Guildhall Surgery

Inspection report

65-69 Guildhall Street
Folkestone
CT20 1EJ
Tel: 01303851411

Date of inspection visit: 23 February 2022 and 25 February 2022
Date of publication: 01/04/2022

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services well-led?	Inadequate

Overall summary

We carried out an announced inspection at Guildhall Surgery on 23 February 2022 and 25 February 2022. Overall, the practice is rated as inadequate.

Overall, the practice is rated inadequate. The three questions reviewed as a part of this inspection were rated as follows;

Safe - inadequate

Effective – requires improvement

Well-led – inadequate

Following our previous inspection on 10 March 2016, the practice was rated Good overall and for all key questions. The full reports for previous inspections can be found by selecting the 'all reports' link for Guildhall Surgery on our website at www.cqc.org.uk.

Why we carried out this inspection

We conducted a comprehensive inspection in response to risk identified.

We undertook this inspection at the same time as Care Quality Commission inspected a range of urgent and emergency care services in Kent and Medway. To understand the experience of GP Providers and people who use GP services, we asked a range of questions in relation to urgent and emergency care. The responses we received have been used to inform and support system wide feedback.

How we carried out the inspection

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

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

This included:

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

Our findings

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

- what we found when we inspected
- information from our ongoing monitoring of data about services and

Overall summary

- information from the provider, patients, the public and other organisations.

We have rated this practice as inadequate overall and for all population groups.

We found that:

- There was a lack of governance systems to provide global oversight of the actions of individuals and the service, leading to some risks not being identified or mitigated.
- Discussions between staff needed to be formalised, actions assigned, outcomes monitored and learning shared and embedded into practice.
- Improvements were required to ensure the safe prescribing and monitoring of patients with long term conditions.
- Although staff were committed, conscientious and caring the provider failed to ensure staff had adequate training, supervision and employment checks.
- The majority of patients who completed the Friends and Family Test would recommend the practice.
- The practice had adjusted how it delivered services to meet the needs of patients during the COVID-19 pandemic which had an effect on the service..

We found four breaches of the regulations. The provider **must**:

- Ensure care and treatment is provided to service users in a safe way.
- Safeguard service users from abuse and improper treatment
- Ensure systems and processes are established and operate effectively to ensure care and treatment is provided in a safe way to patients.
- Ensure fit and proper persons are employed.

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

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of 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 to 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 a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the service the reassurance that the care they get should improve.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

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

Background to Guildhall Surgery

Guildhall Surgery is located in Folkestone, Kent. The practice is part of a wider network of GP practices as part of Total Healthcare Excellence (THE) WEST Primary Care Network (PCN) and a member of the Kent and Medway Clinical Commissioning Group (CCG) and delivers General Medical Services (GMS) to a patient population of about 9137. This is part of a contract held with NHS England.

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

Information published by Public Health England report deprivation within the practice population group as the second on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice has a high prevalence of patients experiencing mental health and depression than the local and national averages.

The practice team consists of; three GP partners, two salaried GPs, an ST3 Registrar, long term locum GP, long term locum advanced nurse practitioner, four practice nurses, one healthcare assistant, PCN clinical pharmacist and First Contact physiotherapist. The extensive clinical team is supported by an administrative team (including; medical secretaries, prescription clerks and receptionists) overseen by a practice manager.

Due to the enhanced infection prevention and control measures put in place since the pandemic and in line with the national guidance, most GP appointments were telephone consultations. If the GP needs to see a patient face-to-face then the patient is offered an appointment at the practice.

The practice does not provide out of hours services to its patients and there are arrangements with another provider (the 111 service/Integrated Care 24 limited) to deliver services to patients when the practice is closed. Extended access is provided locally via the 111 service, where late evening and weekend appointments are available.

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 Surgical procedures Treatment of disease, disorder or injury Maternity and midwifery services	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Fit and proper persons checks had not been conducted prior to the appointment of staff; • The practice did not follow the requirement of conducting Disclosure and Barring Service (DBS) checks (The DBS helps employers make safer recruitment decisions) for their staff. • Not all staff employed had a valid DBS check. • A staff member had been appointed without necessary checks .

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding systems and processes were not operating effectively to prevent abuse of service users; • We found some vulnerable patients did not have appropriate flags on their clinical record and there was no narrative recorded to alert the clinician to the nature of the concerns. • Some staff had not completed mandatory safeguarding training.

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.

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 Care and Treatment was not provided in a safe way for service users; • We found some recommended emergency medicines were not available. A risk assessment had not been recorded to demonstrate the practice had considered how they would respond to certain conditions. • A health and safety risk assessment had not been carried out since March 2018. • We found no cleaning documentation advising staff of the control of substances hazardous to their health (COSHH). • We found the practice had not conducted a Legionella risk assessment or regular monitoring of water temperatures. • The practice had not addressed actions identified in the external fire risk assessment. • The provider did not have effective systems to ensure fire safety. • Staff had not received training in basic life support. • Staff had not received formal training in sepsis and aide memoirs were not available to assist staff to identify deteriorating or acutely unwell patients. • The effectiveness of the practice's business continuity plans had not been tested. • We found the practice did not have detailed cleaning schedules identifying tasks and frequency of cleaning required for the practice to undertake and those undertaken by the external cleaning company. The provider did not actively monitor the attendance of the cleaning staff. • The practice had not produced an annual infection control statement as required under the Health and Social Care Act 2008 Code of Practice on the prevention and infection and related guidance, Appendix D. • Staff had not completed infection prevention control training or their competencies in this area.

This section is primarily information for the provider

Enforcement actions

- We identified patients who had not been appropriately monitored, potentially placing their health at risk.
- Patients were at risk due to having missed diagnosis.
- Staff were not regularly appraised or supervised in role.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider failed to ensure established and effective systems to monitor the safety and quality of the service; • We found the practice did not have effective governance systems in place to identify and act on risks through assessments such as, health and safety, fire and legionella. • We found some clinical documentation was completed retrospectively. • The provider failed to ensure staff were aware they were required to report certain incidents (such as patients collapsing and requesting emergency services attendance). • We found not all significant incidents had been discussed with other staff (including clinicians), and learning identified and disseminated. The practice did not conduct an annual review of incidents to identify trends. • We found the practice had failed to achieve the minimum standards required in four of the five childhood vaccinations. • We found clinical audits were not aligned to national clinical standards or guidance and they were little or no narrative to explain how they related to improved patient outcomes. None of the cycles had been repeated to demonstrate embedded learning. • We found the practice lacked established and effective systems to report against their aims and objectives and communicate to staff and stakeholders how they had achieved their goals. • We found the practice did not have a Speak p Guardian or a whistleblowing procedure. • The provider did not have established and effective systems to ensure staff were adequately supported in their roles.

This section is primarily information for the provider

Enforcement actions

- We found the practice had suspended team meetings during the pandemic and not introduced alternative means of maintaining engagement with their staff.
- We found the practice did not have an effective system in place to receive, review, action and report outcomes for patients who may be adversely affected by safety alerts.
- We found inconsistencies in the understanding and actioning of alerts within the clinical system.
- We found the practice did not ensure confidential information was secure.
- We found some patients' records were incomplete and not always contemporaneously recorded.
- The practice did not have a policy on the occupational vaccination status of staff such as high-risk diseases they may be exposed to at work.
- The practice had not undertaken a risk assessment to ensure all staff were appropriately vaccinated or appraised of the risks or taken actions to mitigate them.