

Dr Summerfield & Partners

Quality Report

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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?

Requires improvement 

Are services responsive to people's needs?

Requires improvement 

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 Dr Summerfield & Partners on 17 November 2016.

Overall the practice is rated as inadequate.

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

- The practice was unable to demonstrate that there was an effective system for reporting, recording and learning from significant events. Opportunities to prevent or minimise harm were missed.
- Significant issues that threatened the delivery of safe care were not identified or adequately managed.
- The practice did not always have regard for national guidance on infection prevention and control.
- Blank prescription pads and forms were not always stored securely and the practice was unable to demonstrate that they had a system to track and monitor their use.
- Medicines were not always managed in accordance with national guidance.

- The practice did not have adequate arrangements to respond to all types of medical or clinical emergencies.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- The practice was unable to demonstrate that there was a formal induction process for newly appointed staff.
- The practice was unable to demonstrate an embedded system for training and training updates for existing staff. Not all staff had received regular appraisals.
- The practice had made significant improvements in the last year for its Quality and Outcomes Framework (QOF) results compared to the results from the previous year 2014/15 (QOF is a system intended to improve the quality of general practice and reward good practice).
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice did not have an active patient participation group (PPG).

Summary of findings

- The complaints process was not consistently followed at the practice. For example, timeframes were not met and learning was not effectively shared in practice meetings.
- There were no leaflets or posters displayed in patient waiting areas to help patients understand the complaints system.
- Patients we spoke with told us that they were not always able to get routine appointments when they needed them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients had access to physiotherapy services and daily counselling services.
- There was a 'stop smoking' clinic. Data from the local NHS Trust for 2015/16 showed that the practice was in the top 20 surgeries, in Kent, for smoking cessation out of 152 services taking part (Data supplied by practice and not verified by CQC).
- Not all staff were aware of the requirements of the duty of candour.

The areas where the provider must make improvement are:

- Ensure significant event records are complete and learning from them is shared throughout the practice. Ensure all staff have the training to help identify what constitutes a significant event or near miss.
- Ensure all complaints including verbal complaints are recorded and that patients are responded to in a timely manner.
- Ensure the practice has regard to The Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance.
- Ensure medicines management procedures for vaccines have regard to Public Health England (PHE) guidance and that there is a process for managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Ensure all staff have the necessary employment checks including a current Disclosure and Barring Service check in order to undertake roles such as chaperoning.
- Ensure that all staff receive appropriate support for training, appraisals and induction.
- Ensure that the practice is able to take appropriate action in the event of a clinical or medical emergency.

- Ensure the Care Quality Commission receives statutory notifications and applications regarding changes without delay.
- Ensure risk assessment and management activities include all potential and actual risks to patients, staff and visitors and that recommendations and actions are implemented.
- Ensure governance arrangements are disseminated and implemented effectively.

The areas where the provider should make improvement are:

- Review clinical audit activity to help ensure improvements to patient care are driven by the completion and sharing of clinical audit cycles.
- Review clinical staffing levels and the appointments system to help ensure patients have access to routine GP appointments.
- Review the process for care planning for patients being cared for in nursing homes to help ensure the safety and individual needs of these patients are being met.
- Review how patients access services between 8am and 8.30am every day.
- Continue with plans to develop a patient participation group to help review and improve patients' experience of the service, including areas such as telephone access and making GP appointments.
- Review ways of improving patient satisfaction at the practice and implement an action plan to address these.

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.

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

Summary of findings

Special measures will give people who use the practice the reassurance that the care they receive should 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.

- Significant issues that threatened the delivery of safe care were not identified or adequately managed.
- Risks were not well managed and there were outstanding recommendations on a fire risk assessment, an electrical system test, and a legionella risk assessment had not been carried out.
- The practice was unable to demonstrate that there was an effective system for reporting, recording and learning from significant events. Opportunities to prevent or minimise harm were missed.
- The practice was unable to demonstrate a systematic approach to telling patients about when things went wrong with care and treatment as staff told us some GPs managed significant events independently.
- The practice did not always follow national guidance on infection prevention and control.
- Blank prescription pads and forms were not stored securely and the practice was unable to demonstrate that they had a system to track and monitor their use.
- We reviewed five personnel files and found that not all the appropriate recruitment checks had been undertaken prior to employment.
- The practice did not have adequate arrangements to respond to all types of emergencies and major incidents.

Inadequate



Are services effective?

The practice is rated as inadequate for providing effective services.

- The practice had made significant improvements in the last year for its Quality and Outcomes Framework (QOF) results compared to the results from the previous year 2014/15 (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/16 showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- There was evidence of quality improvement including clinical audit. However, there was not a practice wide systematic approach to clinical audit.

Inadequate



Summary of findings

- The practice was unable to demonstrate that there was a formal induction process for newly appointed staff.
- The practice had a system for appraisals to help ensure the learning needs of staff were identified. However, this had not been effectively implemented and records showed that some staff were overdue for an appraisal.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as requires improvement for providing caring services.

- Results from the national GP patient survey practice were lower than local and national averages in some aspects of care.
- Patients we spoke with said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. However, information on the practice's websites was not always up to date.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice did not have a systematic approach to supporting carers. Staff we spoke with told us there was an information leaflet for carers, but that it required updating.
- Staff told us that they regularly used the translation services that were available for patients who did not have English as a first language and we saw evidence of this during the inspection.

Requires improvement



Are services responsive to people's needs?

The practice is rated as requires improvement for providing responsive services.

- 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. The practice had corroborated with three other local GP practices to obtain funding for a geriatrician (a doctor who focuses on the care and treatment of elderly patients).

Requires improvement



Summary of findings

- Patients told us on the day of the inspection that they were not always able to get routine appointments when they needed them and we saw patients queuing outside waiting for the door to open at 8.30am and at various times during the day in the reception area waiting to speak to reception staff.
- The practice had good facilities and was well equipped to treat patients.
- The complaints process was not consistently followed at the practice. For example, timeframes were not met and learning was not effectively shared in practice meetings.
- There were no leaflets or posters displayed in patient waiting areas to help patients understand the complaints system. A complaints leaflet and reporting form were kept behind the reception desk which staff would hand to patients who indicated they wished to make a complaint. There was information on the website on how to make a complaint.
- Patients had access to physiotherapy services and daily counselling services.
- There were three appointments reserved every day from 2.30pm to 2.50pm for patients aged over 75.

Are services well-led?

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

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. However, staff we spoke with told us the continuing and rapid increase of the practice's list size was compromising the delivery of the practice's vision.
- There was staffing structure and lead roles had been allocated. However, sufficient training had not always been provided to support lead roles. For example, the infection prevention and control lead had not undertaken any extended training.
- The practice had a range of specific policies to govern activity but these were not routinely accessed by staff nor systematically implemented. For example, not all staff were aware of the repeat prescription policy nor was this policy being implemented uniformly.
- Some members of the management team told us they were not aware of 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). Although the practice had governance arrangements for notifiable safety incidents, not all staff were aware of what constituted a significant event or near miss and did not have a consistent approach to reporting them.

Inadequate



Summary of findings

- Whilst the practice valued feedback from patients, the public and staff, it did not have a proactive approach in gaining feedback about the delivery of the service. However, staff told us there were plans to start a patient participation group (PPG) in December 2016, but we did not see any information for patients to promote or advertise the start of a new PPG.

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

- The practice did not always offer proactive, personalised care to meet the needs of the older people in its population. For example only one out of seven patients living in a care home had a comprehensive care plan.
- The practice responded to the needs of older people by offering home visits and urgent appointments for those with enhanced needs. For example, there were three appointments reserved every day from 2.30pm to 2.50pm for patients aged 75 and over.

Inadequate



People with long term conditions

The practice is rated as inadequate for the care of people with long-term conditions. The provider was rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring and responsive 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 and patients at risk of hospital admission were identified as a priority.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- There was a 'stop smoking' clinic. Data from the local NHS Trust for 2015/16 showed that the practice was in the top 20 surgeries, in Kent, for smoking cessation out of 152 services taking part (Data supplied by practice and not verified by CQC).

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, effective and well-led services and requires improvement for providing caring and responsive 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. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was slightly below local and national averages (Data used in this report was obtained from <http://qof.digital.nhs.uk>. The practice had made improvements over the last 12 months.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- In response to a lack of sexual health services locally, the practice provided emergency contraception clinics and chlamydia screening for patients. This service was open to patients registered at the practice who were under 25 and was available during the practice's core opening hours.

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, effective and well-led services and requires improvement for providing caring and responsive 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 was offered online services and information as well as a full range of health promotion and screening that reflects the needs for this age group.
- There was a text messaging service to remind patients about upcoming appointments.

Inadequate



Summary of findings

- Students returning from college or university during holidays were able to register as temporary residents in order to access services.

People whose circumstances may make them vulnerable

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for providing safe, effective and well-led services and requires improvement for providing caring and responsive 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 palliative care, mental health, dementia and patients with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Inadequate



People experiencing poor mental health (including people with dementia)

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

- 87% of patients diagnosed with dementia had received a face to face care review meeting in the last 12 months, which was better than the local average of 81% and the national average of 84%. (This data was obtained from <http://qof.digital.nhs.uk>).
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

Inadequate



Summary of findings

- The practice did not always carry out advance care planning for patients with dementia. For example, we found in two of the records we reviewed that patients who had received a medicine used for dementia did not have a dementia care plan recorded in their notes.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice had 230 patients on the mental health register and we reviewed one care plan from this patient group which was comprehensive and reflected their needs.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was comparable with local and national averages. Two hundred and fifty six survey forms were distributed and 103 were returned. This represented 0.9% of the practice's patient list.

- 55% of respondents found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 56% and the national average of 73%.
- 68% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average 73% of and the national average of 76%.
- 79% of respondents described the overall experience of this GP practice as good compared to the CCG average of 82% national average of 85%.
- 71% 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 74% and the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. All of the 10 patient Care Quality Commission comment cards we received contained positive comments about the service experienced. Patients commented positively about the supportive, efficient and caring attitude provided by all members of staff and especially the nursing team. 'Friendly, caring and professional' were common themes.

We spoke with four patients, their views aligned with the comment cards and they talked positively about the personalised care provided by the practice. Patients we spoke with told us their dignity, privacy and preferences were always considered and respected. However, they also told us that they had come to queue at the practice because they were unable to get through on the telephone, especially during busy times. For example, when the practice opened at 8.30am.

Areas for improvement

Action the service MUST take to improve

- Ensure significant event records are complete and learning from them is shared throughout the practice. Ensure all staff have the training to help identify what constitutes a significant event or near miss.
- Ensure all complaints including verbal complaints are recorded and that patients are responded to in a timely manner.
- Ensure the practice has regard to The Health and Social Care Act 2008, Code of practice on the prevention and control of infections and related guidance.
- Ensure medicines management procedures for vaccines have regard to Public Health England (PHE) guidance and that there is a process for managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA).
- Ensure all staff have the necessary employment checks including a current Disclosure and Barring Service check in order to undertake roles such as chaperoning.
- Ensure that all staff receive appropriate support for training, appraisals and induction.
- Ensure that the practice is able to take appropriate action in the event of a clinical or medical emergency.
- Ensure the Care Quality Commission receives statutory notifications and applications regarding changes without delay.

Summary of findings

- Ensure risk assessment and management activities include all potential and actual risks to patients, staff and visitors and that recommendations and actions are implemented.
- Ensure governance arrangements are disseminated and implemented effectively.
- Review the process for care planning for patients being cared for in nursing homes to help ensure the safety and individual needs of these patients are being met.
- Review how patients access services between 8am and 8.30am every day.

Action the service SHOULD take to improve

- Review clinical audit activity to help ensure improvements to patient care are driven by the completion and sharing of clinical audit cycles.
- Review clinical staffing levels and the appointments system to help ensure patients have access to routine GP appointments.
- Continue with plans to develop a patient participation group to help review and improve patients' experience of the service, including areas such as telephone access and making GP appointments.
- Review ways of improving patient satisfaction at the practice and implement an action plan to address these.

Dr Summerfield & Partners

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 Dr Summerfield & Partners

Dr Summerfield & Partners (also known as The Limes Medical Centre) delivers services from purpose built premises in Margate, Kent. The practice has a car park and patient areas are accessible to patients with mobility issues, as well as parents with children and babies.

Staff at the practice told us they also took over delivering services at the Garlinge Surgery in Margate, Kent in July 2016. We did not visit this site as part of this inspection as the Care Quality Commission (CQC) had not been notified about this change in services. We informed the practice management team about the necessity to notify the CQC about changes to services. This Garlinge was inspected by the CQC on 5 March 2015 and rated overall as Good. The full report is available at www.cqc.org.uk. The practice list size had recently increased from approximately 11400 patients just over 15000. The surrounding area has a high prevalence of people living in deprived circumstances. For example, there are more unemployed patients registered with the practice than local and national averages (practice 10% clinical commissioning group (CCG) 6%, national average 5%). There are also more patients registered with a long-standing health condition than the national average (practice 60%, national 54%).

The practice holds Personal Medical Service contract and consists of four GP partners (three male and one female) and two salaried GPs (one male and one female). However, only two of the GP partners had been added to the partnership registration with the CQC. This was raised by the CQC inspector prior to inspection but the practice was unable to demonstrate that any action had been taken to register all the partners at the practice. We received a notification after the inspection and have informed the practice they will need to complete an application form to complete the process. There are four practice nurses (female) and two healthcare assistants (female). The GPs, nurses and healthcare assistants are supported by a practice manager and a team of administration and reception staff. A wide range of services and clinics are offered by the practice including: asthma, diabetes and child health clinics.

The practice is open from 8.30am to 6pm Monday to Friday. Morning appointments are from 8.50am to 10.40am and afternoon appointments are from 3pm to 4.40pm. There are three appointments reserved every day from 2.30pm to 2.50pm for patients aged over 75. There is extended opening hours every morning for pre-booked appointments with GPs or the nurse practitioner from 7am to 8am. However, patients without an appointment cannot access services until 8.30am.

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

Services are delivered from:

The Limes Medical Centre, Margate, Kent, CT9 1QY

And

Garlinge Surgery 150 Canterbury Road, Margate, CT9 5DB

Detailed findings

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.

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 17 November 2016. During our visit we:

- Spoke with a range of staff including three GPs (two GP partners and one GP locum), two practice nurses, two healthcare assistants, a range of staff from the administration team 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

The practice was unable to demonstrate that there was an effective system for reporting, recording and learning from significant events.

- Staff told us they would inform the practice manager of any incidents. The practice did have a significant events policy which gave examples of what might be considered a significant event, including medication errors/ issues. However, not all staff we spoke with were aware of the policy or what constituted a significant event. Staff had resolved incidents themselves, without reporting them. For example, staff told us unsigned prescriptions had been returned to the practice from the local chemist on two occasions in the last month. Staff took them to the relevant GPs for a signature but no investigations were undertaken to help identify how these errors had occurred, so there was a risk this could happen again.
- The practice was unable to demonstrate a systematic approach to telling patients about when things went wrong with care and treatment, as staff told us some GPs managed significant events independently. Staff we spoke with from the management team were not aware of their responsibilities 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).

Overview of safety systems and processes

The practice's systems, processes and practices did not always keep patients safe:

- There were arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. A GP partner was the lead for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff we spoke with demonstrated they understood their responsibilities to report safeguarding concerns. However, the practice

was unable to demonstrate that all staff had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three.

- Notices in some of the clinical rooms advised patients that chaperones were available if required. However, the practice was unable to demonstrate that staff undertaking this role had received a Disclosure and Barring Service (DBS) check. (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). Nor was there a risk assessment to explain why DBS checks were deemed unnecessary.
- There was a lead member of staff for infection prevention and control and a policy which clearly outlined how the practice intended to manage infection prevention and control. However, this was not effectively implemented. For example, the practice was unable to demonstrate that all relevant members of staff were up to date with basic infection prevention and control training or that the lead member of staff for infection prevention control had received any additional training to support this role. Patients we spoke with told us the practice was clean and tidy. However, the practice was unable to demonstrate that any infection prevention audits had been undertaken. There were carpets and cloth curtains in consulting rooms such as the room used by nurse to assess respiratory conditions. Although invasive procedures were not routinely undertaken in these rooms staff we spoke with told us that they sometimes were. Staff told us clinical equipment was cleaned after every use. However, in the absence of cleaning schedules, the practice was unable to evidence that clinical equipment was routinely cleaned or that the deep cleaning of carpets and soft furnishings had been undertaken. Although there were spillage kit granules stored in reception, not all staff including the infection prevention and control lead were aware of this and told us that no spillage kits were available. Clinical wash-hand basins did not comply with Department of Health guidance. For example, clinical wash-hand basins contained overflows and plugs and some taps were short levered which meant clinical staff had to use their hand to operate them.

Are services safe?

There was, therefore, a risk of cross contamination when staff used these sinks. The practice was unable to demonstrate that there was a risk assessment or action plan to consider this.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not always keep patients safe (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 for three out of the four fridges at the practice. However, the thermometer on the fourth fridge (used to store medicines such as vaccines) was broken and did not record high or low temperatures and could not be reset, meaning staff were unable to record the temperature range over time. Staff we spoke with told us that the thermometer had been broken for at least a year. Staff told us that medicines such as vaccines were ordered weekly so minimal stock was kept and that stocks were checked on a weekly basis. However, the practice did not maintain an inventory for vaccines and was unable to demonstrate that there was an effective process for checking, rotating and auditing stock. There was a policy for handling repeat prescriptions which included the review of high risk medicines. However, not all staff handling repeat prescriptions, including prescription clerks, were aware of the policy and not all GPs were implementing the policy. Blank prescription pads and forms were not stored securely and the practice was unable to demonstrate that they had a system to track and monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. The GP partners provided support for this extended role when required. 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.
- There was evidence that some action had been taken in managing medicine alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). However, the practice was unable to demonstrate that they had a systematic approach for recording, sharing and acting on MHRA alerts.

- We reviewed five personnel files and found that not all the appropriate recruitment checks had been undertaken prior to employment. For example, the practice was unable to demonstrate the appropriate checks through the Disclosure and Barring Service had been undertaken. The practice could not demonstrate that clinical staff had had their Hepatitis B status checked (hepatitis is a viral infection and it is recommended that healthcare professionals have their immunity tested). There were no risks assessments to explain why these checks were deemed unnecessary. The practice did have a confidentiality agreement but was unable to demonstrate that staff had read and signed this.

Monitoring risks to patients

Risks to patients were not always assessed and well managed.

- The procedures for monitoring and managing risks to patient and staff safety were not effective. There was evidence of some up to date fire risk assessments. However, the practice was unable to demonstrate action had been taken when necessary. For example, the practice had not recorded a fire drill evacuation since 2012. Whilst there was some fire exit signage, there were no evacuation protocols displayed for staff and patients to follow in the event a fire evacuation was deemed necessary. The practice had undertaken a premises electrical test in September 2012 which had highlighted some urgent action was required. The practice was unable to demonstrate this had been completed. The practice had undertaken legionella testing (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, the practice was unable to demonstrate there was a risk assessment to consider monitoring the hot and cold water system.
- Staff told us the practice did not maintain official staff rotas but that staff covered each other during times of absence such as holiday or sickness leave. Staff worked across roles to help ensure all areas of care were met. For example, one of the healthcare assistants had received training to undertake prescription clerk duties.

Arrangements to deal with emergencies and major incidents

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

Are services safe?

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff received annual basic life support training and there were some emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- The practice maintained some emergency medicines which were easily accessible to staff in a secure area of the practice and staff knew of their location. All the medicines we checked were in date and stored securely. However, there was not a comprehensive range of medicines to reflect the needs of some patients or the regulated activities undertaken at the practice. For example, Atropine (an emergency medicine for practices that undertake coil fittings or minor surgery). The practice did not keep an inventory of these medicines or a risk assessment as to why some medicines were not deemed necessary.
- The practice was in the process of reviewing and amending the business continuity plan for major incidents such as power failure or building damage. The current plan did not contain staff contact details. The practice was aware of this and planned to include this in their new plan.

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 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 98% of the total number of points available. This was an improvement from 2014/15 data when the practice had achieved 73%. The practice had 14% exception reporting (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). QOF data used in this report was obtained from <http://qof.digital.nhs.uk> and has not been validated by the Care Quality Commission. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the national and clinical commissioning group (CCG) averages. For example, 98% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months, which was higher than the CCG average of 88% and the national average of 89%. Exception reporting 12%.
- Performance for mental health related indicators was similar to the CCG and national average. 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared with a which was higher than the CCG average of 86% and similar to the national average of 89%. Exception reporting 20%.

The practice had reviewed previous QOF figures from 2014/15 and identified this as an area requiring improvement. In

response they had employed a new member of staff for the administration team to concentrate on QOF and recalling patients' with long-term conditions for their annual reviews. This had helped the practice make significant improvements in their QOF figures.

There was evidence of quality improvement including clinical audit. However, there was not a practice wide systematic approach to completing clinical audit cycles.

- There had been four clinical audits undertaken in the last two years, one of these was a two cycle completed audit where improvements made were implemented and monitored. This audit looked at adherence to prescribing guidelines. There had been a 50% improvement in the second phase. However, in other audits it was not clear how findings had been used to implement change. For example, an audit reviewing a medicine used for pain relief had made several recommendations but it was not clear whether these were actioned or further audit was undertaken.
- The practice participated in local audits and national benchmarking.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice was unable to demonstrate that there was a formal induction process for newly appointed staff that covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We reviewed the personnel file of a recently recruited member of staff and found training gaps in areas such as infection prevention and control, fire training and Mental Capacity Act training.
- 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 completed training in areas such as diabetes and asthma.
- 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.

Are services effective?

(for example, treatment is effective)

- The practice had a system for appraisals to help ensure the learning needs of staff were identified. However, this had not been effectively maintained and records showed that some staff were overdue for an appraisal.
- The practice was unable to show us a training schedule for staff and when we reviewed five staff personnel records we saw that all staff were not up to date with attending training courses such as fire training, Mental Capacity Act, safeguarding and infection control.

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 investigation and test results. The practice had 230 patients on the mental health register and we reviewed one care plan for a patient from this register which was comprehensive and reflected their needs. However, we reviewed seven records from care home patients and found only one contained a care plan. Two of the records reviewed were for patients who were receiving a medicine used for dementia; these patients did not have a dementia care plan in their records.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff told us that they 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 meetings took place with other health care professionals on a regular basis when care plans were reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. However, records indicated that not all staff had attended training for this.
- 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 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 and alcohol cessation. Patients were signposted to the relevant service.
- A member of the nursing team ran a smoking cessation clinic. Data from the local NHS Trust for 2015/16 showed that the practice was in the top 20 surgeries, in Kent, for smoking cessation out of 152 services taking part (Data supplied by practice and not verified by CQC).

The practice's uptake for the cervical screening programme was 78%, which was similar to the CCG average of 82% and the national average of 81%. (This data was obtained from <http://qof.digital.nhs.uk> and has not been validated by the Care Quality Commission - CQC). Although this was slightly below local and national averages, the practice had improved from 2014/15 QOF data which was 72%. There was a policy to contact patients who failed to attend their cervical screening test to remind them of the test. A female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems to help 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.

Childhood immunisation rates were similar to local averages. For example, vaccines given to infants aged 12 months and under, ranged from 92% to 96% (CCG average 89% to 94%, national average 73% to 93%), five year olds ranged from 87% to 91% (CCG average 82% to 95%, national average 83% to 95%).

Are services effective?

(for example, treatment is effective)

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 could be overheard in the patient waiting areas and there was a barrier for waiting patients to stand behind to help ensure privacy for those talking with the reception staff. The receptionists were aware of patient confidentiality and we saw that they took account of this in their dealings with patients. There was a private area if patients wished to discuss sensitive issues or appeared distressed.

All of the 10 patient Care Quality Commission comment cards we received contained positive comments about the service experienced. Patients commented positively about the supportive, efficient and caring attitude provided by all members of staff and especially the nursing team. 'Friendly, caring and professional' were common themes.

We spoke with four patients, their views aligned with the comment cards and they talked positively about the personalised care provided by the practice. Patients we spoke with told us their dignity, privacy and preferences were always considered and respected.

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

- 78% of respondents said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 82% of respondents said the GP gave them enough time compared to the CCG and national average of 87%.
- 92% 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%.

- 81% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 86% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 87% of respondents said they found the receptionists at the practice helpful compared to the CCG average of 85% 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.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 83% of respondents said the last GP they saw was good at explaining tests and treatments compared to the CCG and national average of 86%.
- 73% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 82%.
- 82% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the CCG and national average of 85%.

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

- Staff told us that they regularly used translation services were available for patients who did not have English as a first language and we saw evidence of this during the inspection.
- Information leaflets were available in easy read format.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

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's computer system alerted GPs if a patient was also a carer. The practice had identified 173 patients as

carers (1% of the practice list). The practice did not have a systematic approach to supporting carers. Staff we spoke with told us there was an information leaflet for carers, but that it required updating.

Staff told us that if families had suffered bereavement, their usual 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/or 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.

- There was extended opening hours every morning for pre-booked appointments with GPs or the nurse practitioner from 7am to 8am 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 toilets had an emergency cord so patients could call for assistance if required.
- The practice had installed a hearing loop and had plans to train staff and begin using this in the New Year.
- There were three appointments reserved every day from 2.30pm to 2.50pm for patients aged over 75.
- The practice had collaborated with three other local GPs to obtain funding for a geriatrician (a doctor who focuses on the care and treatment of elderly patients).
- There were plans to collaborate with other local GPs to access funding for a paramedic practitioner to provide support for patients aged over 75.
- In response to a lack of sexual health services locally, the practice provided emergency contraception clinics and chlamydia screening for patients under 25 during the practice's core opening hours.
- Patients had access to physiotherapy services and daily counselling services.

Access to the service

The practice was open from 8.30am to 6pm Monday to Friday. Patients calling between 6pm and 6.30pm would be transferred to the duty GP. Patients with pre booked appointments could enter the practice between 7am and

8am for the extended hours service as a receptionist would unlock the door to let them in. However, the practice had not made any arrangements, including via the telephone to make appointments, for patients to access GP services between 8am and 8.30am. Morning appointments were from 8.50am to 10.40am and afternoon appointments were from 3pm to 4.40pm. There were three appointments reserved every day from 2.30pm to 2.50pm for patients aged over 75. There was extended opening hours every morning for pre-booked appointments with GPs or the nurse practitioner from 7am to 8am. In addition appointments that could be booked up to four weeks in advance, urgent appointments were also available for people that needed them. However, on the day we inspected patients were unable to book routine appointments in advance as there were no available appointments in November and the practice had not yet released appointments for December.

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

- 71% of respondents were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) and the national average of 79%.
- 55% of respondents said they could get through easily to the practice by phone compared to the CCG average of 56% and the national average of 73%.

Patients we spoke with told us that they were not always able to get routine appointments when they needed them. On the day of the inspection we saw patients queuing outside the practice waiting for the door to open at 8.30am. Telephone lines did not open until 8.30am. We also witnessed patients queuing in the reception area at various times during the day.

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.

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns but did not effectively implement it. The practice did not consider verbal complaints.

- The practice manager was responsible for handling all complaints in the practice.
- There were no leaflets or posters displayed in patient waiting areas to help patients understand the complaints system. A complaints leaflet and form were kept behind the reception desk which staff would hand to patients who indicated they wished to make a complaint. There was information on the website on how to make a complaint.

The practice had recorded five complaints in 2015/2016. Staff told us they did not formally record verbal complaints. Complaints were handled with openness and transparency. However, records showed that patients were not always responded to in a timely manner. For example, one patient lodged a complaint on the 12 October 2015, the GP did acknowledge the complaint by telephone on 16 October 2015 but the practice did not formally respond until the 21 December 2015. The practice was unable to demonstrate that there was a systematic approach to learning from complaints.

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 a clear vision to deliver high quality care and promote good outcomes for patients. However, due to local circumstances and practice closures resulting in a rapid increase of the practice's list size we found that the practice was experiencing difficulties in the delivery of that aspiration.

- The practice values were about delivering high standards of health care to all patients registered at the surgery. Staff we spoke with understood the values but told us they were working in a busy and stressful environment which made delivering the values challenging.
- The practice may be required to take more patients on to their existing list and did not have an effective strategy or supporting business plan to safely manage this.

Governance arrangements

There was a range of governance arrangements to support the delivery of services. However, these were not always effectively implemented.

- There was a staffing structure and lead roles had been allocated. However, sufficient training had not always been provided to support lead roles. For example, the infection prevention and control lead had not undertaken any extended training.
- The practice had a range of specific policies to govern activity but these were not routinely accessed by staff nor systematically implemented. For example, not all staff were aware of the repeat prescription policy nor was this policy being implemented uniformly.
- The practice had used QOF to improve outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). For example, the practice had identified QOF and long-term conditions as an area requiring improvement. Action had been taken and QOF related patient outcomes had significantly improved.
- Whilst there was evidence of quality improvement through clinical audit, there was not a practice wide systematic approach to clinical audit.
- The arrangements for identifying, recording and managing risks, issues and implementing mitigating actions did not keep patients safe. Practice audits and

processes were not embedded in a systematic manner. For example, the practice was unable to demonstrate they had undertaken infection prevention and control audit in line with their own governance documents. Risks associated with medicines stored in a fridge without a fully functioning thermometer had not been addressed. The practice was unable to demonstrate that there was a system to monitor blank prescription forms and pads. Although Legionella testing had been undertaken, the practice was unable to demonstrate that there was a legionella risk assessment for on going monitoring. The practice had also failed to consider other risks associated with the premises including responding to recommendations regarding the electrical system and on going effective fire risk training and assessments. Not all staff had attended training, or received regular appraisals. The practice was unable to demonstrate new recruits had received an effective induction or recruitment checks including Disclosure and Barring Service (DBS) checks. (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).

Leadership and culture

Staff told us they could approach the GP partners and the practice manager. However, the practice was unable to demonstrate that there were sufficient formal processes available for staff to give feedback and raise concerns. For example, staff meetings and regular staff appraisals.

Some members of the management team told us they were not aware of 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). Although the practice had governance arrangements for notifiable safety incidents, not all staff were aware of what constituted a significant event or near miss and did not have a consistent approach to reporting them.

The systems to help ensure that when things went wrong with care and treatment were not always effectively implemented:

- The practice did not always give affected patients reasonable support, truthful information and a verbal and written apology in a timely manner.

Are services well-led?

Inadequate 

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

- The practice did not keep written records of verbal interactions as well as written correspondence. For example, verbal complaints were not recorded.

There was a clear leadership structure. However, some staff we spoke with told us that they felt under pressure whilst delivering services to patients.

- Staff we spoke with told us they tried to make time for meetings. However, the practice was unable to demonstrate that there was a consistent approach across the practice to staff meetings. Staff from reception and the administration teams told us there were informal discussions where possible. The nursing team did not regularly meet and records showed they held one meeting a year for the last three years; meaning the practice could not demonstrate there were effective systems for staff communication, sharing and learning.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice but that the impact of delivering services to an increasing list size meant they were working in a very pressurised environment.

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

Whilst the practice told us they valued feedback from patients, the public and staff, it did not have a proactive approach in gaining feedback about the delivery of the service.

- The practice had gathered feedback from patients through the GP patient survey results and the friends and family test but had not undertaken any patient surveys themselves. At the time of the inspection the practice did not have an active PPG. Staff told us the Garlinge Surgery used to have an active PPG and there were plans to restart this group and also invite patients from the Limes Medical Centre. There was information on the website about the diversity of patients the practice would like to attract to its PPG. However, the practice was unable to demonstrate time scales for this action and there were no posters advertising the intention to form a PPG.
- The practice had gathered feedback from staff through informal discussions, but the practice was unable to demonstrate that there was systematic approach to obtaining feedback from staff either from regular appraisals or team meetings.

Continuous improvement

- There was a focus on continuous learning within the practice and the practice was involved in training for FY2 doctors and provided opportunities for apprenticeships within the administration team.
- The practice had collaborated with three other local GP practices to obtain funding for a geriatrician (a doctor who focuses on the care and treatment of elderly patients).
- The practice was working with other local GPs towards providing a paramedic practitioner to support patients.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) 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. • The practice failed to assess risks to the health and safety of service users receiving the care or treatment and do all that was reasonably practicable to mitigate any such risks. • The practice failed to ensure proper and safe management of medicines including the storage of vaccines. • The practice was unable to demonstrate they had a system to track and monitor the use of blank prescription pads and forms. • No infection prevention and control audits had been undertaken or improvements made. Therefore, the practice failed to assess the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. 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 Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: All premises and equipment used by the service provider must be properly maintained: • The provider had failed to take urgent remedial action recommended in the HMC electrical report.

This section is primarily information for the provider

Requirement notices

This was in breach of Regulation 15(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Regulation

Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints

How the regulation was not being met

In that

- Verbal complaints were not recorded.
- Information on how to complain was not clearly displayed at the practice.
- Complainants were not always responded to in a timely manner.
- Learning from complaints was not consistently shared through the practice.

This was in breach of Regulation 16(1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Regulation

Regulation 17 HSCA (RA) 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 Regulations 4 to 20A. 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.
- Systems or processes must be established and operated effectively to ensure compliance with the requirements

This section is primarily information for the provider

Requirement notices

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
Family planning services
Maternity and midwifery services
Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

The provider failed to provide appropriate support, training, professional development, supervision and appraisal as is necessary to enable staff to carry out the duties they are employed to perform,

- Staff should be supported to make sure they can participate in training in areas such as infection prevention and control, fire training and Mental Capacity Act.
- Staff did not receive regular appraisal of their performance in their role from an appropriately skilled and experienced person and any training, learning and development needs should be identified, planned for and supported.
- The provider failed to ensure staff received appropriate support when starting work as there was no formal induction programme.

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.