Pacific House

Inspection report

Pacific House
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Eastbourne
BN23 6FA
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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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Overall summary

We carried out this announced, focused inspection of Pacific House (East Sussex Outpatient Services Ltd) in response to concerns about the safe care and treatment of patients and governance arrangements within the service. This report covers our findings in relation to those concerns. The service had not previously been inspected.

In the light of the COVID-19 pandemic, we undertook some of our inspection processes remotely and spent more focused time on site. We conducted staff interviews and our review of information remotely between 8 February and 18 February 2021 and conducted an on-site visit on 12 February 2021. The service was not rated as a result of this inspection.

Pacific House is the administrative and management base for services provided by East Sussex Outpatient Services Ltd. East Sussex Outpatient Services (ESOPS) is an independent provider of consultant-led NHS commissioned outpatient services. Clinical outpatient services are provided from a neighbouring host location at Harbour Medical Centre, 1 Pacific Drive, Eastbourne BN23 6DW. This location is not a registered location under ESOPS's registration with the Care Quality Commission (CQC).

At the time of announcement of our inspection the provider was registered to provide outpatient services from a second location, Anchor Healthcare Centre, Meridian Way, Peacehaven BN10 8NF. The provider told us that this location was no longer in use and immediately submitted an application to remove the location from their registration.

The service is registered with CQC to provide the following regulated activities: Treatment of disease, disorder or injury; Diagnostic and screening services. At the time of announcement of our inspection the provider told us they provided vasectomy services from the Anchor Healthcare Centre location. This service was temporarily closed in conjunction with cessation of services provided from Anchor Healthcare Centre. However, the provider was advised that they were required to be registered to provide the regulated activity surgical procedures, in order to provide vasectomy services.

The medical director is the registered manager. A registered manager is a person who is registered with CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Our key findings were:

- There was a lack of clear, established processes for reviewing patients who may be subject to delays in treatment.
- Systems for reporting and recording significant events had not been clearly established.
- Staff were not always clear who the safeguarding lead was and what procedures they would follow if they had a safeguarding concern.
- There was no audit of infection control processes and no oversight of an audit carried out by the host provider. The lead for infection prevention and control had not completed training to support the role.
- There were clear processes in place to minimise risks associated with Covid-19 with regard to screening patients attending for appointments. However, individual staff risk assessments and support arrangements associated with Covid-19 had not been documented.
- Processes for cleaning and decontamination of some devices were not adequately documented.
- There was a lack of training for administrative staff. Staff had not received training in many key areas. There was no verifiable monitoring of training undertaken by clinical staff employed on a sessional basis.
- There was a lack of performance review, clinical supervision and oversight of clinical staff employed on a sessional basis.
- There was a lack of clear processes for responding to verbal complaints which did not ensure these were recorded to assist with review, audit and learning.

Overall summary

- There was a lack of formal team meetings and a lack of clear processes for sharing information, guidance and learning with staff.
- Staff found leaders approachable and supportive and were keen to contribute to individual and organisational improvements.
- Newly developed policies were comprehensive and formed a good basis for future organisational improvement. However, their sharing with staff was premature due to inaccuracies and required revisions.
- There was a lack of governance and monitoring processes to provide assurance to leaders that premises they were leasing were safe and suitable for use.

We took enforcement action and issued warning notices against the provider in relation to Regulation 12(1) Safe care and treatment, Regulation 17(1)(2) Good governance and Regulation 18(1)(2) Staffing.

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

We are mindful of the impact of the Covid-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team comprised a CQC lead inspector, a second CQC inspector, a GP specialist advisor and a CQC national clinical advisor.

Background to Pacific House

Pacific House is the administrative and management base for services provided by East Sussex Outpatient Services. East Sussex Outpatient Services (ESOPS) is an independent provider of consultant-led NHS commissioned outpatient services. The Registered Provider is East Sussex Outpatient Services Ltd.

Services are provided from:

Pacific House, 1 Easter Island Place, Eastbourne, East Sussex, BN23 6FA.

Clinical outpatient services are provided from a neighbouring host location at:

Harbour Medical Centre, 1 Pacific Drive, Eastbourne BN23 6DW.

Opening times are Monday to Friday 9am to 5pm.

Services are provided by specialist consultants who are employed on a sessional basis to provide outpatient consultation and diagnostic services in a range of specialties which include, gynaecology, Ear, Nose and Throat (ENT), musculoskeletal (MSK), urology, colorectal, ophthalmology, gastroenterology and general surgery. Two nurses and a healthcare assistant provide support to those outpatient services. Services are managed by a team of five directors and an office manager, who are supported by administration and reception staff. Administration staff were located at both Pacific House and Harbour Medical Centre and some staff worked across both sites.

The service works closely with local referring GP services who refer patients for outpatient consultation, diagnostic and treatment services. Patients requiring treatment are referred onwards to local secondary care providers.

How we inspected this service

Prior to the inspection we reviewed a range of information that we hold about the service and gathered and reviewed information received from the provider.

During our inspection we:

- Spoke with a range of operational support staff, including the registered manager/medical director, the business and operations director, the office manager and administrators.
- Spoke with a nurse and one clinical consultant.
- Made observations of the internal and external areas of the main premises.
- Reviewed information the service used to deliver care and treatment.
- Reviewed documentation relating to the service, including policies and procedures.

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?

These questions formed the framework for the areas we looked at during the inspection

Inspected but not rated

Are services safe?

Risks to patients

There was a lack of systems in place to assess, monitor and manage risks to patient safety.

- We reviewed patient referral and tracking processes. Patient referrals were received electronically from referring GPs. Referrals were screened and triaged by the relevant ESOPS consultant and each patient priority level was determined. Patient progress through initial consultation, diagnostic investigations and referral to treatment, was monitored via the provider's electronic patient tracking list.

- We reviewed the clinical records of 20 patients via the provider's electronic patient tracking list and their patient clinical records system, EMIS. Our selection of records included two groups of patients: patients who were subject to 40-week and 52-week breaches following referral to treatment to secondary care providers, due to delays caused by Covid-19; patients whose treatment may have been affected by a sudden withdrawal of the provider's main endoscopy service provider.

- We found that the service did not have clear processes and guidance for staff to follow for reviewing patients who may be subject to delays in treatment. There was a lack of oversight, governance and leadership of risk assessment and patient review processes by ESOPS directors. A variety of administrative risk assessment processes had been undertaken and were still being developed at the time of our inspection, in order to assess and review the risks associated with delays to treatment for individual patients. The provider had recently been given notice of withdrawal of services by their main provider of endoscopy services. Their approach to addressing this risk and managing the endoscopy patient list effectively, was unclear.

- We reviewed patients who had been subject to a 52-week harm review in October 2020. These were patients whose wait for treatment, following referral to the service, had exceeded 52 weeks. We found that governance processes to ensure a full review of those patients were incomplete. Documents completed as part of the process indicated that each harm review and outcome should be 'signed off' by the medical director but these were incomplete. Some harm reviews had also not been signed or fully completed by the reviewing consultant. There was a lack of audit and monitoring processes to identify those errors. Staff told us that the 52-week harm review processes had been a trial suggested by a secondary care provider. They told us that they no longer used that process to assess risks associated with patient treatment delays.

- Staff told us that they had recently introduced a new process whereby all patients experiencing delays in treatment were subject to regular risk reviews by their referring consultant. Parts of this process were recorded within the provider's patient tracking list and some stages were not always captured within the patient's clinical record on EMIS, in a timely manner. We found that completeness of those processes could therefore not always be confirmed. ESOPS directors had not formally agreed or authorised this revised process and within discussions with inspectors, made suggestions for further amendments to the process. There was therefore no clear, current, documented process which detailed the provider's confirmed approach to reviewing the risks associated with individual patient delays in receiving treatment.

- We reviewed staff records and found that staff had received no training in health and safety or fire safety. Records confirmed that staff working at Pacific House had not participated in a fire drill since April 2019. There were no records to show that staff working at Harbour Medical Centre had participated in a fire drill. Some staff we spoke with had a poor understanding of fire evacuation procedures at Harbour Medical Centre, where services were provided from first floor rooms, and confirmed they had never participated in a fire drill.

Inspected but not rated

Are services safe?

- The provider had a chaperone policy in place dated November 2020 which confirmed that all staff who undertook a chaperone role must be trained in the role. Staff told us that nurses and healthcare assistants undertook chaperoning for intimate examinations. However, administration staff who were required to act as chaperones for non-intimate examinations had not received training to support the role. Managers told us that all administration staff had been subject to disclosure and barring service (DBS) checks and our review of staff records confirmed this.

- The provider had recently developed an infection prevention and control policy and other associated COVID-19 polices. These included a 'face to face consultation standard operating procedure' which gave clear guidance to staff on personal protective equipment (PPE) requirements, including those for staff involved in carrying out aerosol generating procedures. The provider had determined that some Ear, Nose and Throat (ENT) diagnostic procedures, such as nasolaryngoscopies, were aerosol generating. (A nasolaryngoscopy involves a thin flexible tube with a light and a camera at the end being passed through the nose to the back of the throat.) We found during our site visit that there were adequate supplies of personal protective equipment, including FFP3 masks, available to staff. (An FFP3 mask is a surgical mask affording the wearer high levels of protection and requiring individual face fit testing). Two rooms were available for each ENT clinic, to allow for cleaning and fallow time in between procedures, in line with the provider's policy. However, staff told us that ENT consultants were not supported by a nurse during their outpatient clinics and cleaning of the rooms in between patients was undertaken by administration staff. Those staff had received no training in infection prevention and control. At our site visit we found there were no cleaning logs or checklists in the consulting rooms to confirm what items staff should clean or if they had cleaned them. Staff involved in the cleaning confirmed that there were no records kept of the daily cleaning undertaken between patients.

- The provider had identified a lead for infection prevention and control. However, that staff member had not completed training at an appropriate level to support the role. The provider had not undertaken an audit of their infection prevention and control processes. They had no oversight of any infection prevention and control audit carried out by the host provider, Harbour Medical Centre, in relation to the rooms they leased for their outpatient services. Staff told us they intended to seek external support to implement an infection prevention and control audit and hand washing audit in the future. We were unable to see evidence of documented guidance for staff working at Harbour Medical Centre which reflected a joint approach to minimising Covid-19 and other risks of infection.

- The lead for infection control had developed processes for the weekly cleaning of ESOPS's equipment located within Harbour Medical Centre and we saw evidence of those cleaning records. However, processes for cleaning and decontamination of some devices were not adequately documented and there was no system of assurance to ensure that all staff were consistent in their approach to decontamination processes. For example, staff told us that ultrasound probe cleaning and disinfection processes were implemented in between patients. The service used some intracavity ultrasound probes which required high levels of disinfection. We were told that appropriate and effective systems for cleaning and disinfection were in place for those probes. However, there was a lack of recording specific to individual patients, probe identifiers and cleaning activities, in line with current guidance, to enable incident tracking to be undertaken if required. Staff were unclear on defined processes for decontamination in some specialty areas, where consultants worked without the assistance of nursing staff. There was a lack of documented processes and clinical oversight by directors with regard to approaches undertaken by individual consultants.

- The provider had developed clear processes for the triaging of patients in order to minimise risks associated with Covid-19. Patients were asked a series of questions at each stage of booking and attendance. Patients attending for appointments were asked to remain in their cars until telephoned by staff. They were then met at the entrance to the practice and underwent temperature checks and screening questions before entering.

Inspected but not rated

Are services safe?

- The provider had developed an overarching Covid-19 risk assessment dated July 2020 which identified some risks and mitigations in place in each area of service delivery. However, individual risk assessments which reflected the support needs of staff had not been documented. For example, we identified one clinician who had experienced some difficulties with the fitting of their FFP3 mask. They had used their own respirator closed helmet system for a period of time for some procedures. The provider confirmed that this had not been documented or subject to formal review.

Inspected but not rated

Are services effective?

Effective staffing

Staff did not have the skills, knowledge and experience to carry out their roles.

- We reviewed the training records available within the service and found that there was no clear plan of required training for staff. The provider told us that administrators had completed adult safeguarding training in April 2019. We reviewed staff files and found there was no evidence of that training and no other training had been recorded since that time. Following our inspection the provider sent us evidence of that safeguarding training which had been obtained from the trainer on 15 February 2021. Administration staff had not received training in key areas including but not limited to: infection control, fire safety, basic life support, health and safety, equality and diversity, mental capacity, confidentiality. Staff who were required to act as chaperones for non-intimate examinations had not received training to support the role. The lead staff member for infection prevention and control within the service had not completed training at an appropriate level to support their role. We reviewed a list of e-learning topics which the provider told us they intended to schedule for administration staff within 2021. We noted that this list included some but not all of the essential training listed within the provider's training policy developed in October 2020.

- We reviewed appraisal records for five out of ten administrators employed by the service. We found that all of those staff had undergone appraisal in December 2020. However, the appraisals did not refer to required training or include a training needs analysis or objective setting.

- Training completed by clinical consultant staff, who provided services to ESOPS on a sessional basis was not monitored or recorded. The medical director told us they confirmed verbally with each clinician on an annual basis, that all mandatory training had been completed externally. However, there was no verifiable monitoring of their training and no evidence gathered to confirm completion.

- Nursing staff employed on a sessional basis told us they were not subject to monitoring of their completed training and did not undergo appraisal or any form of clinical supervision within their ESOPS role.

Inspected but not rated

Are services well-led?

Governance arrangements

There was a lack of clear responsibilities, roles and systems of accountability to support good governance and management.

- The provider had recently commissioned an external provider to ensure that their policies and procedures were fit for purpose. A web-based suite of policies was developed between September 2020 and January 2021. At the time of our inspection, staff had access to those policies despite many not having been checked by directors for relevance and accuracy. The medical director told us that they were still working their way through their policy reading list. Staff told us that clinical consultants did not have access to ESOPS policies.

- We reviewed a wide range of the provider's policies and found they were comprehensive and formed a good basis for future organisational improvement. However, their sharing with staff was premature due to inaccuracies and required revisions. We noted that the policies did not always support protocols which staff were required to follow. For example, the safeguarding of vulnerable adults policy did not include reference to a separately stored algorithm which provided guidance and local authority contact details for staff needing to raise a safeguarding concern. We found the complaints policy did not include information to be provided to patients to inform them on how to make a complaint. Policies were not always accurate, for example one staff member was named as the infection prevention and control lead within the infection control policy which directors told us was incorrect; the training policy included a comprehensive list of required training which staff were required to complete but this did not reflect the list of training managers told us they planned to implement; some policies referred to home visits which the provider did not undertake.

Managing risks, issues and performance

There was a lack of clear and effective processes for managing risks, issues and performance.

- The provider told us prior to our inspection that they had recorded no complaints, significant events or safeguarding concerns within the last 12 months.

- We reviewed the provider's complaints log and found there were no complaints recorded between July 2019 and January 2021, when one complaint had been recorded. Staff told us that patients were informed that formal complaints must be put in writing to the medical director. They told us that if patients raised lower level complaints they were managed and resolved verbally without being entered onto the complaints log. We found there was a lack of clear processes for responding to those verbal complaints which did not ensure they were recorded in order to assist with review, audit and learning. The provider's complaints policy reflected this approach to, where possible, achieving a prompt, verbal resolution to lower level complaints and thus avoid the need for a formal written complaint. However, the policy stated that those verbal complaints should be reported, assessed and logged. Staff told us that some concerns raised by patients were recorded in clinical records which was contrary to accepted guidance.

- The provider had two significant event policies and three different forms for reporting significant events. We were unable to establish which form staff were expected to use to report an incident. Staff were unclear on what constituted a reportable incident. Staff told us they had never been made aware of the outcome of any incidents and had not been part of any discussions or meetings to promote shared learning when incidents had occurred. We reviewed the provider's incident log and found that there had been one incident recorded since July 2019. We asked the provider to confirm whether a recent whistleblowing concern and also the sudden withdrawal of ESOPS's main endoscopy provider would be classified as recordable incidents. They confirmed that both events should have been recorded as such but had been omitted in error.

Inspected but not rated

Are services well-led?

- We reviewed the provider's safeguarding policy which provided comprehensive safeguarding information. However, the policy did not include or provide reference to, a separately stored algorithm which provided guidance and local authority contact details for staff needing to raise a safeguarding concern. Some staff we spoke with were unclear who the provider safeguarding lead was and what procedures they would follow if they had a safeguarding concern. Clinical consultants confirmed they did not have access to the provider's policies. The provider told us that no safeguarding concerns had been raised. Patient clinical records were held within EMIS. However, as data sharing agreements with referring GP practices had not been initiated, staff were unable to access shared records and were unable to identified patients flagged as vulnerable within a GP practice record. Staff were able to flag a patient as vulnerable within their own records but no staff member we spoke with was able to give an example of when this had occurred.

- The provider confirmed there had been no formal meetings or documented minutes of meetings within the last 12 months. There were no arrangements in place to review incidents, complaints or safeguarding concerns as a team nor to disseminate learning or actions taken. Staff told us that communications from ESOPS leaders were generally verbal or via email.

- There was no verifiable monitoring of training undertaken by clinical staff employed on a sessional basis. The medical director told us they confirmed verbally with each clinician on an annual basis, that all mandatory training had been completed externally. We reviewed the provider's records and found that this was recorded as a 'yes' noted against the clinician's name each year, with no detail provided. This annual verbal review with the medical director also included a similar 'yes' noted on the record, as a confirmation of completion of the consultant's external performance appraisal but there was no oversight of the outcome of that appraisal. There was no formal appraisal or documented review of each clinician undertaken by the provider.

- Nursing staff employed on a sessional basis were not subject to monitoring of their completed training and did not undergo appraisal or any form of clinical supervision within their ESOPS role.

- The provider leased a suite of rooms within Harbour Medical Centre for the purposes of providing services to patients. They told us that they sought verbal assurances from the practice manager of Harbour Medical Centre with regard to safety, maintenance and premises checks of those areas. However, we were unable to see evidence of clear governance processes which would enable ESOPS managers to assure themselves that the premises they were leasing were safe and suitable for use. We reviewed some records held by the provider in relation to Harbour Medical Centre which included a copy of the fire policy and a fire alarm testing record. A copy of a legionella risk assessment, dated October 2019, highlighted a number of required remedial actions which at the time of our inspection, the provider had taken no steps to assure themselves had been remedied.

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.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was unable to demonstrate that systems and processes were in place 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. The provider was unable to demonstrate that systems and processes were implemented effectively to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. In particular: • Systems for reporting and recording significant events had not been clearly established. • Staff were not always clear who the safeguarding lead was and what procedures they would follow if they had a safeguarding concern. • There was a lack of performance review, clinical supervision and oversight of clinical staff employed on a sessional basis. • There was a lack of clear processes for responding to verbal complaints which did not ensure these were recorded to assist with review, audit and learning. • There was a lack of formal team meetings and a lack of clear processes for sharing information, guidance and learning with staff. • Service policies had not been adequately reviewed to ensure they provided accurate and relevant guidance to staff. • There was a lack of governance and monitoring processes to provide assurance to leaders that premises they were leasing were safe and suitable for use.

This section is primarily information for the provider

Enforcement actions

This was in breach of regulation 17(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Warning Notice issued.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had failed to ensure that persons employed in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular: • There was no clear plan of required training for staff. • Administration staff had not received training in key areas including but not limited to: infection control, fire safety, basic life support, health and safety, equality and diversity, mental capacity, confidentiality. • The lead for infection prevention and control had not completed training to support the role. • Administration staff who were required to act as chaperones for non-intimate examinations had not received training to support the role. This was in breach of regulation 18 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Warning Notice issued.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was unable to demonstrate effective systems or processes to assess the risk of, and prevent, detect and control the spread of, infections, including those that are health care associated. In particular:

This section is primarily information for the provider

Enforcement actions

• There was no audit of infection control processes and no oversight of an audit carried out by the host provider.

• Processes for cleaning and decontamination of some devices were not adequately documented.

• There were no cleaning logs or checklists in the consulting rooms and no records kept of the daily cleaning undertaken between patients.

• There was a lack of documented guidance for staff working at the host location which reflected a joint approach to minimising infection risks.

• Individual Covid-19 risk assessments which reflected the support needs of staff had not been documented.

The provider had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:

• There was a lack of clear, established processes for reviewing patients who may be subject to delays in treatment.

• Staff had received no training in health and safety or fire safety and had not recently participated in a fire drill.

This was in breach of regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Warning Notice issued.