Caskgate Street Surgery

Inspection report

3 Caskgate Street
Gainsborough
DN21 2DJ
Tel: 01427619033

Date of inspection visit: 24 May 2023
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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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Overall summary

We carried out an announced comprehensive inspection at Caskgate Street Surgery on 24 May 2023. Overall, the practice is rated as Inadequate.

Safe - Inadequate,

Effective - Requires Improvement

Caring - Good

Responsive - Good

Well-led - Inadequate,

Following our previous inspection on 3 November 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 Caskgate Street Surgery on our website at www.cqc.org.uk

Why we carried out this inspection

We carried out this comprehensive inspection to follow up concerns in response to risk in line with our inspection priorities. During our inspection we reviewed our 5 key questions of safe, effective, caring, responsive and well led.

How we carried out the inspection/review

This inspection was carried out in a way which enabled us to spend a minimum amount of time on site.

This included:

- Conducting staff interviews using video conferencing.
- To ensure we gathered staff feedback we used a questionnaire which was given to staff electronically via email.
- Completing remote clinical searches on the practice's patient records system (this was with consent from the provider and in line with all data protection and information governance requirements) and discussing findings with the provider.
- Reviewing patient records remotely to identify issues and clarify actions taken by the provider.
- Requesting evidence to be submitted to us electronically from the provider.
- A site visit.

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

We found that:

Overall summary

- The practice did not provide care in a way that kept patients safe and protected them from avoidable harm.
- Safety alerts were not being received and acted upon, which put patients at risk.
- There were gaps in systems to assess, monitor and manage risks to patient safety.
- Not all patients received effective care and treatment that met their needs. Patients with long tern conditions were not always reviewed effectively.
- Staff did not have the information they needed to deliver safe care and treatment.
- Staff dealt with patients with kindness and respect and involved them in decisions about their care.
- Patients could access care and treatment in a timely way.
- Patients' needs were not assessed, and care and treatment was not delivered in line with current legislation.
- Leaders could not demonstrate they had the capacity and skills to deliver high quality sustainable care.
- The overall governance arrangements were inadequate.

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

- Ensure care and treatment is provided in a safe way to patients.
- Ensure patients are protected from abuse and improper treatment
- Ensure all premises and equipment used by the service provider is fit for use.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The provider **should**:

- Obtain Staff immunisation records for non-clinical staff.
- Improve the number of carers, childhood immunisations and cervical screening rates.
- Consider a patient feedback survey.

I am, therefore, placing this service in 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 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.

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

Dr Sean O'Kelly BSc MB ChB MSc DCH FRCA

Chief Inspector of Hospitals and Interim Chief Inspector of Primary Medical Services

Our inspection team

Our inspection team was led by a CQC lead inspector, second CQC inspector and a GP Specialist Advisor who undertook a site visit.

Prior to the inspection the GP specialist advisor remotely completed clinical searches and records reviews and the lead inspector spoke with a number of staff using video conferencing facilities.

Background to Caskgate Street Surgery

Caskgate Street Surgery is located in Gainsborough:

3 Caskgate Street

Gainsborough

Lincolnshire

DN21 2DJ

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

The practice is situated within the Lincolnshire Integrated Care System and delivers General Medical Services (GMS) to a patient population of about 12,000. The practice list is weighted to reflect the healthcare needs of its patient population. The reason for weighting for patient demographics is that certain types of patients place a higher demand on practices than others. The adjustment for deprivation acknowledges that deprived populations have higher health needs than less deprived populations with a similar demographic profile.

Information published by Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the lowest decile (1 of 10). The lower the decile, the more deprived the practice population is relative to others.

Caskgate Street Surgery is part of the Trent Care Primary Care Network (PCN) which includes 5 surgeries covering aprox 40,000 patients.

Caskgate Street Surgery's population is different from the Lincolnshire and England averages. It has a deprivation score of 41 in comparison to Lincolnshire 19.9 and Trent Health 24.7 with unemployment at 12.2% which is the highest in the PCN. The practice also has higher number of patients with asthma related conditions, mental health and depression.

According to the latest available data, the ethnic make-up of the practice area is 98% White, 1% Asian.

The practice is open between 8am to 6.30pm Monday to Friday. The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

Extended access is provided locally by Cleveland Surgery where late evening and weekend appointments are available. Appointments are available between 6.30pm and 8pm Monday to Friday 10am to 12 noon Saturdays and 10am to 11.30am on Sundays.

Out-of-hours services are provided by Lincolnshire Intergrated Care Board.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment We found systems and processes were not established or operated effectively to ensure compliance with safeguarding service users from abuse and improper treatment. We could not be assured that safeguarding referrals had been made in a timely manner. We found that the practice did not have a vulnerable adults safeguarding register on the patient record system, to ensure that staff were kept aware and able to take steps to provide safe care and treatment. We found that the safeguarding register on the patient record system in place to protect children and young people where there are known risks and can respond appropriately to any signs or allegations of abuse were not effective. Safeguarding training was reviewed and we could not be assured that the GPs had received the appropriate level of training required as no certificates were available on the day of the inspection. Although there was some evidence of discussion between the practice and other providers, there was no formal process in place to ensure regular safeguarding information sharing meetings took place between you and other appropriate agencies. Regulation 13 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Family planning services	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment
Maternity and midwifery services	There was a lack of leadership and oversight around governance systems, quality and assurance and monitoring and mitigating risk. This resulted in issues not being identified or adequality managed, with the potential to impact upon the delivery of safe and effective care. For example, a lack of oversight of the premises, fire safety, management of legionella, electrical and gas safety. The practice had not ensured all actions identified on risk assessments had been completed as recommended. For example, actions from their fire and legionella risk assessments had not been completed as required. This was in breach of Regulation 15 (1) of the Health and Social Care Act
Surgical procedures	
Treatment of disease, disorder or injury	

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance. **How the regulation was not being met:** There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular: The practice did not have systems and processes for managing risks, issues and performance for: There was ineffective oversight of incoming electronic mail. We looked at the system the practice had in place for the management of tasks and correspondence. There was a backlog of incoming clinical and non-clinical correspondence which required reconciliation. We were told and we found that there was a backlog of which dated back to 17 April 2023.
Family planning services	
Maternity and midwifery services	
Surgical procedures	
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

There was no effective system in place for medicines reviews. We found concerns that patients who received medicines were not reviewed in a timely manner and did not always receive regular monitoring in accordance with national guidance.

We looked at the system the practice had in place for the summarisation of patient notes and found there was a backlog of patient records that required summarisation.

The provider was not able to demonstrate it had adequate systems in place to monitor and ensure the safety of the premises at Caskgate Street Surgery in relation to the building, emergency medicines, legionella and fire safety.

There was oversight of non-medical prescribers or Additional Roles Reimbursement Scheme (ARRS) roles to ensure correct prescribing practices were in place

Patient Group Directions had not been signed and dated by the lead GP.

We found Lloyd George patient notes all over the ground and 1st floor of the building. They were on open wooden racks with no security from unauthorised access or reasonable protection from fire or flood.

Meeting minutes did not have set agendas and minutes were limited which meant that staff were not kept updated.

This was in breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Family planning services	Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment
Maternity and midwifery services	**How the regulation was not being met:**
Surgical procedures	The provider had not ensured that care and treatment is provided in a safe way. In particular;
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Enforcement actions

The system to ensure Medicines & Healthcare products Regulatory Agency (MHRA) and patient safety alerts were received and actioned appropriately was not effective.

Historic MHRA and patient safety alert searches were not carried out and reviewed to see if any new patients were affected (placed on medication after an alert has been issued).

The provider did not ensure there were effective arrangements in place for identifying, managing and mitigating risks. For example, people had not received appropriate physical health monitoring with appropriate follow-up in accordance with current national guidance.

There was no effective recall system in place to manage the healthcare needs of patients with long term conditions. We found patients who were prescribed 10 medicines or more that had not had a medication review in the last 18 months.

Leaders had not identified the need to have an effective process in place to ensure clinicians were reviewing patients' monitoring information prior to prescribing. For example, not all patients on high risk medicines whose records we looked at had received appropriate monitoring.

We found patients who were prescribed Methotrexate did not have instructions on what day of the week to take the medicine as per a MHRA safety alert in 2020.

In patient records we reviewed that was a lack of care plans in place

This was in breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.