records of:</p>	

Medicines management	Y/N/Partial
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- Five of the 32 patients prescribed methotrexate and found that two patients had not received the appropriate three-monthly monitoring blood test since November 2021 and January 2022.
- Patients prescribed a direct acting oral anticoagulant (DOAC - medicines used for blood thinning). We saw that 188 patients were prescribed DOAC's and of these 44 patients had not had the required monitoring. Of the five patient records we looked at; all five patients had not had one of the two appropriate blood tests within the required timescale of 12 months.
- Nine patients prescribed ACEI/ARB (used for treating patients with high blood pressure, heart problems or kidney disease) and potassium sparing diuretics (used to increase the amount of fluid passed from the body in urine, whilst also preventing too much potassium being lost with it). We found that three of the five patients had not had the required blood test within the last six months.

During our site visit the practice management team gave us an overview of the actions they had taken in relation to the above patients' records. We were told that some patients had received blood tests, but these had not been coded correctly or were located in another software platform and hadn't been linked to the patient's records. Where this had occurred, the GPs had corrected these. We were also told that patients requiring blood test monitoring would be called to attend the practice. There had also been patients that had had their medicines ceased by secondary care providers and these had not been coded correctly. The practice management team had also completed a further search, in order to identify the records of patients that had not be inspected as part of our process.

In response to our clinical search findings of DOAC's the practice had commenced an audit of these. The audit format had been set by the CCG and had a final date for submission (30 June 2022), which the practice was on target to achieve.

Following the inspection, the provider sent us documentary evidence, in the form of an action plan, to show that the number of patients where action had been taken, those that needed to be contacted and a date for ensuring these would be completed by. The provider had also set a date to review the action plan again to ensure they had met their target. We saw that the action plan was clear, comprehensive and realistic in terms of timescales and actions to be taken (31 July 2022). We saw that practice had sampled five records (additional to those we reviewed) of patients prescribed the above medicines and reviewed all those that were remaining. For example:

- Of the 32 patients prescribed methotrexate; only two of these required an appointment for a blood test, which had been scheduled
- Of the 108 patients prescribed a DOAC; 94 patients had a creatinine clearance recorded and were on the correct dose and 14 patients whose blood results were borderline, were required to have a review before deciding on a adjustments being made.

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:	31
Number of events that required action:	6
Explanation of any answers and additional evidence: Significant events were held on a central platform, which was reviewed and updated by all members of the staff team. Daily morning meetings were held, and we saw that discussions took place in relation to lessons learned, learning points and what the practice team could do to improve outcomes for patients and those involved in such events.	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
An electrocardiogram (ECG - a simple test that can be used to check heart rhythm and electrical activity) was conducted on the wrong patient.	The practice had discussed this at a practice meeting and subsequently completed a review of their policy for the checking of a patient's identity when conducting tests, in order to reduce the risk of this incident being repeated.
A fire drill that did not have the required outcome.	The practice held a fire drill and found that procedures within the practice required updating. The changes had been disseminated to staff during meetings and further fire drills had been successful.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts. For example, regarding sodium valproate. However, not all historical safety alerts were being routinely reviewed to ensure that patients being newly prescribed certain medicines (identified in historical alerts) were highlighted in the system, to ensure the guidance was applied. We raised this with the GPs and practice manager at the time of the clinical searches. During our inspection, we saw that a new system had been implemented for the routine monitoring of these. We saw that there would be a rolling six-month programme, to be completed in June and December. And that coding of medicines in historical alerts was in progress, to ensure they were flagged when being newly prescribed. The practice had a clear, comprehensive and realistic action plan to monitor the new system would be embedded.	

Effective

Rating: Requires Improvement

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.	Partial
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.	N
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
The practice had taken appropriate action to address the issues we identified during our clinical searches. At the time of our inspection visit, we found that patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. Care, as well as treatment, was not always delivered in line with current legislation, standards and evidence-based guidance.	
We looked at the records of patients who were:	
<ul style="list-style-type: none">Identified as having a potential missed diagnosis of diabetes, of which there were 10 in total. Of the five reviewed, we found that none of them had not been coded as diabetic or had a HbA1c blood test (a blood sugar level test) result which was at the acceptable level; three had not been informed of the diagnosis and two had not been added to the diabetic register.	
Additionally, we reviewed the register of patients with a diagnosis of Chronic Kidney Disease stage 3. The search identified a large number of patients (72) who should have been on the CKD stage 3 register but were not coded as such.	

We also looked at the records of the medicine reviews of five patients with polypharmacy (the concurrent use of multiple medication items by a patient). We found that four of these had been coded as having received a review but there was no discussion recorded in their records.

During our inspection, we were told that some patients had received blood tests, but these had not been coded correctly or were located in another software platform and hadn't been linked to the patient's records. Where this had occurred, the GPs had corrected these. We were also told that patients requiring blood test monitoring would be called to attend the practice.

The practice provided us with evidence to show that of those identified as having a potential missed diagnosis of diabetes; a review of these patient's records had been completed. The results of which showed that one was steroid induced and hadn't been coded appropriately. Eight had blood tests taken too close together and needed a repeat blood test in a longer period of time, we saw that recalls had been tasked on the patients notes which allowed more time between tests. We were told that one patient had a definite missed diagnosis and was being reviewed early next week. Records viewed confirmed this.

For those patients with a diagnosis of Chronic Kidney Disease stage 3; the practice had completed the same review and we found that an action plan had been implemented (set for completion by 31 July 2022). The plan included details of how all patients would be allocated to a named GP, who would check when the patient's last blood test was (within the last 18 months) and repeat tests again if required. The practice had also implemented a rolling audit moving forward and had revised their CKD protocol to ensure processes were more effective.

The practice management team had also completed a further search, in order to identify the records of patients that had not be inspected as part of our process and sampled five records (additional to those we reviewed). They had identified a significant number of patients with polypharmacy. The practice management team had approached the clinical commissioning group medicines optimisation team to discuss a multi-disciplinary approach to the recall of these patients for review, as they had recognised the practice team would not be able to achieve their target without support.

Following the inspection, the provider sent us documentary evidence, in the form of an action plan, to show the number of patients where action had already been taken, those that needed to be contacted and a date for ensuring these would be completed by. The provider had also set a date to review the action plan again to ensure they had met their target. We saw that the action plan was clear, comprehensive and realistic in terms of timescales and actions to be taken.

We saw that practice reviewed five patients with a possible missed diagnosis of diabetes and the remaining five patients had been booked an appointment for a review by no later than 31 July 2022.

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.
- 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 considered 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 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.

Management of people with long term conditions

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions. For example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with COPD were offered rescue packs.

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)	69	73	94.5%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received	65	70	92.9%	Met 90% minimum

Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
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)	65	70	92.9%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	70	91.4%	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)	63	69	91.3%	Met 90% minimum

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

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)	80.7%	N/A	80% Target	Met 80% target
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.6%	63.4%	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)	72.7%	68.1%	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)	71.4%	56.4%	55.4%	No statistical variation

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

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

Records showed that five clinical audits had been carried out in the last two years. These were part of an overarching programme. The audits were aligned to significant event investigation findings or changes in clinical best practice guidance.
The practice was partaking in an audit that was a primary care network (PCN) initiative, in relation to cancer peer to peer working. The purpose of the audit was to improve where COVID-19 had impacted on the two week wait system. The results were being correlated at the time of our inspection.
The practice was also involved with the National Cancer Diagnosis Audit, the results of the practices findings had been fed back into the national findings. The purpose of the audit was to better understand pathways to cancer diagnosis, identify good practice and support targeted quality improvement.

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: The provider understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained.	

Staff were encouraged and given opportunities to develop. Staff could be funded to undertake additional training. For example, QOF courses run by Invicta Health; training to progress from receptionist to general practice assistant (GPA); health care assistants studying for a Nursing Associate qualification; nurses completing advanced practice skills and clinical reasoning and GP's studying for Post Graduate Certificates.

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-centered care when they moved between services.	Y

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
<p>Explanation of any answers and additional evidence:</p> <p>We saw that information was available for patients in the waiting room. For example, local campaigns for health advice, fitness and dietary programmes; as well as external bodies who provided support services.</p> <p>The practice worked with the local foodbank and had a donations box in the reception area. Additionally, the practice supported Ukraine by accepting donations of clothes, sanitary products and toys; which was well supported by patients and well received by Ukrainian refugees moving into the locality.</p>	

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

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Reviews left on the NHS Choices website	
Total reviews	1
Number of reviews that were positive about the service	1
Number of reviews that were mixed about the service	0
Number of reviews that were negative about the service	0

Experience shared with CQC directly via our website	
Total received	1
Number received which were positive about the service	0
Number received which were mixed about the service	0
Number which were negative about the service	1

Examples of feedback received	Source
<ul style="list-style-type: none">Feedback about the practice captured in the national GP patient survey (results published in July 2021) was positive.The review left on the NHS Choices website, interviews with patients and experience shared with CQC directly about services, was positive.The main theme from negative feedback we received from patients was that they found it difficult when contacting the practice by telephone.	Reviews left on the NHS Choices website over the last 12 months, interviews with patients and experience shared with CQC directly via our website.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2021 to 31/03/2021)	96.0%	88.2%	89.4%	Tending towards variation (positive)
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 (01/01/2021 to 31/03/2021)	94.1%	87.2%	88.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2021 to 31/03/2021)	99.2%	95.4%	95.6%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	88.9%	80.2%	83.0%	No statistical variation

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

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: Easy read and pictorial materials were available.	

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	96.8%	93.1%	92.9%	No statistical variation

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

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 192 patients who were carers (2.6% of the practice list).
How the practice supported carers (including young carers).	<p>There was a dedicated section on the practice's website that indicated support available to carers and encouraged patients to identify whether they were carers.</p> <p>The practice offered carers an annual influenza vaccination and an annual health check.</p> <p>Policies and procedures were clear on how to identify and record carers onto the patient record within the practices software system.</p>
How the practice supported recently bereaved patients.	<p>All bereavements were notified to all staff, so they were aware when talking to relatives. The patients' named GP called the family to offer a consultation.</p> <p>The practice also provided help by signposting relatives to other support services where appropriate.</p>

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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: Patients told us they were treated with dignity, respect and kindness during all interactions with staff. They said that relationships with staff were positive, caring and compassionate.	

Responsive

Rating: Good

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday to Friday	8.30am to 6pm
Appointments available:	
Monday to Friday (GP's only)	8.30am to 11am and 2pm to 4pm
Additional information	Routine appointments were offered for a Friday between 9-5 dependent on availability.

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

- 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.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday.
- 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.

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	Y
The practice offered a range of appointment types to suit different needs (For example, face to face, telephone, online)	Y
Patients were able to make appointments in a way which met their needs	Y
There were systems in place to support patients who face communication barriers to access treatment	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
Explanation of any answers and additional evidence:	

Video consultations were available, however, uptake for these was low. The practice continued to offer these, as it was meeting the needs of a minority of patients.

We reviewed the practices appointment system and found that the next routine appointment was available on 28 June 2022. We saw that blocks of appointments on Mondays, Tuesdays and Wednesday's, for each GP, were available for routine appointments to be scheduled. The practice had a system, whereby, all calls that were acute in presentation, were first directed to the paramedic practitioner; whilst any issue that was chronic was booked with a GP. There was a duty doctor system in use; who reviewed test results if patients own GP was not available on that day and provided on the day appointments.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	54.7%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	64.7%	66.5%	70.6%	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 (01/01/2021 to 31/03/2021)	60.3%	63.1%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	78.2%	80.7%	81.7%	No statistical variation

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.	11
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice kept a record of all verbal complaints made and those that became considered significant events.</p> <p>We saw from meeting minutes that complaints were a standard agenda item for discussion.</p>	

Example of learning from complaints.

Complaint	Specific action taken
A patient complained that a throat swab had been carried out on a patient and the results provided to their twin.	The practice acknowledged the complaint and spoke with the patient. An investigation into the complaint had identified that the swab had been taken on the correct patient but not recorded in the correct patients notes, due to the patients having the same date of birth. Systems and processes had been amended to ensure all results were delivered to the correct patient, to avoid breaches in patient confidentiality.

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.	Y
Explanation of any answers and additional evidence: The practice had a clear business and contingency plan in operation. Staff we interviewed told us that the GP partners and practice manager were approachable, compassionate and inclusive.	

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: All staff that we spoke with were aware of the practices' vision, values and strategy. They understood their role in supporting the development and achievement of these.	

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> <p>Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported.</p> <p>We saw that there was a culture of collective responsibility and positive relationships between staff and teams, where conflicts and sharing of lessons learnt/improvements were discussed constructively and effectively.</p> <p>There were processes for providing all staff at every level with the development they needed, including high-quality appraisal and career development conversations.</p>	

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

Source	Feedback
Staff interviews	<p>We spoke with eight staff members and they told us that the practice management team firmly believed that training was an important part of their development and that they could actively raise concerns, whilst being supported to do so.</p> <p>They told us that pride and positivity in the running of the practice, their employment and focus on the needs of patients; was actively encouraged. This led to staff members feeling that they were one team with a common purpose.</p>

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
<p>Explanation of any answers and additional evidence:</p> <p>The GP partners and practice manager ensured that governance in the practice, functioned effectively. The structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services; were clearly set out and understood by all staff.</p>	

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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.	Partial
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: The practice had an effective and comprehensive process to identify, understand, monitor and address current and future risks. Clinical and internal audit processes functioned well and had a positive impact on quality governance. From our clinical searches, we saw that reviews and monitoring of patients were not always being completed in line with best practice guidance. We raised this with the provider and action had been taken to address this by the time of our site visit, with a clear and comprehensive action plan having been implemented to ensure all reviews would be managed effectively.	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice continued to operate throughout the pandemic providing a range of appointments including; face to face, video and telephone consultations, as well as home visits.</p> <p>All digitally excluded patients were coded as such on their patient records and offered face to face appointments.</p>	

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.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw from records viewed that meetings had were structured and minutes were being comprehensively maintained, stored, accessible and detailed learning and actions from complaints; safeguarding; and significant event investigation outcomes. We saw that previous meeting minutes were discussed, and any outstanding actions were addressed.</p>	

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.	Y
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

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.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We saw that the practice engaged and involved all staff (including those with protected equality characteristics) and ensured that the voices of all staff were heard and acted on to shape services.</p> <p>There was a transparent, collaborative and open approach with all relevant stakeholders about performance.</p> <p>The practice did not have an active patient participation group (PPG), as the existing group disbanded during the pandemic. The practice was in the process of advertising for new members, in order to establish a new PPG (either physical, virtual or a mixture of both).</p>	

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> <p>We saw from records viewed and staff we spoke with that learning and improvement was high on the practice's agenda. Discussions about lessons learnt, additional training needs and improvements required (following complaints and significant events) were clearly documented and followed up.</p> <p>The practice was involved in training junior doctors at FY2 level (These are fully qualified doctors who have worked at least one year as hospital doctors who work under supervision). All the staff were, to some degree, involved in the training of future GPs, nursing, reception and administration staff.</p>	

The practice made effective use of internal and external reviews, and learning was shared effectively and used to make improvements both within the practice and the primary care network they were part of (Sittingbourne PCN).

We saw that staff were encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This was used to make improvements.

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.