

Care Quality Commission

Inspection Evidence Table

Devon Road Surgery (1-552310815)

Inspection date: 12 July 2022

Date of data download: 11 July 2022

Overall rating: Good

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
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
Explanation of any answers and additional evidence: <p>The provider had a designated safeguarding lead. 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. Safeguarding concerns were discussed in clinical meetings and there was information that displayed the relevant phone numbers to call if staff needed to raise a safeguarding concern.</p> <p>Staff demonstrated they understood their responsibilities. We looked at the training records of five members of staff and saw that they had all received the appropriate level of safeguarding training for their role.</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 and had received a Disclosure and Barring</p>	

Safeguarding	Y/N/Partial
Service check (DBS). (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).	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Records reviewed confirmed the provider carried out staff checks at the time of recruitment, where appropriate. Disclosure and Barring Service (DBS) checks were completed where required.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 05 May 2022	Yes
There was a fire procedure. Date of fire risk assessment: 05 May 2022	Yes
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Legionella (a bacterium found in water supplies which could cause severe respiratory illness) testing, and routine systems and processes for monitoring this were being maintained. Records viewed confirmed this.</p> <p>We saw numerous policies, procedures and risk assessments that collectively made up a health and safety risk assessment. The provider took appropriate action where applicable. For example, removing items that may pose a trip hazard.</p> <p>During the inspection, we asked to see the records of a recent fire drill. Records showed that the last planned fire drill was on 17 December 2019. The provider told us that they had not been able to conduct a fire drill, due to circumstances arising as a result of the pandemic. After the inspection, the provider wrote to us with evidence that an unannounced fire drill had taken place on 13 July 2022.</p> <p>We saw that a fire risk assessment had been carried out within the last 12 months. The risk assessment identified risks. However, it did not include a timeline to address the issues identified. For example, the provider identified the need to complete portable appliance testing but there was no planned completion date written in the risk assessment. During the inspection we saw that portable appliance testing had been completed. After the inspection, the provider wrote to us with evidence of a revised fire risk assessment.</p> <p>We looked at the training records of five members of staff and saw they all had received appropriate training in fire safety.</p> <p>We saw that the provider's fire safety policy, detailed that the practice had three designated fire marshals. However, records showed that they had not completed their fire marshal training. After the inspection, the provider sent evidence to show two staff members had been placed on a waiting list to</p>	

complete this training and one staff member was on leave and would be booked to complete their fire marshal training when they returned.

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.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 11 November 2020	Partial
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy.</p> <p>We saw the provider had a monthly rolling programme of auditing compliance with their hand hygiene policy. The provider conducted a hand hygiene audit on 22 February 2022. This involved the infection control lead observing staff members to ensure they were following the correct guidance.</p> <p>During the inspection, we saw the provider had completed weekly infection control checks for each room in the practice. For example, ensuring the cleanliness of the walls, floor, furniture, sinks and blinds.</p> <p>There was an up to date infection prevention and control (IPC) policy. However, the practice had not completed an IPC audit within the last 12 months. After the inspection, the provider wrote to us with evidence that an IPC audit had been conducted. The audit identified risks and actions required. It identified who was responsible for each action and included a timeline to address the issues.</p> <p>We looked at the training records of two members of non-clinical staff and three members of clinical staff. Records showed that two members of clinical staff had not completed IPC training. After the inspection, the provider wrote to us with evidence that both clinical staff members had completed their IPC training.</p>	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes

There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
<p>Explanation of any answers and additional evidence:</p> <p>There was an induction system for all new staff. This involved sharing key information and a structured development programme. Their performance was monitored via regular one to one meetings with an appointed staff member.</p> <p>We looked at the training records of five members of staff and saw that all five had completed basic life support training appropriate to their role. However, records showed that two members of staff had not completed sepsis training. After the inspection, the provider wrote to us with evidence that both staff members had now completed this training.</p> <p>During the inspection, we spoke to three members of non-clinical staff and they were able to explain who they would seek guidance from if they came across deteriorating or acutely unwell patients.</p> <p>The practice had a comprehensive business continuity plan for major incidents such as; power failure or building damage. The plan included emergency contact numbers for staff.</p>	

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

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)	0.70	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)	6.7%	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)	5.29	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)	107.6‰	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)	0.72	0.62	0.60	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	2.6‰	6.9‰	6.8‰	Variation (positive)

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

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

Medicines management	Y/N/Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	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 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).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Yes
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
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.	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.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The arrangements for managing medicines at the practice, including emergency medicines and oxygen, kept patients safe. Medicines which required refrigeration were kept between two and eight degrees centigrade and consistent records were available to demonstrate this.</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 received medicine reviews and two patients who had been prescribed leflunomide (a disease modifying anti-rheumatic drug). We found that all patients received monitoring in line with best practice guidance.</p> <p>We also looked at the records of five patients who had been prescribed amiodarone (used to treat or prevent heart rhythm disorders, such as atrial fibrillation) and found that four of the patients had not had the relevant blood tests in line with current best practice guidance. After the inspection, the provider sent us evidence to show that all four patients had been contacted to book an appointment for a blood</p>	

Medicines management	Y/N/Partial
<p>test. The provider also showed us that to improve monitoring of this medicine, an alert had been created on the clinical system to alert staff if a patient on amiodarone had not had a recent blood test.</p> <p>We reviewed the records of five patients who had been prescribed a high-risk medicine (gabapentinoid – used to treat epilepsy and neuropathic pain) and found that one patient was overdue a medicine review. This was not in line with current best practice guidance. After the inspection the provider wrote to us with evidence to show that the patient had a review with a nurse in a weeks' time.</p>	

Dispensary services (where the practice provided a dispensary service)	Y/N/Partial
There was a GP responsible for providing effective leadership for the dispensary.	Yes
The practice had clear Standard Operating Procedures which covered all aspects of the dispensing process, were regularly reviewed, and a system to monitor staff compliance.	Yes
Dispensary staff who worked unsupervised had received appropriate training and regular checks of their competency.	Yes
Where the Electronic Prescription Service is not used for dispensary prescriptions, prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions.	Yes
Medicines stock was appropriately managed and disposed of, and staff kept appropriate records.	Yes
Medicines that required refrigeration were appropriately stored, monitored and transported in line with the manufacturer's recommendations to ensure they remained safe and effective.	Yes
If the dispensary provided medicines in Monitored Dosage Systems, there were systems to ensure staff were aware of medicines that were not suitable for inclusion in such packs, and appropriate information was supplied to patients about their medicines.	Yes
If the practice offered a delivery service, this had been risk assessed for safety, security, confidentiality and traceability.	Yes
Dispensing incidents and near misses were recorded and reviewed regularly to identify themes and reduce the chance of reoccurrence.	Yes
Information was provided to patients in accessible formats for example, large print labels, braille, information in a variety of languages etc.	Yes
There was the facility for dispensers to speak confidentially to patients and protocols described the process for referral to clinicians.	Yes
<p>Explanation of any answers and other comments on dispensary services:</p> <p>We looked at the arrangements for the dispensing of medicines to patients. We spoke with dispensing staff, who had received appropriate training in pharmacy services. Medicines were prepared, and prescriptions checked and counter-signed by doctors daily before being issued to patients.</p> <p>The dispensary was in a secure room and there were systems to help ensure that medicines were stored safely and securely. Prescriptions that had been prepared and were awaiting collection by patients were also stored appropriately.</p>	

There were clear stock records and audit checks kept of the medicines held in the dispensary, as well as stocks held of controlled drugs (medicines that required extra checks and special storage because of their potential misuse). We saw there were procedures to manage them safely, including those that were returned to the practice and any that required destruction.

Any dispensing errors, complaints and incidents were investigated, actioned and recorded for learning. The practice had a system to monitor the quality of the dispensing process.

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.	Yes
Number of events recorded in last 12 months:	16
<p>Explanation of any answers and additional evidence:</p> <p>We looked at the records of two significant events that had been recorded within the last 12 months. We saw that details of the event had been investigated and necessary action taken. Records also showed that learning had been shared with practice staff to help manage such an event should it happen again.</p>	

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

Event	Specific action taken
A task was sent to a GP requesting that they call a vulnerable patient. However, the GP was not in the practice.	Despite not being at the practice, the GP saw the task and so was able to call the patient. Staff were reminded to turn on their "out of office" message on the clinical system. Receptionists were also advised to book an appointment in the clinician's calendar, if a patient requires an urgent phone call.
A member from the admin team answered a phone call from the pathology department. A message was shared regarding an urgent blood test result. However, when this was relayed to the clinician, the clinician was unsure what the result was referring to.	The partners at the practice discussed this and it was decided that the procedure should be updated; phone calls regarding urgent blood test results should be transferred to a clinician. This message was shared with non-clinical members of staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>During our clinical searches we reviewed one safety alert and saw that they had not always been managed well. For example, we reviewed the safety alert indicating that regular blood tests were required when a patient had been prescribed ACE inhibitors/angiotensin receptor blockers (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).</p> <p>We reviewed the records of five patients who had been prescribed these medicines and found that two of the patients had not been monitored in line with current best practice. After the inspection, the provider shared evidence to show that one of the patients had been invited for a blood test and the other patient would be contacted to confirm whether they were still taking the potassium sparing diuretic, as their medical notes suggested the patient had not taken this medication in over a year. The provider told us that a blood test would be booked for the patient if they still required this medicine.</p> <p>The provider also showed us that to improve monitoring of these medicines, an alert had been created on the clinical system to alert staff if a patient on these medicines has not had a recent blood test.</p>	

Effective

Rating: Good

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

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. However, improvements to some patient reviews were required.

	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
<p>Explanation of any answers and additional evidence:</p> <p>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.</p> <p>We looked at the records of:</p> <ul style="list-style-type: none">• Two patients who were identified by the search as having a potential missed diagnosis of diabetes and found monitoring was in line with best practice guidance.• 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 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 all five patients had not received appropriate monitoring, in that the patients were not followed up seven days after they had been prescribed the steroid. This was not in line with best practice guidance. After the inspection, the provider showed us that they had created an alert on their clinical system. This meant that if a patient was prescribed a rescue steroid, then an alert would appear on the screen to remind clinicians to schedule a telephone review appointment seven days after the patient had been prescribed the steroid.
- Five patients who were diagnosed with chronic kidney disease (stage 4 or 5). We found that two patients had not received a blood test in line with current best practice guidance. After the inspection, the provider shared evidence that both patients had been invited for a blood test. The provider also showed us that they had added an alert to their clinical system which would notify clinicians if a patient with chronic kidney disease had not had recent monitoring tests.
- Five patients who were diagnosed with hypothyroidism. We found that three of the patients had not received a blood test in line with current best practice guidance. After the inspection, the provider sent evidence to show that one patient had been invited for a blood test, one patient received a medical review and one patient had been contacted to discuss the need for a blood test to be taken.

Effective care for the practice population

Findings

Health checks, including frailty assessments, were offered to patients.

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. This included regular video or phone calls during the pandemic.

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.

Patients who were carers were invited for appropriate vaccinations.

There were systems in place to support patients who faced communication barriers.

The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder

Patients with poor mental health were referred to appropriate services and offered annual physical health checks.

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 offered extended appointments from 6.30pm to 7.30pm every Monday, Tuesday and Thursday.

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.

Management of people with long term conditions

Findings

For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

The provider followed up patients in vulnerable circumstances who had not attended their appointments.

The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

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.

There was a medicines delivery service for housebound patients.

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 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)	66	74	89.2%	Below 90% minimum

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	70	94.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	70	94.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	66	70	94.3%	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)	71	78	91.0%	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>

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 one indicator.

The provider shared unverified data which showed uptake rates had improved.

Unverified data showed that to date:

100% of children aged 1 had a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib) and Hepatitis B (Hep B).

The provider told us that in an attempt to increase uptake for childhood immunisations; they regularly reviewed their records and sent recall letters/text messages to remind parents of the need to book an appointment for their child's immunisations; provided additional appointments outside of working hours and opportunistic appointment bookings, when the parent attended the practice with their child for other matters.

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)	76.2%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.7%	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)	68.1%	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)	54.3%	56.4%	55.4%	No statistical variation

Any additional evidence or comments
<p>Published results showed that the provider's uptake for cervical screening as at December 2021 was below the 80% target for the national screening programme. The provider shared unverified data which showed uptake rates had improved.</p> <p>Unverified data showed that to date 83% patients aged 25 to 49 years and 82% patients aged 50 to 64 years registered at the practice had received cervical screening.</p> <p>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.</p>

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.	Yes
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

As part of this inspection, we asked the provider to submit a copy of any clinical audits carried out within the last 12 months with any action plans. 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.

We saw a two-cycle audit, that had been conducted to analyse whether appropriate monitoring had taken place for patients on direct oral anticoagulant medicines. The audit identified actions that were needed to improve upon the results of the first cycle audit. For example, 41% of patients did not have an alert attached to their medical record to show that a blood test had taken place in the last 12 months. Results from the second audit showed an improvement in monitoring of patients on this medicine, alerts had been attached to the patients records and policies and procedures had been updated as a result.

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.	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

Explanation of any answers and additional evidence:

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.

We looked at the training records of five members of staff and found that some staff had not completed training in sepsis and infection prevention and control.

The practice had three designated fire marshals. However, records showed that they had not completed the required fire marshal training.

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
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance. However improvements were required.

	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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>During the inspection, we asked to see examples of DNACPR forms to see if decisions were made in line with relevant legislation. The provider told us that they did not hold copies of the forms and that the original form had remained with the patient. We looked at two patient records and saw that it had been recorded that a DNACPR decision was in place.</p> <p>After the inspection, the provider wrote to us with evidence that they had revised their DNACPR policy. The policy explained the clinician must make clear notes in the patient's medical record about the discussion that had taken place and the reasons for a DNACPR decision. The policy also outlined that a copy of the DNACPR form should be kept on the patient's record.</p>	

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 used a triage system to prioritise patients based on clinical need and provided a range of appointments including; face to face, telephone consultations, video and home visits. Patients who called the practice requesting an appointment were booked in for a telephone call on the same day; the clinician would call the patient to discuss the care and treatment of the condition and if deemed medically necessary, a face to face appointment for the same day would be offered. If the patient was unable to attend the practice on the day, then a face to face appointment would be booked for them on an alternative day. The practice offered appointments between 8.30am and 6.30pm, Monday to Friday. The practice offered extended appointments between 6.30pm and 7.30pm every Monday, Tuesday and Wednesday. There were arrangements with other providers to deliver services to patients outside of the practice's working hours.	

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.	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 and an increase in demand from patients, staff had been recruited. For example, three receptionists. The practice also had the support of a pharmacist and two paramedics via the NHS England Additional Roles Reimbursement Scheme (ARRS). The provider told us the additions to the team had helped meet patients' needs and address challenges identified by them. The provider told us they regularly reviewed staffing numbers and were continually trying to increase their staffing levels. 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 staff were approachable and always took the time to listen to them. For example, admin staff expressed their views that Friday afternoons were busy and that they found it difficult to meet patient demand and complete tasks. They suggested that additional cover was needed. This was discussed with the partners and extra staff were scheduled to work on Friday afternoons. Senior management told us that this helped with staff morale 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
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	No
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Feedback from staff confirmed that there was an open culture within the practice, the leadership team were approachable, they felt comfortable raising any issues and felt confident and supported in doing so.</p> <p>There was an emphasis on the well-being of staff. The provider told us that well-being courses and information regarding counselling had been shared with all staff, especially during the pandemic and that staff had recently attended a team event that had previously been postponed due to the pandemic. Staff told us that well-being incentives had also been given in the attempt to help boost morale.</p> <p>We saw there were systems to receive feedback and to share information with all staff, by way of meetings and the use of secure social media platforms.</p> <p>The provider told us the practice did not have a Freedom to Speak Up Guardian (an appointed member of staff to support staff members to speak up when they feel they are unable to do so) because there was open communication within the practice. The provider told us that staff were able to speak to line management and partners if they had any concerns. Staff we spoke to during the inspection confirmed this. The provider also told us that going forward they would consider appointing a Freedom to Speak Up Guardian.</p>	

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

Source	Feedback
Written feedback from staff to CQC	<p>Staff said there was a good team ethos, a nice environment to work in and that management and partners were supportive and willing to listen to feedback.</p> <p>They told us that the practice management team encouraged opportunities to complete courses as part of their wider learning and career development.</p> <p>Some staff expressed that the practice was very busy and that they've experienced pressure with meeting patient demand.</p>

	Some staff also said that improvements were required in relation to communication within the practice and staffing levels.
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Governance arrangements

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

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>We looked at 17 governance documents and found that they were up to date. The provider had a system to ensure the documents were reviewed regularly.</p> <p>We saw that clinical and non-clinical meetings took place to discuss various topics related to the running of the practice and any improvements that were required. We saw the meeting minutes were reflective of discussions held in relation to appointments, complaints, safeguarding and significant events. We also saw that information was shared with staff via the use of secure social media platforms.</p>	

Managing risks, issues and performance

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

	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:</p> <ul style="list-style-type: none"> • monitoring of some high-risk drugs • monitoring of some medicines usage • management of safety alerts 	

- staff training
- management of infection prevention and control audits
- management of fire risk assessments
- management of fire drills
- management of DNACPR forms

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 with chronic kidney disease who had not had the required blood test in the last 18 months and patients who were prescribed medicine for an underactive thyroid. After the inspection, the provider wrote to us with evidence that the patients had been invited for the relevant tests and that new systems had been embedded in the clinical system to help ensure monitoring of patients in line with current best practice guidance.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice continued to offer services to patients during the pandemic and offered a range of appointments to suit the needs of its patients.</p> <p>The provider told us the circumstances arising from the pandemic had a knock-on effect in relation to patient care and treatment. For example, many patients required medication reviews before a prescription for medicine could be given; including blood tests, blood pressure monitoring, height and weight checks. With a focus on managing the backlog of activity and providing good quality of care, the provider created a new staff role; pre-screening. The pre-screener reviewed patient notes and informed the patient of the necessary tests required prior to a medicine review. If applicable, the pre-screener would book a blood test appointment for the patient or invited the patient to use the Surgery Pod that was located in the practice (a secure computer system which has the capability to record patient data and take readings such as weight and blood pressure measurements). This enabled patients (without</p>	

the need of an appointment or clinical supervision), to perform their own checks. The provider told us this streamlined the process to ensure the correct staff were involved at the right point in the process and that this improved patient experience.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	Yes
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the time of our inspection, the provider told us that formal meetings with the practice's patient participation group (PPG) had not taken place since the pandemic in March 2020. However, the practice was still in contact with the members of the PPG and would occasionally contact them for feedback. For example, a survey was sent to the members for their views and suggestions about plans to renovate the building.</p> <p>In order to monitor patient satisfaction, the provider collected feedback from patients. The provider was aware of issues that some patients had experienced when they called the practice. For example, the phone line cutting off or the call back feature not working. The provider said they would be installing a new phone system within the next few months and that they aimed to monitor the efficacy of this to see if it had improved patient experience.</p> <p>We also saw an example of the provider acting on patient feedback when they received concerns about data protection and security with the repeat prescription post box. In response, the provider had replaced the prescription box with a more secure and tamper free one.</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.	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. We saw evidence that learning from significant events was shared with staff.</p> <p>The practice had a focus on staff personal development. For example:</p>	

- a non-clinical staff member was completing training for a care co-ordinator role. This training will allow the staff member to become proficient in tasks such as phlebotomy, NHS health checks and completing electrocardiogram tests (ECGs).

The provider worked together with three 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.

The provider had received approval for extending the premises and work for this was due to commence in September 2022. The provider planned for an extra storey to be built which would allow for extra consultation rooms and a ramp to be installed outside the practice for ease of access for wheelchair users.

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.