

Hartland Way Surgery

Inspection report

1 Hartland Way
Shirley
Croydon
CR0 8RG
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Requires Improvement



Are services well-led?

Requires Improvement



Overall summary

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

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

This included:

- Conducting staff interviews using video conferencing
- Completing remote clinical searches on the practice's patient records system and discussing findings with the provider
- Remotely reviewing a selection of patient records to identify issues and clarify actions taken by the provider
- Requesting documentary evidence from the provider
- A short site visit

We carried out an announced focused inspection at Hartland Way Surgery on 19 May 2021 and a remote clinical review on 17 May 2021 to follow up on breaches of regulations.

The practice was previously inspected on 13 November 2019. Following that inspection, the practice was rated as requires improvement overall (requires improvement in safe, effective and well-led) for issues in relation to recruitment checks, health and safety checks, fire safety checks, medicines management, management of significant events, staff training and governance arrangements.

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

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

We rated the practice as **requires improvement** for providing safe services.

At this inspection, we found the provider had made some improvements in providing safe services. In particular, the provider had made improvements to their systems and process in relation to health and safety risk assessments, significant events and medicines management. However, we found new issues in relation to medicines management and the provider had not actioned some of the issues found in their infection prevention and control audit which were actions identified in their last inspection.

We rated the practice as **requires improvement** for providing effective services.

At this inspection, we found the provider had made some improvements in providing effective services. In particular, the provider had made improvements to their systems and processes in relation to staff training and quality improvement. However, we found the provider did not have an effective system to identify patients with commonly undiagnosed conditions, for example diabetes. Their uptake for childhood immunisations and cervical screening were below average and the provider could not demonstrate the prescribing competence of the pharmacist.

We rated the practice as **requires improvement** for providing well-led services.

Overall summary

We found the provider had made improvements in providing well-led services in relation to good governance and had implemented systems and process in response to the findings of our previous inspection. However, governance arrangements in place still required improvement especially in relation to identifying, managing and mitigating risks.

We have rated this practice as requires improvement overall and requires improvement for population groups people with long-term conditions and families children and young people.

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

- Ensure that care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with fundamental standards of care.

(Please see the specific details on action required at the end of this report).

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

- Improve practice process for recruitment checks.
- In consultation with the local fire safety team, implement fire drills or suitable alternatives.
- Improve recording of discussions in meetings.

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

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Population group ratings

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

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist advisor.

Background to Hartland Way Surgery

Hartland Way Surgery provides primary medical services in 1 Hartland Way, Shirley, Croydon CR0 8RG to approximately 6,400 registered patients and is one of the 48 practices in Croydon Local Area Team and part of the South West London Clinical Commissioning Group (CCG).

The clinical team at the surgery is made up of two part-time female GP partners and a part-time clinical associate pharmacist partner, two salaried GPs (one male and one female), a female practice nurse and a female healthcare assistant. The non-clinical practice team consists of a practice manager, reception supervisor and eight administrative or reception staff members.

The practice is a teaching practice for medical students and GP trainees.

The practice population is in the least deprived decile in England. The practice population of children is below the CCG (Clinical Commissioning Group) and national averages and the practice population of older people is above the CCG and national averages.

The practice is registered as a partnership with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

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	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	The provider had not ensured that care and treatment is provided in a safe way for patients.
Maternity and midwifery services	The provider did not ensure they had appropriate systems in place for the safe management of medicines.
Surgical procedures	The provider did not ensure they consistently acted on medicines and safety alerts.
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance
Family planning services	The provider had not ensured that effective systems and processes were in place to ensure good governance in accordance to fundamental standards of care.
Maternity and midwifery services	The provider did not ensure all the issues found during their infection prevention and control audit were actioned.
Surgical procedures	The provider did not ensure the prescribing competence of non-medical prescribers were reviewed.
Treatment of disease, disorder or injury	The provider did not ensure they always identified patients with commonly undiagnosed conditions. For example, diabetes.
	The provider did not have effective systems in place to improve uptake of childhood immunisations and cervical screening.