

Care Quality Commission

Inspection Evidence Table

Oakfield Health Centre, Practice 2 (1-552805452)

Inspection date: 4 August 2022

Date of data download: 02 August 2022

Overall rating: Requires Improvement

We rated the practice as Requires Improvement overall because:

- Appropriate standards of cleanliness and hygiene were met. However, improvements were required.
- Staff had the information they needed to deliver safe care and treatment. However, improvements were required. For example, oversight of the task and document management system.
- Improvements were required in relation to the monitoring and assessment of patients' health in relation to the use of high-risk medicines.
- Improvements were required in relation to the monitoring of medicines that required refrigeration.
- Improvements were required in relation to documenting evidence of learning and dissemination of information.
- Systems for managing safety alerts were not always effective.
- 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.
- Performance relating to cervical cancer screening 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:

- Appropriate standards of cleanliness and hygiene were met. However, improvements were required.
- Staff had the information they needed to deliver safe care and treatment. However, improvements were required. For example, oversight of the task and document management system.
- Improvements were required in relation to the monitoring and assessment of patients' health in relation to the use of high-risk medicines.
- Improvements were required in relation to the monitoring of medicines that required refrigeration.
- The practice did not have a documented risk assessment in place relating to some recommended emergency medicines that were not held in the practice.

- Improvements were required in relation to documenting evidence of learning and dissemination of information.
- 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.

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
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>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. 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. Staff demonstrated they understood their responsibilities.</p> <p>We looked at the training records of five staff members and identified that all but one clinical staff member was not up to date with safeguarding training appropriate to their role. The staff member had started employment in June 2022 and completed level one and level two training in safeguarding vulnerable adults and children. After the inspection, the provider told us that this had not been completed due to mitigating circumstances. They wrote to us with evidence that the staff member had now completed their level 3 training in safeguarding vulnerable adults. We were sent evidence that the staff member had enrolled on the level 3 training for safeguarding children and was in the process of finishing the course.</p> <p>There were notices in the practice and on the waiting area television that advised patients chaperones were available. We also saw staff who acted as chaperones wore badges to inform patients of this. We saw all staff who acted as chaperones were trained for the role and had received a Disclosure and Barring 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).</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>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: 17 March 2022	Yes
There was a fire procedure. Date of fire risk assessment: 17 March 2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Records showed that portable appliance testing (PAT) and calibration testing of equipment had been carried out within the last 12 months.</p> <p>Records also showed that a health and safety risk assessment had been carried out on 17 March 2022. There was an action plan that contained a timeline to address issues identified. During the inspection we saw these issues had been rectified. For example, the risk assessment identified the need for regular fire alarm testing and to send water samples for testing of legionella (a bacterium found in water supplies which could cause severe respiratory illness). We saw evidence that both of these had taken place.</p> <p>The provider's latest fire risk assessment concluded all was satisfactory. We also saw evidence that the provider had booked an external company to complete a fire risk assessment on 15 August 2022. This had been booked prior to our inspection. After the inspection, the provider wrote to us with evidence that this had taken place.</p> <p>We also saw the provider conducted periodic health and safety risk assessments, including fire prevention, to ensure compliance with health and safety law.</p> <p>We looked at the training records of five members of staff and saw that one member of staff had not received training in fire safety. After the inspection, the provider wrote to us with evidence that the staff member had completed their training.</p> <p>We saw that the provider had a fire evacuation plan and three designated fire marshals. Records showed that they were up to date with their fire marshal training.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met. However, 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: 27 July 2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
<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. We looked at the training records of five staff members and saw that they received appropriate training in infection prevention and control (IPC).</p> <p>There was an up to date IPC policy. We saw the provider had a monthly rolling programme of conducting infection control audits. This included; general cleanliness of the premises, correct usage of sharps bins, observing staff were adhering to correct hand washing guidance and checking whether the treatment room curtains are clean. There was an action plan to address issues identified. For example, the audit identified mold present on the wall in one of the patient toilets and we saw that this had been resolved appropriately.</p> <p>During the inspection we saw that some areas of the practice had carpeted floor. We did not see that this was identified in the IPC audit or that there was an action plan to address the potential IPC issue. After the inspection, the provider wrote to us with a comprehensive action plan; it explained the cleaning programme to mitigate any risks relating to IPC, such as contamination from spills; a risk assessment and a request for quote from a cleaning company for a deep clean of the carpeted areas. The provider also told us they would be reviewing plans to decide if they should replace all carpeted floors with medical treatment room flooring.</p>	

Risks to patients

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

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

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 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.

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.

We saw there was an inventory of the emergency equipment and that regular monitoring took place. During the inspection we saw that the provider did not hold a spare set of defibrillator pads. The provider showed evidence that this had been ordered prior to the inspection.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, improvements were required.

	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.	N/A
<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> <p>The provider's task management system showed approximately 600 outstanding tasks. We looked at two tasks and saw appropriate action had been taken. We informed the provider of this and after the inspection, the provider sent evidence of a comprehensive action plan and evidence that they had reviewed a sample of 23 tasks; all of which showed that action had been completed as a result of the task and there was no patient harm experienced. The provider analysed the results and concluded that the high number of outstanding tasks were due to; auto generated messages, reminders set by clinicians, and staff not marking the task as complete on the clinical system once they had taken appropriate action.</p> <p>The provider shared their action plan detailing how they would review and complete all outstanding tasks; training would be provided to all staff and they would be reminded of the importance of marking</p>	

tasks as complete in a timely manner. The provider also told us they would be conducting a series of spot checks on the task management system to ensure tasks are completed in an efficient manner. We saw that the action plan was clear, comprehensive and realistic in terms of timescales and actions to be taken.

We also looked at the document management system and found 16 documents dating from 14 July 2021 that had not been viewed. These documents were assigned to a former staff member. Following the inspection, the provider sent evidence they had reviewed all documents and confirmed there was no patient harm experienced.

The provider created a policy which outlined how the document management system would be monitored; GP partners would have oversight of the inboxes for all clinicians; monthly reports of outstanding documents and pathology results would be downloaded and discussed in clinical meetings; training or support for staff would be identified when required; and clinicians who are due to leave employment would have their inbox reviewed to ensure outstanding tasks are complete. The provider also told us this policy would be shared with all staff in an upcoming meeting.

We also saw the provider created a significant event about these findings which showed analysis, reflection and learning.

Appropriate and safe use of medicines

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

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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)	0.96	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)	10.6%	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)	5.17	5.75	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	133.1‰	132.4‰	128.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) <small>(NHSBSA)</small>	1.00	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) <small>(NHSBSA)</small>	8.1‰	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.	Yes
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
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
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes

Medicines management	Y/N/Partial
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>The provider had a designated team that worked closely with the GP partners to monitor and update policies relating to medicines optimisation, prescriptions, safety alerts and repeat prescribing. They also completed audits to ensure patients had the required monitoring, for example if they were prescribed a high-risk medicine. They supported clinicians in the management and preparation of prescriptions as well as liaising with patients about their prescriptions. Staff told us they have a 48 hour turn around for repeat prescriptions but that they work towards a 24 hour turn around period. They also liaised with the medicines optimisation team in the Kent and Medway Integrated Care Board (ICB) to keep up to date with best practice.</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>The provider completed regular reviews of the prescribing practice of non-medical prescribers to ensure their prescribing competence. For example, the provider reviewed antibiotic prescribing and found areas of improvement such as the continuing need to reduce the prescribing of a particular antibiotic. We saw evidence that learning was disseminated to the relevant healthcare professionals.</p> <p>Newly recruited clinical staff told us they received consistent support and supervision by the GP partners which helped ensure appropriate care was being delivered.</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"> • Leflunomide (a disease modifying anti-rheumatic drug). We found the provider had robust systems in place to frequently recall patients for relevant reviews and that monitoring took place in line with best practice guidance. • ACE inhibitor or angiotensin II receptor blockers (used for treating patients with high blood pressure, heart problems or kidney disease). Our search identified there were 976 patients who had been prescribed this medicine and that 87 patients had not had the required monitoring. We looked at a sample of five patients and found blood tests were overdue for one patient. The provider attempted to recall the patient for further monitoring on one occasion in December 2021. After the inspection, the provider wrote to us with evidence that on 5 August 2022, the patient had their blood test and blood pressure reading taken. We also saw the provider had analysed the reasons why appropriate monitoring had not taken place and the changes they would embed to help ensure this doesn't occur again. <p>The practice held emergency medicines and we saw monitoring of these were handwritten on paper. We checked the medicines held for use in an emergency and found benzylpenicillin (used to treat suspected bacterial meningitis), soluble prednisolone tablets (used to treat croup in children) and diclofenac (used to treat pain) were not held in the emergency medicine box. We did not see that a documented risk assessment was in place. After the inspection, the provider told us that should an emergency arise, they could obtain required medicine from the community pharmacy located within the same building as the practice. The provider also said they are located in close proximity to a hospital. After the inspection, the provider also wrote to us with evidence that these medicines were now</p>	

Medicines management	Y/N/Partial
available in the practice. We were also provided with a new electronic template for the monitoring and recording of emergency medicines.	
We saw that vaccines that required refrigeration were stored securely in the treatment rooms. We looked at a sample of vaccines and found they were in date. We asked the provider how they monitored the designated refrigerators to ensure the cold chain was maintained (a term used to describe the cold temperature conditions in which certain products need to be kept during storage and distribution, of between two and eight degrees centigrade).	
We were told that each working day a staff member would download the information from the data logger (an electronic device that records temperature over a defined period of time) and this was kept in a folder on their computer system. We did not see evidence that this was formally recorded on a standard form, including a signature after each entry on a recording sheet. This was not in line with UK Health Security Agency (UKHSA) guidance.	
We looked at a sample of the data downloaded and found three instances where the temperature was showing as being outside of the acceptable limits. We did not see evidence that the provider took action as a result of these readings or that any action taken had been documented. After the inspection, the provider wrote to us with evidence they had retrospectively assessed the incidents including the cause of the temperature fluctuations; they confirmed that the cold chain was maintained. We also saw the provider had updated their cold-chain policy; created a flow chart to inform staff how they should record the temperatures and what action they need to take if the temperature falls outside the acceptable limits; and created a monitoring form to record the daily temperatures. The form required staff to provide a signature after each reading and confirmation of whether any action had been taken. The provider told us a lead member of staff would review the temperature logs twice a month to ensure they are completed correctly. The provider sent evidence that the process of monitoring the fridge temperatures had been embedded.	

Track record on safety and lessons learned and improvements made

Improvements were required in relation to documenting evidence of learning and dissemination of information.

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:	17
Number of events that required action:	12
<p>Explanation of any answers and additional evidence:</p> <p>We saw information about significant events and details of how to report an event was readily available to staff. We looked at two significant events that had been recorded within the last 12 months. We saw that details of the event had been investigated, escalated to the GP partners where necessary, discussed in clinical meetings and action taken. Staff we spoke to told us that significant events had</p>	

been discussed in meetings. However, we did not see documented evidence of learning or that any learning from these significant events were shared with relevant staff. After the inspection, the provider wrote to us with evidence they had reviewed the significant events and recorded further information about the investigation, analysis, changes implemented and how they shared any learning with staff across the practice. Following our inspection, we were provided with minutes from a practice meeting that took place after our inspection. They showed that staff were reminded of the importance of recording significant events and how these should be reported. The minutes also showed that discussion, including learning and suggested improvements, about the two significant events we looked at during our inspection had taken place.

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

Event	Specific action taken
A prescription for medicine had been issued for a patient. The patient had not requested this medicine. The patient returned the medicine to the pharmacy and queried this with the reception team.	The provider investigated this and found the medicine had been issued from the patient's past medication list. The provider spoke to the relevant team members; it was concluded that this occurred due to human error. There was no patient harm identified as the patient had not taken the medicine. The provider implemented changes to prevent incorrect prescriptions being issued again, for example, staff issuing medicines from patients' past medicines list had to obtain authorisation from a lead staff member. The provider told us this had been shared with wider practice staff during a meeting. After the inspection, we saw practice meeting minutes which showed the provider reminded staff of the learning from this significant event.
A patient was issued with a three-month supply of medicine. There weren't clear directions on the prescription to explain the process of increasing the dosage over time. The pharmacy queried the dose of the medicine that was prescribed as there was a possibility of the patient exceeding the maximum daily dose.	The provider investigated this and found a text message had been sent to the patient explaining the dosage regime however the prescription itself did not have the dose specified. Further, the patient did not understand the instructions sent in the text message. The provider amended their policy in prescribing medicines that required the patient to gradually increase the dose to help ensure this did not occur again. For example, the provider would have to prescribe a one-month supply, conduct a review and then issue another prescription with the higher dosage. The provider told us this had been shared with all clinicians and they were reminded that the prescription must contain the dosing information. After the inspection, we saw practice meeting minutes which showed the provider reminded staff of the learning from this significant event.

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.</p> <p>We reviewed the safety alert indicating that the dosage of one medicine (for high cholesterol) should be reduced if a patient was also taking a specific medicine for high blood pressure. The search identified 15 patients who had been prescribed these medicines. We reviewed the records of five patients and found that appropriate action in relation to the safety alert had not taken place for all five patients. After the inspection, the provider wrote to us with evidence to show that they had subsequently contacted all 15 patients; reviews were conducted, the patients were informed of the risks and prescribed an alternative medicine. We also saw the provider had analysed the reasons why appropriate action had not taken place and the changes they would embed to help reduce the risk of reoccurrence.</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 required improvement.

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

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 reviewed the records of five patients who had received medicine reviews and five patients who had been diagnosed with chronic kidney disease stage 4 or 5. We found monitoring was in line with best practice guidance for all patients.

Our search identified seven patients as having a potential missed diagnosis of diabetes. We shared this with the provider and after the inspection, they confirmed that four had not been coded correctly; three had been receiving treatment for diabetes and one had not been treated on clinical grounds. The remaining one patient required a follow up blood test. The provider sent evidence to show the patient had been asked to have a blood test in May 2022. After the inspection, the provider shared evidence to show they had called the patient, conducted a review and requested the patient to have a blood test the next working day. We also saw evidence of a consultation with the patient when the blood test results were received. The provider also sent evidence they had reviewed the additional two patients that had been identified by the search as having a potential missed diagnosis of diabetes.

Additionally, we reviewed five patients who had been prescribed 12 or more inhalers used to relieve shortness of breath in patients with asthma, in the last 12 months. We found four patients were overdue an asthma review. After the inspection, the provider shared evidence that they had contacted all four patients; asthma reviews had been completed for three patients and one patient had been invited for an asthma review.

We reviewed five patients with asthma who had been prescribed two or more courses of rescue steroids in the last 12 months. The clinical search identified three patients who had not received the required monitoring in line with best practice guidance. After the inspection, the provider wrote to us with evidence they had reviewed all three patients; one patient no longer needed asthma treatment, one patient was invited to have a review and one patient received an appropriate review by a respiratory consultant in April 2022.

Our search identified 298 patients diagnosed with hypothyroidism; 24 of these patients were identified as not having a blood test in the last 18 months. We looked at five records and found that two patients had not received a blood test in the last 18 months. This was not in line with current best practice

guidance. The provider shared evidence that after the inspection, they had spoken to both patients and booked a blood test appointment.

We reviewed 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 one patient required a follow up appointment to check their blood pressure. After the inspection, the provider shared evidence they subsequently conducted a telephone review with the patient and booked an appointment for a face to face review.

After the inspection, the provider shared an action plan which detailed how each patient would be reviewed and how they would review their systems and processes. We saw evidence that the results of all the clinical searches, improvements identified and changes to processes had been discussed in the provider's clinical meeting.

Effective care for the practice population

Findings

Patients had a named GP who supported them in whatever setting they lived.

The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.

Health checks, including frailty assessments, were offered to patients over 75 years of age.

Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

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

End of life care was delivered in a coordinated way which 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.

In an attempt to streamline the process involved in referring patients with dementia to the appropriate healthcare professional, the provider trained administrative staff to collect all relevant information from the patient. The provider told us this had improved referral times as there were no longer delays caused by the need of several GP appointments.

The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.

Parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

The practice actively contacted schools in the area and offered to administer COVID-19 vaccinations to teachers, teaching staff and administrators.

Management of people with long term conditions

Findings

For patients with complex long-term conditions, the GP worked with other health and care professionals to deliver a coordinated package of care.

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

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

Adults with newly diagnosed cardio-vascular disease were offered statins.

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 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.

The provider developed a structured template and diagnostic checklists to collect comprehensive information to help improve the referral process and support that may be needed by patients with attention deficient disorder (ADHD) and autism.

The provider recognised that services needed to be adapted for patients with impaired mobility and it had not been identified in their medical records. When patients attended appointments, the provider coded the record with those with impaired mobility so that future appointments would be appropriately adapted for the patients' needs.

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)	132	136	97.1%	Met 95% WHO based target

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	112	122	91.8%	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)	112	122	91.8%	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)	111	122	91.0%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	127	154	82.5%	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 higher than the World Health Organisation (WHO) target of 95% for one indicator and below the 90% minimum target one indicator.

The provider shared unverified data which showed uptake rates had slightly improved. (Unverified data refers to data that has been provided by the practice and has not been published; therefore, has not been verified by the data owner, for example, UK Health Security Agency, NHS Digital, NHS England and Improvement).

Unverified data showed that to date:

- 83% of children aged 5 received their immunization for measles, mumps and rubella.

The provider told us that in an attempt to increase the uptake for childhood immunisations; they conducted weekly audits to identify children that required the necessary immunisations and sent recall letters/text messages to remind parents of the need to book an appointment for their child's immunisations. The provider would also liaise with health visitors so that parents could be encouraged to book an appointment. We were told they recruited a practice nurse which may help improve uptake.

The provider shared an action plan which detailed how they aim to increase the uptake for childhood immunisations, including having discussions with other practices in similar deprivation bands with high rates of uptake in the effort to understand and apply any learning.

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)	69.2%	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)	65.5%	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)	62.9%	68.0%	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)	52.9%	56.4%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments
<p>Published results showed that the provider's uptake for cervical cancer screening as at December 2021 was below the 80% target for the national screening programme.</p> <p>Unverified data showed that to date 71% of persons eligible for cervical cancer screening were screened adequately within a specified period. (Unverified data refers to data that has been provided by the practice and has not been published; therefore, has not been verified by the data owner, for example, UK Health Security Agency, NHS Digital, NHS England and Improvement).</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; offered a range of appointments during the day and evening; and took the opportunity to speak to the patient when they attended the practice for other matters. We also saw information about cervical cancer screening had been displayed in the reception area and on the patient waiting room television.</p> <p>The provider shared an action plan which detailed how they aimed to increase the uptake for cervical cancer screening, including calling patients before their appointment, calling patients if they didn't attend their appointment; and having discussions with other practices in similar deprivation bands with high rates of uptake in the effort to understand and apply any learning.</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 in past two years

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 high-risk antibiotic prescribing. The first audit in January 2022 identified there clear and accurate diagnoses were recorded in patients' notes when clinicians prescribed antibiotics. The provider highlighted areas for improvement; an action plan had been implemented in the attempt to reduce antibiotic prescribing. The second audit was repeated in July 2022; it was identified that there was a 38% reduction in the prescribing of high-risk antibiotics.

We also saw a first cycle audit conducted in June 2022 which monitored opioid prescribing. The aim of the audit was to review the records of patients who had been prescribed a high dose of opioids to see if usage could be reduced. We saw the provider had analysed the results and created an action plan to help achieve this. The provider had planned to complete a second cycle audit in December 2022.

We saw the provider had conducted an audit to analyse whether patients who had been referred for an appointment under the two week wait referral process had received one. The audit identified good practice as well as improvements required; to help ensure patients who needed an urgent appointment were given one. We saw an action plan which explained the changes that would be implemented, for example, completing regular searches on the system to identify patients who had been given an appointment under the two week wait process and contacting them for a general review; and keeping a record of patients who did not attend their appointment and advising them to contact their GP. The provider had planned to complete another cycle in September 2022 to see whether the action plan they implemented had made any improvements.

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
<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>The provider had a system to track the training needs of staff and provided protected time and training to meet them. We looked at the training records of five members of staff. We could not see evidence that one member of clinical staff had completed sepsis and safeguarding training appropriate to their role. The staff member had started employment in June 2022 and completed level one and level two training in safeguarding vulnerable adults and children. After the inspection, the provider told us that this had not been completed due to mitigating circumstances. They wrote to us with evidence that the staff member had now completed sepsis training and their level 3 training in safeguarding vulnerable adults. We were sent evidence that the staff member had enrolled on the level 3 training for safeguarding children and is currently finishing the course.</p> <p>Staff were encouraged and given opportunities to develop; we saw evidence that the provider maintained a record of each staff member's skill set and encouraged them to obtain new roles and responsibilities across the practice.</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
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
<p>Explanation of any answers and additional evidence:</p> <p>The provider regularly reviewed the type of appointments being booked and services that are requested by patients to identify trends and improve the services offered to patients. For example, the provider identified there was a high demand of patients wanting to speak to a specific healthcare professional as they were a specialist in the area of menopause and hormone replacement therapy. As a result, the provider offered regular clinics to help provide patients a holistic approach to the management of menopause and associated health conditions.</p>	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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
Explanation of any answers and additional evidence: We reviewed two DNACPR decisions; we saw a copy of the form was in the patient's clinical record and accessible to clinicians. Where possible, the patient's views had been sought and respected. We also saw that information had been shared with relevant agencies.	

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had remained open throughout the pandemic providing a range of appointments, including; face to face appointments, telephone consultations and video calls.</p> <p>The practice offered appointments between 8.30am and 6.30pm, Monday to Friday. The practice offered extended appointments every Monday, Wednesday, Thursday and Friday between 7am and 8.30am and every Tuesday and Wednesday between 6.30pm and 7pm.</p> <p>There were arrangements with other providers to deliver services to patients outside of the practice's working hours.</p> <p>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 5 August 2022 and the next routine face to face appointment with a GP was 17 August 2022. The next available appointment with a practice nurse was 9 August 2022.</p> <p>The provider told us they ensured emergency appointments were available for patients who needed to be seen urgently.</p>	

Well-led Rating: Requires Improvement

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

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

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
<p>Explanation of any answers and additional evidence:</p> <p>The provider told us they ensured adequate staffing levels by completing staff rotas three months in advance, identified peak times of annual leave and established a policy that detailed the minimum and maximum staffing levels.</p>	

The provider also told us they regularly reviewed their telephone system to identify the busiest times for calls so that more reception staff could be scheduled to attend the phones.

The practice had the support of one paramedic, two clinical pharmacists, one physiotherapist and three care coordinators 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.

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, a staff member told us they had noticed a trend in the amount of complaints from patients expressing their dissatisfaction in obtaining an appointment relating to women's health. The staff member suggested to the provider that they hold a clinic for women's health on Friday afternoons. This was subsequently implemented. Another staff member told us that during the COVID-19 vaccination clinics, they provided suggestions to help improve the efficiency of the process and this was applied.

We saw important information was shared with staff via meetings and the use of secure social media platforms. We also saw the provider had regular communication with the nearby pharmacy where information about stock of medicines and other queries were discussed via secure social media platforms.

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: Staff told us they were aware of the practices' vision, values and strategy. They understood their role in supporting the development and achievement of these. We also saw the practice's mission statement had been posted around the practice.	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes

There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Leaders modelled and encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported.</p> <p>Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so. For example, staff told us they felt comfortable telling the wider leadership team about any concerns they may be experiencing and that they would be offered the option of flexible working. Also, when the GP partners received feedback from staff that they felt more cover was required in reception; they reviewed their staffing policy, recruited more staff and ensured senior members were available to provide leadership.</p>	

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"> • there was a good team ethos, they enjoyed working at the practice and worked well within the team, • the atmosphere was positive and happy, • all staff were patient focused, • all GPs and management were organised, approachable, supportive, willing to listen and focused on staff wellbeing. For example, reviewing their zero-tolerance policy and letter, to be sent to patients when they had been either verbally or physically abusive to reception staff. • important information was shared with staff via meetings and the use of secure social media platforms, • GPs and management encouraged wider learning and development.

Governance arrangements

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

	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
Explanation of any answers and additional evidence:	

We looked at 15 governance documents and found that they were up to date. The provider had a system to ensure the documents were reviewed regularly.

We found that improvements to some systems were required. For example, systems in relation to the monitoring of some high-risk medicines and patients with long-term conditions; documented evidence of learning and dissemination of information from significant events; management of safety alerts, management of IPC, monitoring of medicines that required refrigeration; monitoring of the task and document management system and monitoring of emergency medicines.

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>The principal GP was the practice's Caldicott guardian. Staff told us that the practice held multiple meetings to discuss the importance of confidentiality.</p> <p>Our inspection identified that improvements were required in identifying, managing and mitigating some risks in relation to; IPC; oversight of the task and document management system; monitoring of medicines that required refrigeration, cervical screening and childhood immunisation uptake rates, the management of safety alerts and read codes within patient care records.</p> <p>We also found improvements to care and treatment were required for some types of patient reviews. For example, patients who had been prescribed 12 or more inhalers to relieve asthmatic symptoms in the last 12 months, 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> <p>After the inspection, the provider wrote to us with evidence they had reviewed and taken appropriate action on all the above. They also shared a comprehensive action plan which detailed how they would monitor and improve systems and processes.</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
<p>Explanation of any answers and additional evidence:</p> <p>The practice continued to operate throughout the pandemic and provided a range of appointments including; face to face, video and telephone consultations, as well as home visits.</p> <p>The needs of vulnerable patients were coded as such on their patient records and offered longer face to face appointments.</p> <p>The provider told us they encouraged patients to wear face masks by offering masks for a small donation to the Gravesend Food Bank. As of December 2021, the practice raised £258.34. During our inspection, we saw the practice was continuing to raise money.</p>	

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 most patients who had been prescribed high risk medicines, received medicine reviews and who had been diagnosed with chronic kidney disease stages 4 or 5. However, some improvements</p>	

were required for the management of safety alerts, the management of some high-risk medicines and monitoring of long-term health conditions.

NHS England results also showed improvements were required for the uptake of childhood immunisations and cervical cancer screening.

After the inspection, the provider wrote to us with evidence they had reviewed and taken appropriate action on all patients where required. They also shared a comprehensive action plan which detailed how they would monitor and improve systems and processes, including the uptake of childhood immunisations and cervical cancer screening.

Governance and oversight of remote services

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

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 provider told us they had received numerous complaints from patients about the telephone system, for example being cut off or not knowing where they were in the queue. Due to this, the provider implemented a new telephone system which offered a call back option and informed the patient where they were in the queue; we were told that positive feedback was received about this. The provider also</p>	

told us that the new phone system has allowed them to analyse which times of the day were the busiest and acted accordingly. For example, scheduling more receptionists to answer the phones at a particular time.

The practice had an established patient participation group (PPG). The PPG supported the practice as a critical friend and to help drive improvements. Minutes of PPG meetings showed that they discussed the background of the practice, aims of the PPG, challenges and improvements. We also saw the provider listened to suggestions from the PPG members. For example, aiming to recruit more PPG members from different demographics so that feedback is collected from a wider patient population; sharing information with patients regarding the different roles and responsibilities in the practice so that they are better informed and promote any changes made.

As a result of feedback from the PPG, we saw the provider implemented the “You Said, We Did” approach. For example, the provider displayed information on the waiting room television about the new telephone system and the data they had analysed regarding phone access.

We also saw meeting minutes from the PPG meeting had been posted in the practice.

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 shared evidence that they had created a significant event following this inspection. We saw they had analysed and reflected on the feedback provided. We also saw they had shared the learning with all staff.</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, dietitians, care co-ordinators and physiotherapists.</p> <p>The provider told us they regularly reviewed staffing numbers in order to meet the demands and needs of its patient population.</p>	

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.