

# Care Quality Commission

## Inspection Evidence Table

### Gravesend Medical Centre (1-549517306)

Inspection date: 27 July 2022

Date of data download: 20 July 2022

## Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- Improvements were required in relation to the management and oversight of staff personnel files, particularly in relation to non-clinical staff, for example, Disclosure and Barring Service checks and staff immunisations.
- The provider did not have processes to regularly check the temperature of the hot and cold outlets on the premises in relation to the control of legionella.
- Appropriate standards of cleanliness and hygiene were met. However, some improvements were required.
- Not all staff were suitably trained in basic life support.
- Blank prescriptions were not always kept securely, and their use were not monitored in line with national guidance.
- Improvements were required in relation to the monitoring and assessment of patients' health in relation to the use of high-risk medicines and patients with long-term conditions.
- Systems for managing safety alerts were not always effective.
- Performance relating to cervical cancer screening and the identification and timely referral of new cancer cases required improvement.
- There were processes for managing risks, issues and performance. However, these were not always effective.

## Safe

## Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- Improvements were required in relation to the management and oversight of staff personnel files, particularly in relation to non-clinical staff, for example, Disclosure and Barring Service checks and staff immunisations.
- The provider did not have processes to regularly check the temperature of the hot and cold outlets on the premises in relation to the control of legionella.
- Appropriate standards of cleanliness and hygiene were met. However, improvements were required.
- Not all staff were suitably trained in basic life support.
- Blank prescriptions were not always kept securely, and their use were not monitored in line with national guidance.

- Improvements were required in relation to the monitoring and assessment of patients' health in relation to the use of high-risk medicines.
- Systems for managing safety alerts were not always effective.

## Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse. However, some improvements were required.**

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	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>The provider had a designated safeguarding lead and deputy. All staff knew how to identify and report concerns. There were policies which were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare.</p> <p>We looked at the training records of five staff members and identified that one non-clinical and one clinical staff member were not up to date with safeguarding training appropriate to their role. After the inspection, the provider wrote to us with evidence that both staff members had completed their training.</p> <p>There were notices in the practice that advised patients chaperones were available if required. All staff who acted as chaperones were trained for the role.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	No
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the recruitment records for one non-clinical staff member that had been employed within the last 12 months. We could not see that a Disclosure and Barring Service check (DBS) had been completed or that they had been risk assessed as not requiring checking. (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 also did not see evidence of their vaccination status in relation to hepatitis B and measles, mumps and rubella or that they had been risk assessed as not requiring this.</p>	

We also looked at the staff vaccination status of another non-clinical and three clinical members of staff. We could not see evidence of their vaccination status in relation to hepatitis B and measles, mumps and rubella. After the inspection, the provider wrote to us with evidence of the vaccination statuses for the three clinical staff members. We did not receive evidence of the vaccination status of the non-clinical staff member or that a risk assessment had been carried out in lieu of obtaining this information.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 July 2022	Yes
There was a fire procedure.	Yes
Date of fire risk assessment: 20 December 2021 Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Records showed that fire alarm, fire drills and emergency lights were regularly tested. Records also showed that portable appliance testing (PAT) and calibration testing of equipment had been carried out within the last 12 months.</p> <p>We saw numerous policies, procedures and risk assessments that collectively made up a health and safety risk assessment. The assessment included any actions that were required, the name of the person responsible for the action and a planned completion date. The provider took appropriate action where applicable. For example, removing items that may pose a hazard.</p> <p>We saw that a fire risk assessment had been carried out within the last 12 months. The risk assessment identified potential risks. However, it did not include a timeline to address the issues identified. For example, the provider identified that a fire warden was not present during the time the practice was opened for extended hours appointments. Additionally, the provider had four designated fire marshals. Fire marshals are required to complete training every three years and to refresh their knowledge on this topic annually. We did not see evidence that all four fire marshals had received the required training. After the inspection, the provider wrote to us with a revised fire risk assessment. This risk assessment included actions that were required, the name of the person responsible for the action and a planned completion date. It showed that additional staff members had been assigned as fire marshals during the time the practice is open for extended hours. All staff who required this training had been placed on a waiting list to complete this training.</p> <p>We looked at the training records of five members of staff and saw that they all had received appropriate training in fire safety.</p> <p>Records showed that legionella (a bacterium found in water supplies which could cause severe respiratory illness) routine water sample testing had been completed. However, the practice did not have a process to regularly check the temperature of the hot and cold outlets on the premises. After the inspection, the provider wrote to us with evidence that they implemented a process to regularly monitor the temperature of the practice's outlets to control the risk from legionella.</p>	

## Infection prevention and control

**Appropriate standards of cleanliness and hygiene were met. However, some improvements were required.**

	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: 1 July 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We observed the premises to be clean and tidy. We saw that all relevant staff were adhering to current best practice guidance on COVID-19.</p> <p>At the time of the inspection, there was not an up to date infection prevention and control (IPC) policy. After the inspection, the provider wrote to us with evidence that they had revised their IPC policy.</p> <p>The provider had completed an IPC audit every month in the last 12 months to confirm monitoring of IPC processes. The latest audit highlighted risks, however, did not include an action plan to explain how the risks would be reduced, who the responsible person would be and the completion date. For example, the audit identified that some consultation rooms had carpeted floor but did not include an action plan to address the potential IPC issue. After the inspection, the provider wrote to us with an action plan; it explained the cleaning programme to mitigate any risks relating to IPC, such as contamination from spills. It also detailed the provider's long-term plans of replacing all carpeted floors with medical treatment room flooring.</p>	

## Risks to patients

**There were systems to assess, monitor and manage risks to patient safety. However, improvements were required.**

	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.	Partial
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
<p>Explanation of any answers and additional evidence:</p>	

There was an induction system for all new staff, this involved sharing key information and a structured development programme. The performance of new staff was monitored via regular one to one meetings with an appointed staff member.

The provider had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff.

We saw there was an inventory of the emergency equipment and that regular monitoring took place. We looked at the monitoring records and saw it had headings for example, resus trolley, defibrillator, oxygen cylinder, nebuliser, comments, signature and date that the check had been completed.

We saw that all required emergency equipment was available. However, we found two paediatric oxygen masks, one paediatric nebuliser kit and three hypodermic needles had expired. The provider was informed of this during the inspection; they removed these from their stock and ordered replacements.

We asked to see the basic life support training records of six members of staff. Records showed that two non-clinical members of staff were not up to date with this training. When we spoke with these members of staff, they were able to explain what action they would take if they came across deteriorating or acutely unwell patients.

The provider told us they had organised face to face basic life support training, however, this had been cancelled when the majority of staff fell ill with COVID-19. After the inspection, the provider wrote to us with evidence to show they had organised in house training to take place next month.

## Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
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:	
The provider had a documented approach to the management of test results, and this was managed in a timely manner. The provider demonstrated that when patients used multiple services, all the information needed for their ongoing care, was shared appropriately and in line with relevant protocols.	

## Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, improvements were required.

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)	0.53	0.83	0.79	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/04/2021 to 31/03/2022) (NHSBSA)	11.6%	9.2%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)	4.50	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)	88.7‰	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)	0.14	0.62	0.60	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	5.8‰	6.9‰	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.	Partial
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about 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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
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
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We looked at five patient group directions (PGDs - a written instruction for the administration of medicines to groups of patients not previously prescribed for) and saw that they were correctly completed.</p> <p>We saw that the provider had processes to check blank prescription forms when they were delivered to the practice. However, we did not see evidence that the provider was appropriately tracking these, when they were distributed throughout the practice. For example, there was no record of a stock control system to show when prescription forms were issued to an authorised prescriber, the serial numbers of these forms, details of who issued the forms and the serial numbers of any unused prescription that had been returned. This was not in line with national guidance.</p> <p>We also saw that not all blank prescriptions were always kept securely in the practice. For example, we found some blank prescriptions were not kept securely on the day of the inspection. These were removed at the time and after the inspection, the provider wrote to us with evidence, to show they had revised their policy and implemented a system to record the distribution of blank prescriptions within the practice. The policy also detailed how all blank prescriptions would be locked away at the end of the day.</p> <p>During the inspection we saw that the majority of emergency medicines were available. However, the practice did not hold atropine (used to treat a slow heart rate). The provider told us that there was a national shortage of this, and the independent pharmacy located in their practice would inform them when the medicine was back in stock. After the inspection, the provider confirmed that atropine was now present in the practice.</p>	

Medicines management	Y/N/Partial
<p>We looked at the temperature log records of the designated refrigerators for the storage of vaccines between January 2022 and July 2022. Records showed that the temperature of one of the refrigerators had been recorded as being outside of the acceptable limits (of between two and eight degrees centigrade) on three occasions in June 2022. We identified that staff had taken appropriate action (in line with the practice's policy) on one of these occasions but not for the other two. After the inspection, the provider wrote to us with evidence to show that appropriate action had taken place. For example, investigating how long the temperature had been outside of the acceptable limits and whether the medicines were safe to use as per the practice's policy.</p> <p>We completed a series of searches on the practice's clinical records system. These searches were completed with the consent of the provider, and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.</p> <p>We reviewed the records of five patients who had been prescribed:</p> <ul style="list-style-type: none"> <li>• Benzodiazepine (a sedative) and Z drugs (used to treat insomnia). We found that prescribing and monitoring of all patients was in line with best practice guidance.</li> <li>• Leflunomide (a disease modifying anti-rheumatic drug). We found that one patient did not have an alert on the clinical system to explain why they were prescribed this medicine: there wasn't a shared care protocol in their notes; a record of a recent blood test, weight or blood pressure reading. Therefore, they had not received monitoring in line with best practice guidance. After the inspection, the provider told us they had reviewed the patient notes and that the patient had received the appropriate blood test whilst they attended hospital.</li> <li>• Direct acting oral anticoagulants (DOAC – a drug that treats or prevents blood clots). We found that all five patients had not received monitoring in line with best practice guidance; the patient's creatinine clearance had not been calculated (a test to calculate how well the kidneys are working). After the inspection, the provider sent an action plan that explained how they would review these patients.</li> </ul>	

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

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

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	2
Number of events that required action:	2
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the two significant events that had been recorded within the last 12 months. We saw that details of the event had been investigated and action taken. We saw that learning from these had been</p>	



recorded on the significant event form. However, we did not see evidence of meeting minutes or emails, the learning had been shared with staff across the practice. Staff we spoke with told us that learning from significant events were shared during practice meetings.

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

Event	Specific action taken
Data breach - a medical certificate was given to the incorrect patient.	The provider was open and transparent with the patient. They apologised for the error and explained what action they would do to prevent this from happening again. The medical certificate was returned and appropriately destroyed. The provider analysed the event and learning identified.
Temperature for one fridge designated for vaccines fell below two degrees centigrade.	NHS England screening team were informed of the incident and the manufacturer of the medicines was contacted to ascertain their validity. The appropriate medicines were disposed of, and the remaining medicines were moved to another fridge. An investigation showed that the fridge was faulty. The fridge was removed, and it was decided that all fridges designated for vaccines were to be checked twice a day to prevent this from happening again.

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>Explanation of any answers and additional evidence:</p> <p>The practice had a system for receiving, sharing and acting on safety alerts. Staff we spoke with understood how to process these alerts.</p> <p>During our clinical searches we reviewed one safety alert and saw that it had not always been managed well. We reviewed the safety alert for sodium-glucose cotransporter-2 inhibitors (SGLT-2 inhibitors – medicine to help lower blood glucose). This alert indicated that patients needed to be informed of the risks and early warning signs of a rare complication, so that early presentation of symptoms could be noted and treated if required. We reviewed the records of five patients who had been prescribed this medicine and could not see evidence that any of these patients had been informed of the risks.</p> <p>After the inspection, the provider shared an action plan that detailed all clinicians were aware of the safety alert, but the conversation with patients had not been routinely documented. The action plan explained that this would be discussed with all clinicians in an upcoming clinical meeting to consolidate and embed these plans.</p>	

## 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.

We rated the practice as Requires Improvement for proving effective services because:

- Improvements were required in relation to the monitoring and assessment of patients with long-term conditions.
- Performance relating to cervical cancer screening and the identification and timely referral of new cancer cases required improvement.

### Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment were 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.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	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 had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence:  During our inspection, we completed a series of searches on the practice's clinical records system. These searches were completed with consent and to review if the practice was assessing and delivering care and treatment in line with current legislation, standards and evidence-based guidance.	

We looked at the records of:

- Five patients who had been diagnosed with chronic kidney disease stage 4 or 5 and found monitoring was in line with best practice guidance for all five patients.
- Five patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. We found that two patients had not been monitored in line with current best practice; one patient needed a review as they had requested several courses of oral steroids. The provider told us they would investigate this further. The second patient also required a review. We saw the provider had sent text messages to this patient requesting that they book an appointment. However, the patient did not respond. The provider told us they would call the patient to complete a review.
- Five patients who were identified by the search as having a potential missed diagnosis of chronic kidney disease stage 3, 4 or 5. We found that three patients required further monitoring and relevant blood tests. We did not see evidence that this had been completed or whether it had been noted that the patients had other medical conditions, which influenced these test results. For example, patients with diabetes that reduces renal function.
- Five patients who received medicine reviews. We found that all five patients had been coded as receiving a medicine review. However, the notes of two patients did not include a full explanation of what the review entailed. For example, it did not contain information about the review of specific medicines and any monitoring tests. This was not in line with current best practice.
- Five patients who were diagnosed with diabetic retinopathy (diabetic retinopathy is a complication of diabetes, caused by high blood sugar levels damaging the back of the eye. It can cause blindness if left undiagnosed and untreated). We found that management of this condition was not in line with best practice guidance for two of the patients; both patients had not responded to the provider's requests of booking a review.
- Our search identified there were 379 patients diagnosed with hypothyroidism and that 94 patients had not received the required blood test in the last 18 months. We looked at five patient records and found that all five patients had not received the required blood test in the last 18 months. This was not in line with current best practice guidance.

After the inspection, the provider shared an action plan which detailed that each patient would be reviewed; clinicians would document in depth information when completing medicine reviews and how they would review their systems and processes, so that patients who do not respond to their requests for an appointment can be followed up more actively. The provider also told us they would be conducting a clinical audit in the attempt of improving the prescribing of rescue steroids.

## Effective care for the practice population

### Findings

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.

All patients with a learning disability were offered an annual health check.

End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice 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.

The practice offered extended appointments from 6.30pm to 8pm every Monday and Tuesday.

Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a Primary Care Network. Appointments were also available on Saturday.

The practice had a system to refer patients to lifestyle and health and well-being coaches to help with weight management.

The practice worked closely with the local pharmacist to provide a smoking cessation programme.

The practice arranged help for patients who require transport to hospital appointments.

The practice made reasonable adjustments if patients found it difficult to access services.

## Management of people with long term conditions

### Findings

GPs followed up patients who had received treatment in hospital or through out of hours services.

Patients with COPD were offered rescue packs.

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 those with a learning disability and dementia.

The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

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	196	217	90.3%	Met 90% minimum

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)				
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)	219	261	83.9%	Below 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)	220	261	84.3%	Below 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)	222	261	85.1%	Below 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)	184	222	82.9%	Below 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>

### Any additional evidence or comments

Childhood immunisations were carried out in line with the national childhood vaccination programme.

NHS England results (published in March 2021) showed that uptake rates were lower than the World Health Organisation (WHO) target of 95% and below the 90% minimum target for four indicators.

The practice told us they had audited non-responders and had identified several patients who fit the criteria for these types of immunisations but were choosing to have their children immunised in their country of origin, such as Eastern European countries.

The provider also told us that in an attempt to increase the uptake for childhood immunisations they had taken the opportunity to talk with the parent/guardian when they attended the practice with their child for other matters.

These combined had an impact on the overall target achieved and in response, the practice told us they had a meeting with the Kent and Medway Integrated Care Board (ICB) in July 2022 to discuss new ways of engagement, to ensure improvements in targets are attained.

We were provided with evidence of unverified data which indicated uptake rates had improved for some indicators, as of 8 August 2022. The information shared from the provider suggested:

- 89% of children aged 2 had received their Pneumococcal booster.

- 85% of children aged 2 had received their Haemophilus influenza type b (Hib) and Meningitis C (MenC) booster.

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: 31/03/2022) (UK Health and Security Agency)	60.4%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	62.8%	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)	56.9%	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)	21.1%	56.4%	55.4%	Tending towards variation (negative)

#### Any additional evidence or comments

Published results showed that the provider's uptake for cervical cancer screening as at March 2022 was below the 80% target for the national screening programme.

We were provided with evidence of unverified data which indicated uptake rates for cervical cancer screening had improved, as of 8 August 2022. The information shared from the provider suggested:

- 68% of patients aged 25 to 49 years and 73% of patients aged 50 to 64 years registered at the practice had received cervical cancer screening.

The provider told us that to increase uptake for cervical screening; they regularly reviewed the updated figures and sent recall letters/text messages to remind patients of the need to book an appointment and took the opportunity to speak to the patient when they attended the practice for other matters. We were also told their care coordinator would be reviewing updated figures and would call the relevant patients to invite them for an appointment.

Published results showed that the number of new cancer cases that had been identified and referred in a timely manner were below the England and clinical commissioning group (CCG) averages. The provider told us they aimed to complete an audit to assess if any changes could be made to the process of cancer diagnosis and two week wait referral process. After the inspection, the provider wrote to us with evidence to show they had implemented a system to monitor all two week wait referrals that had been made.

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

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

As part of this inspection, we asked the provider to submit a copy of any clinical audits carried out within the last 12 months. A clinical audit aims to improve the quality of patient care by looking to see if healthcare is being provided in line with standards. It can help identify improvements that may be needed.

The provider sent evidence of clinical audits that were part of an overarching programme. For example, a second cycle audit had been conducted to monitor and identify improvements that could be made in the prescribing of short acting beta agonists (SABA) inhalers and thus improve asthma management.

The first audit identified potential reasons for the high prescribing of SABA inhalers. For example, patients not attending their asthma review appointments due to the consequences of the COVID-19 pandemic or not being well informed of the importance of having an asthma review. An action plan had been implemented in the attempt to improve asthma management. As a result of the audit, it was identified that there was an 80% reduction in the prescribing of SABA inhalers compared to the first audit.

## Effective staffing

**Staff did not always have 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.	Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an induction programme for newly appointed staff and ongoing training for existing staff. Subjects covered included: basic life support, safeguarding, fire safety, information governance, infection prevention and control. Staff had access to e-learning training modules and in-house training.</p> <p>We looked at the training records of six members of staff and could not see evidence that two members of non-clinical staff had completed basic life support training. One of these non-clinical staff members also did not have training in safeguarding children. After the inspection, the provider sent evidence that the staff member had completed their safeguarding children training.</p> <p>The provider told us that they had organised face to face basic life support training. However, this had to be cancelled when the majority of staff fell ill with COVID-19. The provider sent evidence that inhouse training for basic life support had now been organised.</p> <p>The practice had four designated fire marshals. However, records showed that they had not completed the required fire marshal training. After the inspection the provider sent evidence to show that all four fire marshals had been placed on a waiting list to complete this training.</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-centered 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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	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



## 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
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes

## Responsive

**Rating: Good**

The data and evidence we reviewed in relation to the responsive key question as part of this inspection did not suggest we needed to review the rating for responsive at this time. Responsive remains rated as Good.

## 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	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	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:	

The practice had remained open throughout the pandemic providing a range of appointments, including; face to face appointments, telephone consultations and video calls.

The practice offered appointments between 8am and 6.30pm, Monday to Friday. The practice offered extended appointments between 6.30pm and 8pm every Monday and Tuesday.

There were arrangements with other providers to deliver services to patients outside of the practice's working hours.

The practice had timely access to appointments. We looked at the practice's appointment system and saw that the next available telephone consultation with a GP was 27 July 2022 and the next face to face appointment with a GP was 29 July 2022. The next available appointment with a practice nurse was 3 August 2022.

The provider told us they ensured emergency appointments were available for patients who needed to be seen urgently.

## Well-led

## Rating: Requires Improvement

We rated the practice as Requires Improvement for providing well-led services because:

- There were processes for managing risks, issues and performance. However, these were not always effective.

### 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:

The provider told us that due to shortfalls in staffing levels new staff had been recruited. For example, two non-clinical roles. The practice also had the support of two paramedics, two clinical pharmacists, two physiotherapists and a care coordinator via the NHS England Additional Roles Reimbursement Scheme (ARRS). They told us the additions to the team had helped address the challenges identified and also helped to meet patients' needs.

We were told the provider ensured there were adequate staffing levels by completing staff rotas at least four weeks in advance and they regularly reviewed appointment figures, as well as, discussed in team meetings with a view to increase appointments for patients. We reviewed meeting minutes which confirmed this.

Staff told us they would inform management and partners whether there was an increase in demand for appointments and that they were responsive to this feedback.

Through being an accredited training practice, the provider has trained GP Registrars who are in the final stages of their professional training to becoming a General Practitioner. The provider told us they have been successful in recruiting GP Registrars after they had completed their training.

Clinical leadership and clinical supervision were provided by one of the GP partners, although all staff were able to contact any of the GP partners if required.

There was a clear leadership structure. Staff told us that the GP partners and practice management team were approachable and always took the time to listen to them. For example, staff expressed that they found communication and teamwork difficult when the admin staff were split between two rooms. This was discussed with the partners and it was agreed to move rooms, so that all admin staff were together. Staff reported that this helped with team morale, communication and performance.

### 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

### 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
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: Feedback from staff confirmed that the leadership team were approachable and had been proactive in supporting the team during the pandemic and making changes to improve the practice. Staff felt	

comfortable raising any concerns with the leadership team and told us they worked well in their team and enjoyed working together.

Staff shared an example of collaborative working when they informed line management that some patients found it difficult to complete the eConsult forms (a form based online consultation and triage platform that collects medical or administrative requests). It was agreed that staff could offer to complete the form for patients, which staff said had worked well for patients based on the positive feedback they received.

There was an emphasis on the well-being of staff. The provider told us that health and well-being courses had been shared with all staff and that the provider had organised team events to help boost morale.

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

Source	Feedback
Written feedback from staff to CQC	<p>Staff told us:</p> <ul style="list-style-type: none"> <li>• there was a good team ethos, the practice was a nice environment to work in, management and partners were supportive, were willing to listen to feedback and encouraged staff to share ideas.</li> <li>• that partners and line management were open, transparent and shared information with them.</li> <li>• the practice was patient focused and also cared for its employees.</li> <li>• the practice management team encouraged opportunities to complete courses as part of their wider learning and career development.</li> </ul>

#### Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a system to regularly review governance documents. We looked at 14 governance documents and found three were incomplete; the vaccine fridge temperature monitoring policy, complaints policy and grievance policy were missing details about the nominated staff member responsible for certain roles. Further, the IPC policy was due to be reviewed in March 2022. However, this had not been completed.</p>	

After the inspection, the provider wrote to us with evidence that they had revised these policies accordingly.

## Managing risks, issues and performance

### Processes for managing risks, issues and performance required further improvement.

	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
<p>Explanation of any answers and additional evidence:</p> <p>Our inspection identified that improvements were required in identifying, managing and mitigating some risks in relation to the management of some high-risk drugs; safety alerts; medicines reviews; patients with a potential missed diagnosis of chronic kidney disease stage 3, 4 or 5; blank prescription forms; recruitment checks; staff training; management of medicines that required refrigeration; legionella and infection prevention and control audits.</p> <p>We also found improvements to care and treatment were required for some types of patient reviews. For example, asthmatic patients who had been prescribed two or more courses of rescue steroids in the last 12 months, patients who were prescribed medicine for an underactive thyroid and patients with diabetic retinopathy.</p>	

### 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.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes

There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

## Appropriate and accurate information

### The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a sample of patient records and it showed that monitoring was in line with best practice guidance for patients who had been prescribed benzodiazepine and Z drugs and patients who had been diagnosed with chronic kidney disease stage 4 or 5. However improvements were required for the monitoring of some high-risk medicines and long-term health conditions.</p> <p>NHS England results also showed improvements were required for the uptake of childhood immunisations; cervical cancer screening and the identification and timely referral of new cancer cases.</p> <p>Our inspection also identified improvements to monitoring processes were required, for example in relation to legionella and infection prevention and control.</p> <p>After the inspection, the provider shared an action plan which detailed how they would monitor and improve systems and processes.</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.	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
The practice advised patients on how to protect their online information.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had an established patient participation group (PPG). The meeting minutes showed information had been shared about changes to the practice's appointment system, new recruits to the practice and the different clinics on offer. We saw the provider held presentations where data was shared. For example, the number of appointments offered to patients, number of eConsult forms completed, average of daily telephone calls received and patient satisfaction scores.</p> <p>We also saw the provider was receptive to its members by answering queries they had. For example, how the practice managed care homes and information about clinics the practice offers.</p> <p>The meeting minutes also showed suggestions made by the PPG members, to help improve patient service. For example, having more staff to answer the phones and offering more appointments without the need for triaging. We also saw PPG members sharing suggestions on how to boost staff morale. For example, coffee mornings.</p> <p>The provider told us they were trying to encourage younger people to join the PPG, so that they received views and feedback from a wider patient population.</p>	

### Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Significant events were used to make improvements. The provider told us that learning from significant events were shared with staff and staff we spoke with confirmed this.</p> <p>The provider worked together with two other GP practices within the Dartford, Gravesham and Swanley Primary Care Network and linked with social prescribers, mental health nurses and learning disability care co-ordinators.</p>	

The provider told us that with eight GP partners and an increase in the patient population, clinical space was limited and were anticipating more patients joining the practice due to the increase in housing development in the area. They told us that a refurbishment was planned in order to expand the building.



## Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

## Glossary of terms used in the data.

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