Dr Samuel Bhasme

Quality Report

The Surgery 19 Railway Street
Gillingham Kent ME7 1XF
Tel: 01634 853667
Website: None

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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?	Inadequate
Are services caring?	Good
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Key findings

Contents

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Samuel Bhasme on 11 July 2017. The overall rating for the practice was inadequate and the practice was placed in special measures for a period of six months. The full comprehensive report on the July 2017 inspection can be found by selecting the 'all reports' link for Dr Samuel Bhasme on our website at www.cqc.org.uk.

After the inspection in July 2017 the practice wrote to us with an action plan outlining how they would make the necessary improvements to comply with the regulations.

This inspection was undertaken following the period of special measures and was an announced comprehensive follow-up inspection carried out on 20 March 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 11 July 2017. This report covers findings in relation to those requirements.

Overall the practice remains rated as inadequate.

The key questions are rated as:

Are services safe? – Inadequate.

Are services effective? – Inadequate.

Are services caring? – Good.

Are services responsive? – Requires improvement.

Are services well-led? – Inadequate.

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

- The practice had not made sufficient improvements to:
  - the system for reporting, recording and investigating significant events.
  - the systems, processes and practices that helped to keep patients safe and safeguarded from abuse.
  - the management of infection prevention and control.
  - the assessment and management of risks to patients, staff and visitors.
- Further improvements to medicines management were still required.
- The practice did not have adequate arrangements for responding to emergencies.
- Staff were now assessing patients' needs and delivering care in line with current evidence based guidance.
- Data from the Quality and Outcomes Framework (QOF) demonstrated that the practice was performing in line with local and national averages for patient outcomes with the exception of diabetes related indicators.
- The practice had a system for completing clinical audits.
- Records showed that staff had received appraisals and GPs had revalidated or had a planned revalidation date. However, sufficient support to meet the practice development needs of all staff was not being provided.

Summary of findings

- Records showed that all staff were now up to date with training in chaperoning, safeguarding vulnerable adults, infection prevention and control as well as fire safety.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients we spoke with said they were able to book an appointment that suited their needs. Pre-bookable, on the day appointments, home visits and a telephone consultation service were available. Urgent appointments for those with enhanced needs were also provided the same day.
- Information about services and how to complain was available and easy to understand. However, the practice was unable to demonstrate that learning from complaints had taken place.
- There was a clear staffing structure. However, not all staff were fully aware of their own roles and responsibilities.
- Improvements to governance arrangements were insufficient.
- The practice was able to demonstrate they had improved performance. However, further improvements were still required.
- The practice had systems for notifiable safety incidents. However, they did not always keep records of action taken (or if no action was necessary) in response to receipt of all notifiable safety incidents.
- There was a leadership structure and staff felt supported by management.
- The provider was aware of and complied with the requirements of the duty of candour.
- There had been no patient participation group meeting since our last inspection in July 2017.
- There was insufficient evidence of learning and improvement within the practice from significant events and verbal complaints.

The areas where the provider must make improvements are;

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.

The areas where the provider should make improvements are;

- Carry out Disclosure and Barring Service (DBS) checks, or risk assessments, for all staff who act as chaperones.
- Improve the system that monitors blank prescription forms throughout the practice.
- Record the checking of the automated external defibrillator and medical oxygen.
- Continue to implement plans to create a practice website.
- Include all relevant policies and protocols in the system that keeps governance documents up to date.

This service was placed in special measures in July 2017. Although improvements have been made these are insufficient such that there remains a rating of inadequate for safe, effective, well-led and all patient population groups. I am placing the service into special measures for a further six months.

Services placed into special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate 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 varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within six months, and if there is not enough improvement we will move to close the service.

Special measures will give people who use the service the reassurance that the care they get should improve.

Key findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Dr Samuel Bhasme

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector**.** The team included a GP specialist adviser and a practice manager specialist advisor.

Background to Dr Samuel Bhasme

- The registered provider is Dr Samuel Bhasme.
- Dr Samuel Bhasme is located at The Surgery, 19 Railway Street, Gillingham, Kent, ME7 1XF. The practice has a general medical services contract with NHS England for delivering primary care services to the local community. The practice is in the process of setting up a practice website.
- As part of our inspection we visited Dr Samuel Bhasme, The Surgery, 19 Railway Street, Gillingham, Kent, ME7 1XF only, where the provider delivers registered activities.
- Dr Samuel Bhasme has a registered patient population of approximately 2,500 patients. The practice is located in an area with a higher than average deprivation score.

Inadequate

Are services safe?

Our findings

At our previous inspection on 11 July 2017, we rated the practice as inadequate for providing safe services.

- The practice did not have an effective system to manage significant events.
- The practice's systems, processes and practices did not always keep patients safe and safeguarded from abuse.
- The practice was unable to demonstrate they always followed national guidance on infection prevention and control.
- The arrangements for managing medicines in the practice did not always keep patients safe.
- Risks to patients, staff and visitors were not always assessed and managed in an effective and timely manner.
- The practice did not have adequate arrangements to respond to emergencies.

The practice had partially responded to these issues when we undertook a follow up inspection on 20 March 2018. However, we found that further improvements were still required. The practice remains rated as inadequate for providing safe services.

Safe track record and learning

The practice had not made sufficient improvements to the system for reporting and recording significant events.

- The practice had revised the written guidance available for staff to follow to help them recognise and report significant events. For example, the significant / critical event toolkit.
- Staff told us they would inform the practice manager of any incidents and there was a recording form available. 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).
- Staff did not always follow the practice's written guidance when reporting significant events. Records showed that there had been eight significant events since our last inspection in July 2017. However, only one of these had been reported by staff completing a significant event record form. Seven significant events had been reported by staff making an entry in a book kept in the reception office.
- Records showed the practice had carried out a thorough analysis of the significant event reported by staff completing a significant event form. However, the practice was unable to demonstrate that thorough analysis of the significant events reported by staff making an entry in the book kept in the reception office had taken place.
- Staff told us that significant events were discussed at staff meeting as well as informally. The practice's significant / critical event toolkit stipulated that meetings should be held at which significant events were discussed and should be separately minuted. Records showed that notes from staff meetings were made. These notes showed that the significant event reported by staff completing a significant event form had been discussed and learning from the event had taken place. However, records did not show that the significant events reported by staff making an entry into the book kept in the reception office had been discussed or that learning from them had taken place.
- After our inspection the provider sent us evidence to show that staff had retrospectively completed significant event documentation in line with their written guidance. The evidence demonstrated that most of the significant events reported by staff making an entry in the book kept in the reception office had been discussed by staff and learning had taken place.

Overview of safety systems and processes

The practice had not made sufficient improvements to the systems, processes and practices that helped to keep patients safe and safeguarded from abuse.

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies and other guidance documents were accessible to all staff. The policies and other documents clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. Practice staff attended safeguarding meetings and provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities. All staff were now up to date with safeguarding training and records showed that GPs were trained to child protection or child safeguarding level three.

Inadequate

Are services safe?

- A notice in the waiting room advised patients that chaperones were available if required. One member of staff who acted as a chaperone had not received a Disclosure and Barring Service (DBS) check or risk assessment of using staff in this role without DBS clearance. (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). Staff told us that a DBS check application for the member of staff had been submitted but there were no records to confirm this. After our inspection the provider sent us records to show the DBS check for this member of staff had now been received by the practice. Records showed that staff who acted as chaperones had received training for the role.
- We observed the premises to be clean and all areas accessible to patients were tidy. There were written cleaning schedules that indicated the frequency and method of domestic cleaning to be carried out in the practice. Staff told us that formal cleaning audits were not carried out but regular visual checks of the standard of cleaning conducted took place. However, there were no records to confirm this. There was a lead member of staff for infection control who had recently been appointed but had not yet received training for the role. There was an infection control policy and records showed that clinical staff had received up to date infection prevention and control training. Records showed that an infection control risk assessment had been conducted on 14 December 2017. There was an action plan to address any improvements identified as a result of the risk assessment. However, as was the case at the time of our previous inspection in July 2017 the risk assessment failed to identify that there were no hand washing facilities available in the staff toilet on the first floor of the building. We saw that hand washing facilities were still being provided in the room adjacent to the staff toilet on the first floor of the building. Clinical waste was stored in the correct container and was now kept locked when not in use.
- The practice had made improvements to the arrangements for managing medicines, including emergency medicines and vaccines in the practice to help keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). However, we found that further improvements were still required.
- The practice had revised the processes for handling repeat prescriptions which included the review of patients who were prescribed high risk medicines. Written guidance had been introduced to help ensure staff followed best practice when prescribing high risk medicines. For example, the protocol for repeat prescriptions for methotrexate and warfarin (both high risk medicines). We looked at a random sample of patients' records who were prescribed high risk medicines and saw that blood test results had been recorded in all of them.
- Issued prescriptions that had been signed by a GP and were awaiting collection by patients were now being stored securely overnight. Blank prescription pads and forms were now being securely stored. The practice had revised the system that monitored the use of blank prescription pads and forms. However, this did not record the serial numbers of blank prescription forms.
- Vaccines were now being stored at the practice in line with national guidance. For example, vaccines were stored in a locked medicine refrigerator. Records showed that medicine stored in the practice's medicine refrigerators were being stored at the recommended temperature. The practice had an inventory system to monitor and help control stock levels of the vaccines they held.
- Patient group directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had revised the documentation used to support this. We saw that all documentation relating to PGDs had been completed correctly.
- The practice no longer held controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).
- We reviewed four personnel files and found that most appropriate recruitment checks had been undertaken prior to employment. Records showed photographic identification, references, qualifications and registration with the appropriate professional body had been carried out by the practice prior to employment of staff.

Monitoring risks to patients

The practice had not made sufficient improvements to the assessment and management of risks to patients, staff and visitors.

Inadequate

Are services safe?

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the practice which identified local health and safety representatives.
- The practice had a fire risk assessment dated 4 December 2017. The risk assessment contained an action plan to address some of the identified issues. For example, emergency lighting for the first and second floor of the building was due to be installed in June / July 2018. The practice did not have a fire alarm system. The practice did have smoke detectors fitted. However, the fire risk assessment document stated that fire could not be easily detected and the fire alarm could not be raised in all parts of the premises. There were no records to demonstrate that the smoke detectors were tested regularly or that the practice had carried out any fire drills. After our inspection the provider sent us evidence to show that a new fire detection and alarm system had been installed in the practice.
- Records showed that staff were up to date with fire safety training.
- All electrical equipment was checked to help ensure the equipment was safe to use and clinical equipment was checked to help ensure it was working properly.
- Staff told us that they had received training in the control of substances hazardous to health (COSHH). The practice had a COSHH risk assessment dated 1 March 2018 that contained an action plan to address identified issues. For example, the cleaner was to wear gloves when using bleach.
- The practice had a health and safety risk assessment dated 1 March 2018 which contained an action plan to address issues identified. For example, staff received moving and handling training to reduce the risk of injury when moving items.
- The practice was unable to demonstrate they had an effective system for the routine management of legionella (a germ found in the environment which can contaminate water systems in buildings). There was a legionella management policy and records dated 12 September 2017 showed that the practice had carried out a test for the presence of legionella bacteria in their water system and the result was negative. However, staff told us that the practice had not carried out any other actions in order to reduce the risk of legionella. For example, a legionella risk assessment.
- Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Arrangements to deal with emergencies and major incidents

The practice did not have adequate arrangements for responding to emergencies.

- Staff had received annual basic life support training.
- Emergency equipment and emergency medicines were available in the practice. The practice had access to medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). However, a child's oxygen mask was still not available in the practice.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location.
- Staff told us that checks of emergency equipment and emergency medicines were carried out on a regular basis and records confirmed this. However, staff checks of the medical oxygen and AED were not recorded. Emergency equipment and emergency medicines that we checked were within their expiry date.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 11 July 2017, we rated the practice as requires improvement for providing effective services.

- The practice assessed needs but was unable to demonstrate they always delivered care in line with current evidence based guidance.
- Data from the Quality and Outcomes Framework (QOF) showed performance for diabetes and asthma related indicators were lower than local and national averages.
- There was limited evidence that clinical audits were driving quality improvement.
- There was evidence of appraisals and personal development plans for staff. However, the practice was unable to demonstrate that one member of clinical staff had received any appraisals.
- Not all staff were up to date with mandatory training.
- The practice's uptake for the cervical screening programme was below local and national averages. The practice did not have systems to help ensure results were received for all samples sent for the cervical screening programme.
- Childhood vaccination rates for the vaccinations given were below local and national averages.

These issues had not suffiently improved when we undertook a follow up inspection on 20 March 2018. The provider is now rated as inadequate for providing effective services.

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.

- The practice had revised systems to help keep all clinical staff up to date. For example, the system that helped ensure all governance documents were kept up to date. 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 used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 94% of the total number of points available (clinical commissioning group (CCG) average of 94% and national average 97%). This demonstrated an improvement over the results of 91% published at the time of our last inspection. The overall exception reporting rate was 5% compared with the CCG average of 12% and national average of 10%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

Data from 2016/2017 showed:

- Performance for diabetes related indicators was below local clinical commissioning group (CCG) and national averages. For example, 57% of the practice's patients with diabetes, on the register, whose last IFCC-HbA1c was 64mmol/mol or less in the preceding 12 months compared with the local CCG average of 76% and national average of 80%. This demonstrated deterioration over the results of 63% published at the time of our last inspection. Sixty two percent of the practice's patients with diabetes, on the register, had a last measured total cholesterol of 5mmol/l or less compared with the local CCG average of 78% and national average of 80%. This demonstrated deterioration over the results of 72% published at the time of our last inspection.
- Performance for asthma related indicators was in line with local CCG and national averages. For example, 70% of patients with asthma, on the register, had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three RCP questions compared with the local CCG average of 75% and national average of 76%. This demonstrated an improvement over the results of 60% published at the time of our last inspection.
- Performance for mental health related indicators was higher than local CCG and national averages. For example, 100% of the practice's patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in their records in the preceding 12 months compared with the local CCG average of 89% and national average of 90%. This demonstrated an

improvement over the results of 90% published at the time of our last inspection. One hundred percent of patients with schizophrenia, bipolar affective disorder and other psychoses had their alcohol consumption recorded, in the preceding 12 months compared to the local CCG average of 90% and national average of 91%. This demonstrated maintenance of the results of 100% published at the time of our last inspection.

The practice had a system for completing clinical audits.

- Staff told us the practice had a system for completing clinical audits. For example, an audit of the safe prescribing of high risk medicines. Records showed that this audit had been repeated to complete the cycle of clinical audit.
- Other clinical audits had been carried out. For example, an audit of type two diabetes treatment and control. The practice had analysed the results and implemented an action plan to address its findings. Records showed this audit had been repeated to complete the cycle of clinical audit.

Effective staffing

- 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 attending update training.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff told us they had received an appraisal within the last 12 months. Records showed that staff had received appraisals and GPs had revalidated or had a planned revalidation date. However, sufficient support to meet the practice development needs of all staff was not being provided. For example, the practice manager had not received any formal practice management training since their appointment in 2014. Records did not demonstrate that there were plans to provide them with this training. Also, one member of staff had been appointed as lead for infection prevention and control and had not received any formal training for the role. Records did not demonstrate that there were any plans provide them with this training.
- Records showed that staff were now up to date with training in chaperoning, safeguarding vulnerable adults, infection prevention and control as well as fire safety.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigations and test results.
- 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 on-going 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 that the practice did not hold regular multidisciplinary team meetings. However, they said that telephone meetings with other services took place when required. For example, with district nurses and palliative care staff.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear staff 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.

Inadequate

Are services effective?

(for example, treatment is effective)

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant support service.

The practice's uptake for the cervical screening programme was 70%, which was comparable to the local clinical commissioning group (CCG) average of 75% and national average of 72%. This demonstrated an improvement over the results of 66% published at the time of our last inspection.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practice had introduced systems to help ensure results were received for all samples sent for the cervical screening programme and followed up women who were referred as a result of abnormal results.

At the time of our last inspection published data showed that childhood immunisation rates for the vaccinations given were below the local CCG and national averages. The practice had made improvements to the system that managed the immunisation of children. However, further improvements were still required to achieve the nationally expected coverage of 90% vaccination of children. Practice records showed that, during the period 1 January 2017 to 31 December 2017;

- 74% of children aged two years had received the measles, mumps and rubella vaccine. This demonstrated a small improvement over the results of 73% published at the time of our last inspection.
- 74% of children aged two years had received the pneumococcal conjugate booster vaccine. This demonstrated a large improvement over the results of 46% published at the time of our last inspection.
- 74% of children aged two years had received the haemophilus influenza type b and meningitis C booster vaccine. This demonstrated a small improvement over the results of 73% published at the time of our last inspection.
- 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.

Good

Are services caring?

Our findings

At our previous inspection on 11 July 2017, we rated the practice as good for providing caring services.

The practice remains rated as good for providing caring services.

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 and screens 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.
- Private conversations between patients and staff at the reception desk could be overheard by others. However, when discussing patients' treatment staff were careful to keep confidential information private. Staff told us that a private room was available should a patient wish a more private area in which to discuss any issues.

We spoke with three patients during the inspection. The patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Results from the national GP patient survey published at the time of our last inspection were in line with or above local clinical commissioning group (CCG) and national averages for satisfaction scores on consultations with GPs and nurses. For example:

- 92% of respondents said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 95% of patients said the nurse was good at listening to them compared with the CCG average of 90% and the national average of 91%.
- 92% of respondents said the GP gave them enough time (CCG average 81%, national average 86%).
- 96% of respondents said the nurse gave them enough time (CCG average 92%, national average 92%).
- 97% of respondents said they had confidence and trust in the last GP they saw (CCG average 93%, national average 95%).
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and the national average of 97%.
- 91% of patients said the last GP they spoke with was good at treating them with care and concern compared to the CCG average of 79% and the national average of 86%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 66% of respondents said they found the receptionists at the practice helpful (CCG average 83%, national average 87%).

Care planning and involvement in decisions about care and treatment

Results from the national GP patient survey published at the time of our last inspection were in line with local CCG and national averages about their involvement in planning and making decisions about their care and treatment. For example:

- 87% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 80% and national average of 86%.
- 93% of respondents said the last nurse they saw or spoke with was good at explaining tests and treatment (CCG average 89%, national average 90%).
- 84% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG average 75%, national average 82%).
- 95% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG average 85%, national average 85%).

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.

Patient and carer support to cope emotionally with care and treatment

Timely support and information was provided to patients and their carers to help them cope emotionally with their care, treatment or condition. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Good

Are services caring?

The practice supported patients who were also carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 49 patients on the practice list who were carers (2% of the practice list). The practice had a system that formally identified patients who were also carers and written information was available to direct carers to the various avenues of support available to them. There was written guidance to help staff identify patients who were also carers. For example, the protocol for the identification and assessment of carers 2011 / 2012.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 11 July 2017, we rated the practice as requires improvement for providing responsive services.

- The practice did not have a website.
- Information about how to complain was available and easy to understand. However, verbal complaints were not recorded and the practice was unable to demonstrate they learned from complaints or had implemented appropriate changes.

The practice had partially responded to these issues when we undertook a follow up inspection on 20 March 2018. However, we found that further improvements were still required. The practice remains rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient population groups and to help provide flexibility, choice and continuity of care. For example;

- Appointments were available outside of school hours and outside of normal working hours.
- There were longer appointments available for patients with a learning disability.
- Telephone consultations and home visits were available for patients from all population groups who were not able to visit the practice.
- Urgent access appointments were available for children and those with serious medical conditions. There were also two walk in clinics each week for children who were able to attend the practice without an appointment.
- The practice did not have a website. However, we saw evidence to show that the practice was in the process of setting up a website. Patients were able to book appointments or order repeat prescriptions online.
- The premises and services had been adapted to meet the needs of patients with disabilities.
- The practice provided patients with the choice of seeing a male or a female GP.
- The practice maintained registers of patients with learning disabilities, dementia and those with mental health conditions. The registers assisted staff to identify these patients in order to help ensure they had access to relevant services.
- There was a system for flagging vulnerability in individual patient records.
- Records showed the practice had systems that identified patients at high risk of admission to hospital and implemented care plans to reduce the risk and where possible avoid unplanned admissions to hospital.
- There was a range of clinics for all age groups as well as the availability of specialist nursing treatment and support.

Access to the service

Dr Samuel Bhasme was open Monday, Tuesday, Thursday and Friday 8.30am to 6.30pm as well as Wednesday 8.30am to 12noon. Extended hours appointments were offered Tuesday 6.30pm to 8pm.

Primary medical services were available to patients via an appointments system. There were a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. There were arrangements with other providers (Medway Doctors On Call Care) to deliver services to patients outside of the practice's working hours.

Results from the national GP patient survey published at the time of our last inspection for satisfaction with how they could access care and treatment were mixed when compared with local clinical commissioning group (CCG) and national averages. For example;

- 69% of respondents were satisfied with the practice's opening hours compared to the local CCG average of 67% and national average of 76%.
- 60% of respondents said they could get through easily to the practice by telephone compared to the local CCG average of 59% and national average of 71%.
- 73% of respondents said the last time they wanted to see or speak with someone the last time they tried they were able to get an appointment compared to the local CCG average of 79% and national average of 84%.
- 74% of respondents said their last appointment was convenient compared with the CCG average of 75% and the national average of 81%.
- 56% of respondents described their experience of making an appointment as good compared with the CCG average of 63% and the national average of 73%.
- 69% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 60% and the national average of 64%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

All patients we spoke with on the day of inspection stated that they were able to book an appointment that suited their needs.

Where national GP patient survey results were below average the practice had developed and implemented an action plan to address the findings and improve patient satisfaction. For example, patients who called the practice at 8.30am on two consecutive days that were unable to secure an appointment were offered a telephone consultation with a GP on the same day.

Listening and learning from concerns and complaints

The practice had a made improvements to the system for handling complaints and concerns.

- The practice had revised the complaints policy which was in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Information for patients was available in the practice that gave details of the practice's complaints procedure and included the names and contact details of relevant complaints bodies that patients could contact if they were unhappy with the practice's response.

Records showed that the practice had not received any written complaints since our last inspection in July 2017. Verbal complaints were recorded in a book kept in the reception office. Records showed that the practice had received 13 verbal complaints since our last inspection in July 2017. The practice's complaints policy stipulated that complaints received should be discussed at practice meetings and recorded in the meeting minutes. Records showed that notes from staff meetings were made. However, these notes did not demonstrate that verbal complaints had been discussed or that learning from them had taken place.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 11 July 2017, we rated the practice as inadequate for providing well-led services.

- The practice had a vision to deliver high quality care and promote good outcomes for patients. However, most of the staff we spoke with were not aware of the practice's vision or statement of purpose.
- Governance arrangements were not always effectively implemented.
- The practice was unable to demonstrate they had an effective system to help ensure all governance documents were kept up to date.
- The practice was unable to demonstrate they had an effective action plan to improve performance.
- The practice was unable to demonstrate they had an effective system for the management of medicines.
- The practice had failed to assess and manage in an effective and timely manner all identified risks to patients, staff and visitors.
- The practice was unable to demonstrate they had an effective system that identified notifiable safety incidents.
- There was a focus on continuous learning and improvement at all levels. However, records of significant event management and complaints management were not always complete.

The practice had partially responded to these issues when we undertook a follow up inspection on 20 March 2018. However, we found that further improvements were still required. The practice remains rated as inadequate for providing well-led services.

Vision and strategy

The practice had a vision to deliver high quality care and promote good outcomes for patients.

- The practice had a vision statement and statement of purpose which reflected the vision. However, most of the staff we spoke with were not aware of the practice's vision or statement of purpose.

Governance arrangements

Improvements to governance arrangements at the practice had taken place but were insufficient.

- There was a clear staffing structure. However, not all staff were fully aware of their own roles and responsibilities. For example, the lead member of staff for infection prevention and control.
- Practice specific policies were implemented and were available to all staff. The practice had revised the system that helped ensure all governance documents were kept up to date. We looked at 22 such policies and guidance documents. We found that two were not dated and did not contain a planned review date to help ensure they were kept up to date.
- An understanding of the performance of the practice was maintained. The practice had implemented their action plan and made improvements to performance. For example, improvements had taken place to the uptake of cervical smear tests as well as Quality and Outcomes Framework (QOF) results for patient with asthma. However, further improvements were still required. For example, improvements to the uptake of child immunisations and diabetes outcomes.
- There was evidence that clinical audits were driving quality improvement.
- Improvements had been made to the arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, medicines management as well as health and safety. However, at the time of our inspection further improvements were still required. For example, arrangements for responding to emergencies, monitoring the use of blank prescription forms, infection control risks, fire safety risks and the potential risk of legionella in the building's water system.

Leadership and culture

Staff told us the GPs and the practice manager were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied 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 GP encouraged a culture of openness and honesty.

The practice had systems for notifiable safety incidents and ensured this information was shared with staff to help

Are services well-led?

Inadequate

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

ensure appropriate action was taken. However, the practice did not always keep records of action taken (or if no action was necessary) in response to receipt of all notifiable safety incidents.

The practice had systems to help ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and a verbal apology.

There was a leadership structure and staff felt supported by management.

- Staff told us the practice held regular staff meetings.
- 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 GP in the practice. Staff had the opportunity to contribute to the development of the service.

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

The practice valued feedback from patients, the public and staff.

- The practice gathered feedback from patients through the patient participation group (PPG) and by carrying out analysis of the results from the GP patient survey. However, there had been no PPG meetings since our last inspection in July 2017.
- The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff were involved in discussions about how to run and develop the practice, and the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Continuous improvement

There was evidence of some learning and improvement within the practice. However, this was insufficient. For example, the practice demonstrated learning from the reported incident. At the time of our inspection the practice was unable to demonstrate that learning or improvements as a result of significant events or verbal complaints that had been recorded by staff in a book kept in the reception office.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service provider was not assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. In particular: formal domestic cleaning audits were not being conducted and there were no records to confirm that regular visual checks of the standard of domestic cleaning conducted took place. The infection control risk assessment document was not dated so it was not clear when it had been carried out. The infection control risk assessment failed to identify that there were no hand washing facilities available in the staff toilet on the first floor of the building. The practice was unable to demonstrate they had an effective system for the routine management of legionella. There were insufficient quantities of equipment to ensure the safety of service users and to meet their needs. In particular: a child's oxygen mask was still not available in the practice. This was in breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The service provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was

This section is primarily information for the provider

Requirement notices

necessary to enable them to carry out the duties they were employed to perform. In particular: training for the practice manager and infection prevention and control lead.

This was in breach of Regulation 18(2) 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.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 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 improve the quality and safety of the services provided in the carrying on of the regulated activity. In particular: Staff did not always follow the practice's written guidance when reporting significant events. The practice was unable to demonstrate that thorough analysis of the significant events reported by staff making an entry in the book kept in the reception office had taken place. assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may have been at risk which arose from the carrying on of the regulated activity. In particular: The practice did not have a fire alarm system and the fire risk assessment document stated that fire could not be easily detected and the fire alarm could not be raised in all parts of the premises. maintain securely such other records as are necessary to be kept in relation to – (ii) the management of the regulated activity. In particular: records did not show that the significant events reported by staff making an entry into the book kept in the reception office had been discussed or that learning from them had taken place. There were no records to demonstrate that the smoke detectors were tested regularly or that the practice had carried out any fire drills. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.