Gravesend Medical Centre

Inspection report

1 New Swan Yard
Gravesend
DA12 2EN
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Requires Improvement
Are services safe?	Requires Improvement
Are services effective?	Requires Improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires Improvement

Overall summary

We carried out an announced inspection at Gravesend Medical Centre. We conducted remote clinical searches on the practice's computer system on 26 July 2022 and conducted an onsite inspection of the practice on 27 July 2022 under Section 60 of the Health and Social Care Act 2008, as part of our regulatory functions.

The key questions at this inspection are rated as:

Safe – Requires Improvement

Effective – Requires Improvement

Responsive - Good

Well-led – Requires Improvement

Overall, the practice is rated as Requires Improvement.

Following our previous inspection on 29 June 2016, the practice was rated Good overall and for all key questions.

The full reports for previous inspections can be found by selecting the 'all reports' link for Gravesend Medical Centre on our website at www.cqc.org.uk.

Why we carried out this inspection

We undertook this inspection as part of a random selection of services rated Good and Outstanding to test the reliability of our new monitoring approach.

We checked whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection focused on the following:

- Are services safe?
- Are services effective?
- Are services responsive in relation to access?
- Are services well-led?

How we carried out the inspection

Throughout the pandemic CQC has continued to regulate and respond to risk. However, taking into account the circumstances arising as a result of the pandemic, and in order to reduce risk, we have conducted our inspections differently.

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site. This was with consent from the provider and in line with all data protection and information governance requirements.

Overall summary

This included:

- Conducting staff interviews using video conferencing,
- Completing clinical searches on the practice's patient records system and discussing findings with the provider,
- Reviewing patient records to identify issues and clarify actions taken by the provider,
- Requesting evidence from the provider,
- A short site visit.

Our findings

We based our judgement of the quality of care at this service on a combination of:

- what we found when we inspected
- information from our ongoing monitoring of data about services and
- information from the provider, patients, the public and other organisations.

We have rated this practice as Requires Improvement overall.

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

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

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

- Patients' needs were not always assessed, and care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Performance relating to cervical cancer screening and the identification and timely referral of new cancer cases required improvement.

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

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

We found that:

- The practice adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic. Patients could access care and treatment in a timely way.
- The way the practice was led and managed promoted the delivery of high-quality, person-centre care.

Overall summary

- The practice had systems, practices and processes to keep people safe and safeguarded from abuse however, some improvements were required.
- The practice learned and made improvements when things went wrong.
- The practice always obtained consent to care and treatment in line with legislation and guidance.
- There was compassionate, inclusive and effective leadership at all levels.
- Staff worked together and with other organisations to deliver effective care and treatment.
- Staff were consistent and proactive in helping patients to live healthier lives.
- People were able to access care and treatment in a timely way.
- The practice had a culture which drove high quality sustainable care.
- The practice involved the public, staff and external partners to sustain high quality and sustainable care.
- There was evidence of systems and processes for learning, continuous improvement and innovation.

The areas where the provider **must** make improvements are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider **should** make improvements are:

- Continue to implement and monitor the outcome of plans to improve childhood immunisation uptake.

Details of our findings and the evidence supporting our ratings are set out in the evidence tables.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector who spoke with staff using video conferencing facilities and undertook a site visit. The team included a GP specialist advisor who spoke with staff using video conferencing facilities and completed clinical searches and records reviews without visiting the location.

Background to Gravesend Medical Centre

Gravesend Medical Centre is located at 1 New Swan Yard, Gravesend, Kent, DA12 2EN. The practice is a training practice for trainee GPs.

The practice has a branch surgery at Chalk Surgery, 48 Lower Higham Road, Chalk, Gravesend, Kent, DA12 2NG, however this surgery is currently closed.

The provider is registered with CQC to deliver the Regulated Activities; diagnostic and screening procedures, maternity and midwifery services and treatment of disease, disorder or injury and surgical procedures.

The practice is situated within the Kent and Medway Integrated Care System and delivers General Medical Services (GMS) to a patient population of about 16,050.

The practice is part of a wider network of GP practices in Dartford, Gravesham and Swanley: Gravesend Central Primary Care Network (PCN).

Information published by Public Health England shows that deprivation score within the practice population group is four (out of ten). The lower the score, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 72.6% White, 16.8% Asian, 3.9% Black, 2.7% Mixed and 4.1% Other.

The number of patients under the age of 18 closely mirrors the local and national averages. The practice has a higher than average proportion number of patients aged 18 to 64 and a lower than average proportion number of patients over the age of 65.

The practice consists of eight GP partners (male and female). The GPs are supported at the practice by, two practice nurses (female), one healthcare assistant (female) and a team of reception and administration staff. The practice management team consists of the practice manager, assistant practice manager, administration manager and reception manager; who provide managerial oversight. The practice also has the support of two paramedics, two clinical pharmacists, two physiotherapists and one care coordinator via the NHS England Additional Roles Reimbursement Scheme (ARRS).

The practice is open between 8am and 6.30pm Monday to Friday. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments. The practice offers extended hours every Monday and Tuesday between 6.30pm and 8pm.

Extended access is provided locally by the PCN, where late evening and weekend appointments are available. Out of hours services are provided by NHS 111 and Integrated Care 24 (IC24). NHS 111 and IC24 deals with urgent care problems when GP surgeries are closed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established or where established were not operated effectively to ensure compliance with this part of the above Regulations. In particular: • Disclosure and Barring Service checks were not obtained for one non-clinical staff member. • Vaccinations statuses were not obtained for two non-clinical staff members. • Not all staff were suitably trained in basic life support. • Blank prescriptions were not always kept securely, and their use were not monitored in line with national guidance. • The provider did not have an established process to regularly check the temperature of the hot and cold outlets on the premises in relation to the control of legionella. • Prescribing and monitoring of some high-risk medicines were not always in line with best practice guidance. • Safety alerts were not always actioned in line with best practice guidance. • The level of detail in which medicine reviews were recorded were not always in line with best practice guidance. • The provider's uptake for cervical cancer screening was below the 80% target for the national screening programme. • The number of new cancer cases identified and referred in a timely manner were below the England and clinical commissioning group (CCG) averages. • Monitoring of patients with some long-term conditions did not always follow best practice guidance (potential missed diagnosis of chronic kidney disease, patients

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Requirement notices

with asthma who have had two or more rescue steroids, patients receiving treatment for an underactive thyroid and patients with diabetic retinopathy).

This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.