# High Glades Medical Practice

## Quality Report

9A Upper Church Road
Hastings
East Sussex
TN37 7AT
Tel: 01424754678
Website: www.highgladesmedicalcentre.nhs.uk

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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 | Good |
| Are services well-led? | Good |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection of High Glades Medical Practice on 23 February 2016. Breaches of legal requirements were found during that inspection within the well led domain. The practice was rated as good overall, requires improvement in the well-led domain and good in the safe, effective, caring and responsive domains. After the comprehensive inspection, the practice sent to us an action plan detailing what they would do to meet the legal requirements. We undertook a focused inspection on 06 December 2016 to check that the provider had followed their action plan and to confirm that they now met legal requirements. The provider was now meeting all requirements and was rated as good overall and good under the well-led domain. This report only covers our findings in relation to those requirements.

During the previous inspection on 23 February 2016 we found that the areas where the practice must make improvements were:

- To ensure that significant events are investigated and discussed thoroughly, actions taken and lessons learnt and disseminated and to ensure that the accuracy of recording of significant events and complaints is more robust.

This report should be read in conjunction with the last report from 23 February 2016. The report from our last comprehensive inspection can be read by selecting the 'all reports' link on our website at www.cqc.org.uk.

During this inspection we found that:

- Significant events were seen to have been investigated and discussed thoroughly, actions were taken and lessons learnt. We saw that learning points were disseminated to staff and that the recording of significant events and complaints was accurate.

**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 well-led?**

Good

The practice is rated as good for providing well-led services.

At the last inspection on 23 February 2016 we found that:

- The practice had systems in place for knowing about notifiable safety incidents. However, when there were unintended or unexpected safety incidents, we saw no evidence that reviews and investigations were thorough enough and lessons learned were not communicated widely enough to support improvements. We also saw some errors in accuracy in the recording of some significant events and also in the detail of recording some complaints.

On this occasion we found that:

- The practice systems for identifying, recording, discussing and learning from significant events had been reviewed and revised. We saw evidence that incidents were discussed and the outcomes, actions and learning recorded in a thorough and systematic way. Lessons learned were communicated widely and the recording of significant events and complaints was accurate.

# High Glades Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

The inspection was carried out by a CQC Inspector.

## 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 on 23 February 2016 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

Breaches of legal requirements were found. As a result, we undertook a focused inspection on 06 December 2016 to follow up on whether action had been taken to deal with the breaches.

# Are services well-led?

Good

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

## Our findings

**Governance arrangements**

At the inspection on 23 February 2016 we found that there were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. However, when there were unintended or unexpected safety incidents, we saw no evidence that reviews and investigations were thorough enough and lessons learned were not communicated widely enough to support improvement. We also saw some errors in accuracy in the recording of some significant events and also in the detail of recording some complaints. For example two significant events that we looked at did not have a clear investigation and some important details were missing such as names and dates. No action was evidenced or dated. We found no evidence that six significant events recorded in 2015/2016 had been discussed with appropriate staff.

At this inspection we found that the practice had reviewed and revised their significant events process. A log of significant events was retained as a hard copy and also on the practice computer system. There were comprehensive report forms available for both clinical and nonclinical events and the completed forms were retained as both hard copies and digitally. Significant events were now a standing agenda item at clinical meetings and all clinical complaints were considered as significant events. Clinical events were discussed at the next clinical meeting and the discussion and outcomes recorded in the minutes. The completed significant event form was attached to the minutes and stored both as hard copies and on the computer system where they were accessible to all staff. Minutes were sent to all staff via email on the internal shared drive.

Non clinical significant events were recorded in the same way and investigated by the practice manager and an action plan devised. The issues were discussed with staff at an initial meeting. Anyone unable to attend was told of the issues in subsequent face to face meetings at the earliest convenience. Any necessary training or actions were then commenced. The issue was then placed on the agenda for the next monthly staff meeting and discussed and minuted at that meeting. Staff were sent copies of the minutes via email and both hard and digital copies were retained by the practice and were accessible to staff.

The complaints system had also been reviewed and revised and followed a similar process to significant events. We saw no errors in accuracy in the recording of recent significant events or complaints.