

Orchard House Surgery

Quality Report

Bleak Road

Lydd

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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 service

Inadequate



Are services safe?

Inadequate



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Inadequate



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Orchard House Surgery on 5 July 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- The provider was aware of and complied with the Duty of Candour. The GP encouraged a culture of openness and honesty.
- There was system for reporting and recording significant events. However, reviews, investigations and records of significant events did not always contain dates and timelines.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the arrangements for managing medicines, including emergency medicines and vaccines were not always effective.
- Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness. However, the practice did not always follow national guidance on infection prevention and control.
- The practice was unable to demonstrate that all staff had received Mental Capacity Act training.
- The practice was unable to demonstrate they had safeguarding policies for children or vulnerable adults.
- Staff told us they worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. However, there were no records to confirm this.
- The practice had completed several clinical audits in the last 12 months; two of these were completed audits where the improvements made were implemented and monitored.
- Patients we spoke with told us their dignity, privacy and preferences were always considered and respected.

Summary of findings

- Patient records were not always managed in a secure way in that computer system smart cards were left unattended in clinical rooms where the doors were left open.
- There was continuity of care and urgent appointments were available the same day.
- Information about services was available in the waiting room and on the practice website, which also contained a translation service. However, opening times and how to access services outside of opening times were not visible outside the premises.
- There were a range of mechanisms to manage the governance of the practice. However, governance arrangements were not robust or always effectively implemented.
- The principal GP had recognised the need for support and had accessed this from multiple avenues including the Local Medical Committee (LMC), neighbouring GP practices and the clinical commissioning group (CCG). In response, the CCG had provided a temporary practice manager to help maintain the day to day organisation within the practice whilst a permanent practice manager was recruited.

The areas where the provider must make improvements are:

- Ensure there are robust processes, systems and training to support staff in gaining patient consent.
- Ensure safety incidents are well recorded and that actions are taken to reduce the chance of the same thing happening again.
- Ensure all staff have the necessary employment checks including a current Disclosure and Barring Service check and employment and character references.
- Ensure all staff are up to date with attending training courses and that all newly appointed staff receive a local induction program.
- Revise risk assessments and management activities to include all risks to patients, staff and visitors.

- Ensure the practice develops systems and processes to manage infection prevention control; having due regards to National guidance.
- Revise governance processes and ensure that there are sufficient documents to govern activity and that these are reviewed and kept up to date.
- Ensure patient records are kept secure.
- Ensure Department of Health guidance is followed when managing the storage of vaccines.
- Revise medicines management procedures to help ensure vaccines and emergency medicines are in date and that there is a process for managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Ensure blank prescription forms are stored securely and implement systems to track and monitor their use.

In addition the provider should:

- Review opportunities for patient feedback and how to effectively promote the patient participation group.
- Review how multidisciplinary meetings are recorded.
- Review the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.
- Review the complaints recording system to ensure time frames and dates are included.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If sufficient improvements have not been made so a rating of inadequate remains for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as inadequate for providing safe services.

- There was a system for reporting and recording significant events. However, reviews and investigations of significant events were not sufficiently thorough. For example, significant events records did not always contain dates and timelines for actions undertaken.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, the arrangements for managing medicines, including emergency medicines and vaccines, in the practice to help keep patients safe, were not always robust.
- Whilst most staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, the practice was unable to demonstrate that all staff had received Mental Capacity Act training.
- The practice was unable to demonstrate they had safeguarding policies for children or vulnerable adults.
- Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control. However, the practice did not maintain any domestic cleaning schedules and when we checked the cleaning cupboard cleaning equipment had not been well maintained.
- The practice did not have an up to date fire risk assessments and had not been undertaking regular fire alarm test or fire evacuation drills. However, we saw evidence that the practice had an action plan to address this.
- Patient information was not always kept securely. For example, the inspection team noted on several occasions during the inspection that staff left smart cards in computers unattended in clinical rooms. The doors to these rooms were left open and as such were accessible to patients (Smart Cards are used to allow staff to access confidential patient information).

Inadequate



Are services effective?

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

Requires improvement



Summary of findings

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- There was evidence of quality improvement including clinical audit.
- There were gaps in management and support arrangements for staff, such as appraisal, induction and mandatory training.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had successfully recruited new members of staff across the practice including to the nursing team
- Staff told us meetings took place with other health care professionals on a regular basis. However, the practice was unable to provide us with any minutes or records of these meetings.
- Systems for recording care plans for vulnerable patients had commenced. Unvalidated data supplied to us by the practice showed 66% of patients with mental health and 71% of patients with learning disabilities had a care plan in place. The practice recognised further improvement was required.
- There was a stop smoking service and four patients had been supported to stop smoking in 2015/16.
- The practice was unable to demonstrate that there was a consent policy to govern the process of patient consent.

Are services caring?

The practice is rated as good for providing caring services.

- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Conversations between receptionists and patients, both over the telephone and face to face, could be overheard in the waiting room. The practice was aware of this and played background music to buffer sound as well as displaying signage to remind patients to respect other patients' confidentiality.
- Patients had access counselling service every Friday at the practice.

Good



Summary of findings

- There was a designated carer's page on the practice website which contained extensive advice and links to support carers. However, there was a lack of information for carers readily available in the waiting room at the practice.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice had collaborated with the CCG to reduce the number of appointments lost due to patients failing to attend, by introducing a text message scheme to remind patients about an imminent appointment.
- There was continuity of care, with urgent appointments available on the same day. However, some patients indicated they may have to wait up to a week for a routine appointment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about services was available in the waiting room and on the practice website, which also contained a translation service. However, opening times and how to access services outside of opening times were not visible outside the premises.
- Records demonstrated that lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. However, not all of the complaints reviewed contained enough detail such as time frames and action dates.

Are services well-led?

The practice is rated as inadequate for being well-led.

Inadequate



- There were a range of mechanisms to manage the governance of the practice; however, governance arrangements were not robust or always effectively implemented.
- The practice did not have a consistent approach to identify the learning needs of staff. For example, the practice could not demonstrate that staff received inductions, annual appraisals or regular one to one support.
- Significant issues that threatened the delivery of safe care were not identified or adequately managed.

Summary of findings

- The provider was aware of and complied with the Duty of Candour. The GP encouraged a culture of openness and honesty. The practice had systems that identified notifiable safety incidents.
- The principal GP had recognised the need for support and had accessed this from multiple avenues including: the Local Medical Committee (LMC), the clinical commissioning group (CCG), who had provided a temporary practice manager and neighbouring GP practices.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as inadequate for the care of older people. The provider was rated as inadequate for providing safe and well-led services, requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Home visits were available for older patients who were unable to attend the practice.
- The practice did not always have care plans recorded in older patients' notes to help avoid these patients being admitted to hospital unnecessarily.
- The practice was unable to demonstrate they held regular multidisciplinary staff meetings that included other professionals who specialised in the care of older people.

Inadequate



People with long term conditions

The practice is rated as inadequate for the care of patients with long-term conditions. The provider was rated as inadequate for providing safe and well-led services, requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- Nursing staff had lead roles in chronic disease management.
- Longer appointments and home visits were available when needed.
- Patients from the population group had access to a stop smoking and counselling service at the practice.
- Patients who had long term conditions were continuously followed up throughout the year to ensure they all attended health reviews.
- The practice was unable to demonstrate they held regular multidisciplinary staff meetings that included other professionals who specialised in the care of people with long-term conditions.

Inadequate



Families, children and young people

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for

Inadequate



Summary of findings

providing safe and well-led services, requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice was unable to demonstrate they held regular multidisciplinary staff meetings that included other professionals who specialised in the care of families, children and young people.
- Not all of the non-clinical staff had received training on safeguarding children and vulnerable adults. The practice was unable to demonstrate that staff had access to up to date safeguarding policies for children or vulnerable adults.

Working age people (including those recently retired and students)

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The provider was rated as inadequate for providing safe and well-led services, requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice provided a variety of ways this patient population group could access primary medical services, including telephone appointments and appointments outside of normal working hours.
- Appointments and repeat prescriptions could be accessed on-line.

Inadequate



People whose circumstances may make them vulnerable

The practice is rated as requires inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for providing safe and well-led services,

Inadequate



Summary of findings

requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice did not have an effective system for recording care plans in patients' with learning difficulties notes. For example, There were 59 patients on the learning disability register but only 71% of them had care plans recorded in their notes (this data was supplied by the practice and had not been validated)
- The practice offered longer appointments for patients with a learning disability.
- The practice was unable to demonstrate they held regular multidisciplinary staff meetings that included other professionals who specialised in the care people whose circumstances may make them vulnerable.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Not all of the non-clinical staff had received training on safeguarding children and vulnerable adults. The practice was unable to demonstrate that staff had access to up to date safeguarding policies for children or vulnerable adults.

People experiencing poor mental health (including people with dementia)

The practice is rated as inadequate for the care people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for providing safe and well-led services, requires improvement for providing effective services and good for providing responsive and caring services. The resulting overall rating applies to everyone using the practice, including this patient population group.

- The practice did not have an effective system for recording care plans in vulnerable patients, notes. For example, there were 33 patients on the mental health register but only 66% of them had care plans recorded in their notes (this data was supplied by the practice and had not been validated).
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Longer appointments and home visits were available when needed.

Inadequate



Summary of findings

- The practice was unable to demonstrate they held regular multidisciplinary staff meetings that included other professionals who specialised in the care of people experiencing poor mental health (including patients with dementia).

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing significantly better than local and national averages. Two hundred and twenty nine survey forms were distributed and 111 were returned. This represented 3% of the practice's patient list.

- 98% of respondents found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 71% and the national average of 73%.
- 84% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 86% and the national average of 85%.
- 95% of respondents described the overall experience of this GP practice as good compared to the CCG average of 84% and the national average of 85%.
- 88% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and the national average of 78%.

There were three positive reviews posted on the NHS Choices website for The Orchard House Surgery in the last year. Patients praised the clinical skills of the medical team and the polite and helpful staff.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards, 13 were positive about the service provided at the practice and one contained negative comments. Patients commented positively about the clinical expertise of the GPs and nurses, but also appreciated the polite, friendly and helpful care given by all members of staff. The negative comment was about having to wait for routine appointments. Conversely, some patients commented positively that they could see a GP on the same day if they needed to and appreciated the continuity of care they received.

We spoke with seven patients during the inspection. All of the patients we spoke with talked positively about the personalised and responsive care provided by the practice, especially from the principal GP. Patients we spoke with told us their dignity, privacy and preferences were always considered and respected.

The practice did not have a patient participation group (PPG) and were trying to form a virtual group. This was being advertised on the practice website and at the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure there are robust processes, systems and training to support staff in gaining patient consent.
- Ensure safety incidents are well recorded and that actions are taken to reduce the chance of the same thing happening again.
- Ensure all staff have the necessary employment checks including a current Disclosure and Barring Service check and employment and character references.
- Ensure all staff are up to date with attending training courses and that all newly appointed staff receive a local induction program.
- Revise risk assessments and management activities to include all risks to patients, staff and visitors.
- Ensure the practice develops systems and processes to manage infection prevention control; having due regards to National guidance.
- Revise governance processes and ensure that there are sufficient documents to govern activity and that these are reviewed and kept up to date.
- Ensure patient records are kept secure.
- Ensure Department of Health guidance is followed when managing the storage of vaccines.

Summary of findings

- Revise medicines management procedures to help ensure vaccines and emergency medicines are in date and that there is a process for managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Ensure blank prescription forms are stored securely and implement systems to track and monitor their use.
- Review how multidisciplinary meetings are recorded.
- Review the system that identifies patients who are also carers to help ensure that all patients on the practice list who are carers are offered relevant support if required.
- Review the complaints recording system to ensure time frames and dates are included.

Action the service **SHOULD** take to improve

- Review opportunities for patient feedback and how to effectively promote the patient participation group.

Orchard House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser and a practice manager specialist adviser.

Background to Orchard House Surgery

The Orchard House Surgery serves a rural population in and around the village of Lydd in Kent. The principal GP told us, as a newly registered provider in April 2015, the practice had faced significant challenges including planning extensive building renovation and recruitment across clinical and non-clinical teams. Services are delivered from purpose built premises; all patient areas are on the ground floor and are accessible to patients with reduced mobility, as well as parents with children and babies. There is parking available for patients attending the practice.

There are approximately 4000 patients on the practice list. The practice age range population profile is close to national averages. However, the practice has more patients registered aged over 64 years and the surrounding area has a slightly higher prevalence of people living in deprived circumstances than national averages.

The practice holds a General Medical Service contract and consists of one principal GP(female) and two long term locum GPs (one female and one male). There is one nurse practitioner (female), one practice nurse (female) and two healthcare assistants (female).

The long-term practice manager has recently left the practice so the GPs and nurses are currently supported by a temporary practice manager supplied by the local clinical commissioning group (CCG) as well as a team of administration and reception staff. On the day of the inspection the temporary practice manager had been in post for two weeks. There are a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. Patients have access to a counselling service every Friday.

The practice is open from 8.30am to 6pm Monday to Friday. The practice has an arrangement with Integrated Care 24(IC24) to provide patients with access to a GP between 8am and 8.30am (Monday to Friday) and 6pm and 6.30pm (Monday, Wednesday and Friday). There are extended hour's clinics Tuesday and Thursday evenings until 7.15pm.

An out of hour's service is provided by IC24, outside of the practices normal opening hours, and there is information available to patients on how to access this in the practice information leaflet and on the website.

Services are delivered from:

Bleak Road, Lydd, Kent, TN29 9AE.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 July 2016. During our visit we:

- Spoke with a range of staff including three GPs, the practice nurse, the nurse practitioner two healthcare assistants, the temporary practice manager, receptionists, administrators and patients who used the service.
- Observed how reception staff talked with patients, carers and family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was system for reporting and recording significant events. However, reviews, investigations and records of significant events were not always thorough. For example, significant events records did not always contain dates and timelines for actions undertaken.

- Staff told us they would inform the practice manager of any incidents and then record them in the incident book or complete the practice's incident recording form. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We reviewed the significant events log which contained three significant events in 2016. We did not see any evidence of significant event recording before this time. The three significant events recorded were about the incorrect amount of medicine being administered, the wrong patient being called into the GPs room and the practice manager leaving unexpectedly. Whilst the significant events had been analysed and actioned some records lacked details such as dates and timescales for action.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and some action was taken to improve safety in the practice. A significant event involving medicine administration was analysed and discussed at the practice meeting and staff were reminded to check medicine doses before administering them. Staff we spoke with were aware of the incident, but we did not see any evidence that staff had received revised or amended written protocols to support them in administering medicines in order to reduce the chance of the same thing happening again.

Overview of safety systems and processes

Systems, processes and practices were not always reliable or appropriate to keep people safe. Monitoring whether safety systems were implemented was not robust.

- There were some arrangements to safeguard children and vulnerable adults from abuse. The principal GP was the lead for safeguarding. The principal GP attended

safeguarding meetings when possible and provided reports where necessary for other agencies. Whilst most staff we spoke with demonstrated they understood their responsibilities regarding reporting safeguarding concerns, records showed that not all of the administration team had received training on safeguarding children and vulnerable adults. The practice was unable to demonstrate that staff had access to up to date safeguarding policies for children or vulnerable adults. The GPs and the nurse practitioner were trained to child protection or child safeguarding level 3.

- Notices in clinical rooms advised patients that chaperones were available if required. The practice had a chaperone policy but it failed to state who was able to undertake this role. Staff we spoke with told us said receptionists did occasionally undertake this role. The practice was unable to demonstrate whether these members of staff were trained for the role or had received a Disclosure and Barring Service (DBS) check. Two of the DBS checks we reviewed contained incorrect or out of date information. For example, name or workplace changes (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). The practice did not have any risk assessments to explain why DBS checks were not deemed necessary for some members of staff.
- The premises were in need of updating. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection prevention control. However, the practice did not maintain any domestic or clinical cleaning schedules and when we checked the cleaning storage cupboard, cleaning equipment had not been well maintained. The practice had not completed an infection prevention control audit since 2013, which had been undertaken by the previous provider. The practice was aware of this and at the time of the inspection had initiated but not completed an infection prevention audit. The current infection prevention control policy had not been reviewed since 2013 and related to the previous registered provider. The practice was aware of this and was in the process of reviewing and updating the policy. The principal GP was the infection control clinical lead and was supported in this role by one of the healthcare assistants. Records showed that clinical staff had

Are services safe?

received infection control training, but that a number of non-clinical staff had not received any infection control training and that others had not had their training updated since 2013.

- There was carpet on the floor of some of clinical rooms where invasive procedures were carried out. In the absence of cleaning schedules, there was no evidence to show that deep cleaning of these carpets was undertaken. The practice told us there were plans to replace the carpet with hard flooring, but this was not included in the proposal of works schedule for their next refurbishment. There were kits in all treatment rooms and the reception area to deal with the spillage of body fluids such as urine, vomit and blood.
- The clinical wash-hand basins at the practice did not comply with Department of Health guidance Health Building Note 00-09: Infection control in the built environment. For example, wash-hand basins contained overflows and plugholes. There was, therefore, a risk of cross contamination when staff used them. The practice was unable to demonstrate that there were plans to replace these basins at their next refurbishment.
- The arrangements for managing medicines, including emergency medicines and vaccines, were not always robust (including obtaining, prescribing, recording, handling, storing, security and disposal). Medicines which required refrigeration were kept between 2oC and 8oC and clear, consistent records were available to demonstrate this. However, there was no process for checking, rotating and auditing these medicines and we found twelve out of date vaccines stored in the refrigerator.
- There were processes for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription pads were securely stored. However, blank prescription forms were not always stored securely and the practice was unable to demonstrate that they had a system to track and monitor their use.
- The practice could not demonstrate that they had an effective process for managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Patient information was not always kept securely. For example, the inspection team noted on several occasions during the inspection that staff left smart cards in computers unattended in clinical rooms. The doors to these rooms were left open and as such were accessible to patients (Smart Cards are used to allow staff to access confidential patient information). Records showed that some staff had not received information governance training and that others had not had their training updated since 2013.
- We reviewed ten personnel files and found that not all the appropriate recruitment checks had been undertaken prior to employment. The practice was unable to demonstrate that new members of staff were being recruited in line with local written guidance (the practice's own recruitment policy). For example, references had only been collected in two out of the ten staff files reviewed.

Monitoring risks to patients

Risks to patients were not always assessed or well managed.

- The procedures for monitoring and managing risks to patient and staff safety were not always robust. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice did not have an up to date fire risk assessment and had not been undertaking regular fire alarm testing or fire evacuation drills. The practice had recognised this and formed an action plan which had included a fire alarm test on the 4 July 2016 and planned a fire evacuation at the end of July 2016. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice was unable to demonstrate they had a system for the routine management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).
- The practice had successfully recruited new members of staff across the nursing and administration teams. There were arrangements for planning and monitoring the

Are services safe?

number of staff and mix of staff needed to meet patients' needs. There was a rota system for the different staffing groups to help ensure there was enough staff on duty.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements to respond to emergencies and major incidents.

- There was an alarm system on the telephones in all the consultation and treatment rooms which alerted staff to any emergency.
- Records showed that some staff, including one clinical member of staff, were not up to date on annual basic life support training in line with the Resuscitation Council (UK) Guidelines.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- There were emergency medicines available in the treatment room. These were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. Staff told us these were checked regularly. However, there were no records to confirm this as the practice did not maintain an inventory or audit the checking of these medicines.
- The practice did have a business continuity plan for major incidents such as power failure or building damage. However, this required a review as it this was dated September 2014 and related to the previous registered provider.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework system (QOF). This is a system intended to improve the quality of general practice and reward good practice. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Patients who had long term conditions were regularly recalled by the practice during the year to ensure they all attended health reviews. QOF data available to the CQC was collected in 2014/15 and published in October 2015. Therefore, comparison of QOF data for the Orchard House Surgery to national and local outcomes was not possible as the current sole GP provider had not been operating for all of the data collection period. However, during the course of the inspection the practice showed us data recorded up to 31/03/2016 which demonstrated they had achieved 92% of the total number of points available (this data had not been validated).

There was evidence of quality improvement including clinical audit.

- The practice had undertaken several clinical audits in the last 12 months; two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits and national benchmarking.
- Findings were used by the practice to improve services. For example, the practice had undertaken an audit assessing how many patients had been prescribed a medicine associated with cardiac damage. Findings in the second stage of the audit demonstrated a reduction in prescribing from 19 patients to five.

Effective staffing

There were gaps in management and support arrangements for staff, such as appraisal, induction and mandatory training.

- The practice did not have a systematic approach for the induction of newly appointed staff to help ensure areas such as safeguarding, infection prevention control, fire safety, health and safety and confidentiality were covered.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions had received training in areas such as diabetes, asthma and wound care.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example, by access to on line resources and discussion at practice meetings.
- Staff we spoke with told us the principal GP had an open door policy and that they were able to request training. However, the practice did not have a consistent approach to identify the learning needs of staff. For example, the practice was unable to demonstrate that staff received annual appraisals or regular one to one meetings.
- We reviewed training records and saw that not all staff were up to date with attending training courses such as annual basic life support, infection control and information governance.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- Systems for recording care plans for vulnerable patients had commenced. Unvalidated data supplied to us by the practice showed 66% of patients with mental health and 71% of patients with learning disabilities had a care plan in place. The practice recognised further improvement was required.

Are services effective?

(for example, treatment is effective)

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Staff told us meetings took place with other health care professionals on a regular basis. However, the practice was unable to provide us with any minutes or records of these meetings.

Consent to care and treatment

The practice did not have a consent policy to govern the process of patient consent and guide staff or a consistent approach to staff training for taking patient consent.

- Whilst most staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005, the practice was unable to demonstrate that all staff had received Mental Capacity Act training.
- The practice was unable to demonstrate that there was a policy available for staff to refer to when obtaining patient consent.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. However, some clinical members of staff were not clear about consent for children who were not accompanied by their parents.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. One of the health care assistants worked in collaboration with the local community trust to provide a stop smoking service and in 2015/16 four patients had been supported to stop smoking.

There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice had responded to patient feedback and now ensured a female sample taker was available. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Comparison of immunisation and national screening rates for Orchard House Surgery with local and national averages was not possible as the current provider had not been operating for all of the data collection period.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Conversations between receptionists and patients, both over the telephone and face to face, could be overheard in the waiting room. The practice was aware of this and played background music to buffer sound as well as displaying signage to remind patients to respect other patients' confidentiality. The receptionists were also aware of patient confidentiality and we saw that they took account of this in their dealings with patients. There was access to a private area if patients wished to discuss sensitive issues or appeared distressed.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 14 comment cards, 13 were positive about the service provided at the practice and one contained negative comments. Patients commented positively about the clinical expertise of the GPs and nurses, but also appreciated the polite, friendly and helpful care given by all members of staff. The negative comments were about having to wait for routine appointments. Conversely, some patients commented positively that they could see a GP on the same day if they needed to and appreciated the continuity of care they received.

We spoke with seven patients during the inspection. All of the patients we spoke with talked positively about the personalised and responsive care provided by the practice. Patients we spoke with told us their dignity, privacy and preferences were always considered and respected. The practice showed us a range of thank you letters that patients had sent to the practice that aligned with these views.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 94% of respondents said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 92% of respondents said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 96% of respondents said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 95% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 85%.
- 96% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 88% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language and there was a translation facility on the practice's web site.
- Information leaflets were available in easy read format.
- Patients had access counselling service every Friday at the practice.

Patient and carer support to cope emotionally with care and treatment

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice had 59 patients recorded on the register for patients with learning disabilities and 33 patients recorded on the mental health register. The practice did not have a formal register of carers. However, the principal GP and reception team had good local knowledge of patients who were also carers and offered appropriate support to these

patients when needed. There was a designated carer's page on the website which contained extensive advice and links to support carers. However, there was a lack of information readily available in the waiting room at the practice.

Staff told us that if families had suffered bereavement, the principal GP contacted them or sent them a sympathy card. This call was either followed by a consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice had collaborated with the CCG to reduce the number of appointments lost due to patients failing to attend, by introducing a text message scheme to remind patients about an imminent appointment.

- The practice offered extended hours on Tuesday and Thursday evenings until 7.15pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- There were disabled facilities and translation services available.

Access to the service

The practice was open from 8.30am to 6pm on a Monday and 8.30am to 6pm. The practice had an arrangement with Integrated Care 24(IC24) to provide patients with access to a GP between 8am and 8.30am (Monday to Friday) and 6pm and 6.30pm (Monday, Wednesday and Friday). There were extended hour's clinics Tuesday and Thursday evenings until 7.15pm. Primary medical services are available to patients registered at The Orchard House Surgery via an appointments system, which includes pre-bookable routine, telephone and urgent appointments. Opening times were displayed in the practice leaflet and website, but were not visible outside the premises.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 76% of respondents were satisfied with the practice's opening hours which was the same as the clinical commissioning group (CCG) and national average of 76%.
- 98% of respondents said they could get through easily to the practice by phone compared to the CCG average of 71% and the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them. However, some patients indicated they may have to wait up to a week for a routine appointment.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance for GPs in England.
- In the absence of a practice manager the principal GP was responsible for handling complaints.
- We saw that information was available to help patients understand the complaints system in the form of leaflets and material on the practice's website.

The practice had received three complaints this year; we reviewed these and found they were handled with openness and transparency. Records demonstrated that lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, after a complaint about a lack of notification regarding an appointment change, new protocols were adopted. However, whilst this complaint had resulted in review, learning and new protocols, the subsequent records failed to demonstrate timescales for the adoption or review of the new protocols.

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had faced significant challenges in the fifteen months since registering as an individual provider. The building required extensive renovation, nursing services had been understaffed and the long-term practice manager had suddenly left the practice. The principal GP had recognised the need for support and had accessed this from multiple sources including the Local Medical Committee (LMC) and the clinical commissioning group (CCG) who had provided a temporary practice manager. The principal GP had recognised the potential for professional isolation both as a rural practice and sole provider and had joined collaboration with other local practices from Hythe, Lyminge and New Romney to share resources, learning and obtain support.

- The practice had a vision to improve services and outcomes for patients in the area, including renovating the premises. The schedule of work we reviewed indicated work would commence on the 11 July 2016.
- Whilst the practice did not have a robust strategy and supporting business plan, there was a clear vision to improve the practice and deliver patient centred care with better outcomes for patients. Staff were enthusiastic about the progress made so far and about future plans. Staff we spoke with told us they were in a 'positive mode of transition'.

Governance arrangements

There were a range of mechanisms to manage the governance of the practice; however, governance arrangements were inadequate and not always effectively implemented.

- The practice was unable to demonstrate there were sufficient policies to govern all areas of practice or that there was an effective system to help ensure existing governance documents were kept up to date. For example, there were a lack of policies in some key areas such as patient consent, staff management and medicine management. The business continuity plan had not been updated to reflect the change of provider. However, the practice had identified these gaps and told us that a review of policies was part of this year's work in the improvement plan and we saw that this work had already begun. For example, the infection prevention control policy was already under review.

- Staff were aware of their own roles and responsibilities and were willing to support each other across roles, when necessary, to ensure continuity of care for patients.
- The procedures for monitoring and managing risks to patient and staff safety were not always robust. For example, the practice was unable to demonstrate they had a system for the routine management, testing and investigation of legionella. However, the practice had started to make improvements and identify and manage some risks. For example, there was an action plan to address fire risks.
- There were emergency medicines available in the treatment room. Staff told us these were checked regularly. However, there were no records to confirm this as the practice did not maintain an inventory or audit the checking of these medicines.
- The practice had completed several clinical audits in the last 12 months; two of these were completed audits where the improvements made were implemented and monitored.

Leadership and culture

The principal GP had been proactive in making positive changes over the last 15 months including recruiting new members of staff for the nursing and administration teams. The practice had purchased new seating for the patient waiting room and extensive renovations were planned to improve the premises. However, the GP recognised that there was still much that needed to be improved and was in the process of recruiting a practice manager support change in the practice. At the time of the inspection this process had not been completed.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The principal GP encouraged a culture of openness and honesty. The practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology. However, the system for reviewing significant events failed to ensure that records contained sufficient detail. For example, some records lacked dates and timescales for action.

Are services well-led?

Inadequate 

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

There was a clear leadership structure and staff felt supported by the principal GP, however the systems and processes to support staff were not always adequate, for example regular appraisals.

- Staff told us the practice held monthly practice meetings to which all staff were invited.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the principal GP. Staff we spoke with were involved in discussions about how to run and develop the practice and the principal GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice did not have a systematic approach for monitoring patients' views.

- The practice did not have a patient participation group (PPG) and were trying to form a virtual group. This was being advertised on the website and there was a poster at the practice. However, patients we spoke with during the inspection told us the practice had made improvements when they asked. For example, the practice had provided new seating in the waiting room. The practice had also recruited a female sample taker for cervical smears in response to a patient complaint.
- The practice had gathered feedback from staff through monthly practice meetings and discussion. Staff told us

they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff told us about the 'gripe envelope'. This was accessible to all staff and allowed them to raise concerns, suggestions and provide feedback anonymously if they wished. Comments from the 'gripe envelope' were discussed at the practice meetings. Staff we spoke with told us they felt involved and part of the improvement plans that were being undertaken at the practice over the next year.

Continuous improvement

The principal GP told us, since registering as an individual provider in April 2015, the practice had faced significant challenges, including an increasing patient list, staff recruitment, planned building maintenance and the sudden resignation of the practice manager. The principal GP acknowledged that these challenges had resulted in a loss of focus in key areas of the practice including governance arrangements, staff training and development and seeking patient feedback in an organised way. The principal GP had recognised that these areas required improvement and had accessed support from multiple sources including the CCG, LMC and neighbouring practices. We saw evidence that the principal GP had taken some steps to address the issues within the practice, including initiating the process to recruit a practice manager to drive improvements. Staff we spoke with at the practice were both enthusiastic and committed in supporting changes and improvements in order to provide safe, responsive and high quality care for their patients in the future.

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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: the need for consent regulation 11: The need for Consent How the regulation was not being met: Policies and procedures for obtaining consent to care and treatment must reflect current legislation and guidance - the practice was unable to demonstrate that there was a policy available for staff to refer to when obtaining patient consent. - the practice was unable to demonstrate that all staff had received Mental Capacity Act Training. - Some members of staff were not clear about consent for children who were not accompanied by their parents. This was in breach of Regulation 11(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment. How the regulation was not being met: Care and treatment was not always provided in a safe way for service users.

Requirement notices

- The practice failed to always assess risks to the health and safety of service users receiving the care or treatment and do all that is reasonably practicable to mitigate any such risks.
- the practice failed to ensure proper and safe management of medicines
- Blank prescription forms were not always stored securely and the practice was unable to demonstrate they had a system to track and monitor their use
- The practice failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated
- The practice failed to ensure that timely care planning took place to ensure the health, safety and welfare of the service users, where responsibility for the care and treatment of service users was shared with, or transferred to, other persons, working with such other persons, service users and other appropriate persons.

This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good governance.

How the regulation was not being met:

Systems or processes were not established and operated effectively to ensure compliance with the requirements in this Part. Such systems or processes did not enable the registered person, in particular;

- to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

Requirement notices

- to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

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

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014: Staffing

How the regulation was not being met:

- the practice failed to ensure persons employed by the service provider in the provision of a regulated activity had received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.
- the provider failed to ensure that there was an induction programme that prepared staff for their role.

This was in breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

Diagnostic and screening procedures
Maternity and midwifery services
Treatment of disease, disorder or injury

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Fit and proper persons employed.

How the regulation was not being met:

- the provider failed to ensure persons employed for the purposes of carrying on a regulated activity were of good character.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 19(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Enforcement actions

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.