

Buxted Medical Centre

Quality Report

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East Sussex
TN22 5FD

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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 safe?

Requires improvement



Key findings

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Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Buxted Medical Centre on 10 February 2015. The overall rating for the practice was good but was rated as requires improvement in the safe domain. Following this we undertook a desktop review in 1 July 2016 to confirm that the provider now met all the regulatory requirements. On this occasion the practice was found to be good overall and in all domains. The full comprehensive report on the February 2015 inspection and the July 2016 desktop review can be found by selecting the 'all reports' link for Buxted Medical Centre on our website at www.cqc.org.uk.

This inspection was an unannounced focused inspection carried out on 7 March 2018 in response to information we had received in respect of procedures relating to the timely review and response of clinicians to test results and to correspondence received by the practice. The information alleged that a large backlog of both test results and letters had built up in the past. We carried out an unannounced focused inspection to ensure that systems currently in place to deal with test results and correspondence were working in a way that kept patients safe and were being employed in a timely manner. This report covers our findings in relation to those questions.

Our key findings were as follows:

- Test results and correspondence received electronically were managed appropriately and within expected time frames that kept patients safe.

- There were systems in place which allowed designated staff to identify urgent paper correspondence and forward it to a clinician for action. However we identified an instance when this had failed to work correctly.
- There was a backlog of approximately 25 working days of paper correspondence waiting to be scanned in to the electronic notes.
- Clinicians did not always have all the most recent information available to them at the time of a consultation.

There were areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Additionally the provider should:

- Consider reviewing their workflow systems and protocols to assess which correspondence requires review by a clinician and the time frames in which that should occur.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Buxted Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our team consisted of a CQC lead inspector and second inspector and a GP Specialist Advisor.

Background to Buxted Medical Centre

Buxted Medical Centre is a semi-rural practice which offers general medical services. The practice has a smaller branch surgery (East Hoathly Medical Centre) which was not inspected. The practice is involved in the education and training of doctors and is also able to dispense medicines to its patients. There are approximately 10,750 registered patients.

The practice is run by three partner GPs (two female, one male) who are supported by seven salaried GPs (four female, three male) and three trainee GPs (Registrars). The practice also has an advanced nurse practitioner, five practice nurses, three healthcare assistants, a phlebotomist, a team of receptionists and administrative staff and a practice manager.

The practice runs a number of services for its patients including asthma clinics, child immunisation clinics, diabetes clinics, new patient checks and travel vaccinations and advice.

Services are provided from two locations:

Buxted Medical Centre, Framfield Road, Buxted, Uckfield, East Sussex, TN22 5FD

East Hoathly Medical Centre, Juziers Drive, East Hoathly, BN8 6AE

There are arrangements for patients to access care from an Out of Hours provider through NHS 111.

The practice population has a higher number of patients between 45 and 85 years of age than the national and local Clinical Commissioning Group (CCG) average, with a significant higher proportion of 65-69 year olds and over 85 year olds than the national average. There are a higher number of patients with a long standing health condition and patients within nursing homes. The percentage of registered patients suffering deprivation (affecting both adults and children) is significantly lower than the average for England.

Why we carried out this inspection

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Detailed findings

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Are services safe?

Our findings

The practice is rated as being requires improvement for providing safe services.

Information to deliver safe care and treatment

Staff did not always have the information they needed to deliver safe care and treatment to patients.

The practice received the majority of its test results from a local District General Hospital electronically. Although each clinician had responsibility for reviewing and actioning any tests that they had ordered, one of the partners had oversight of all results and ensured that they were checked and actioned on a regular basis. We looked in detail at the results currently awaiting action or filing on the practice computer system and found that action had been taken within appropriate time frames to keep patients safe.

We also reviewed the systems for dealing with electronic communications from hospitals and other external agencies. Each GP had their own inbox for incoming documents, but again one GP did have oversight of the whole system although at the time of inspection the system had just been upgraded and their overall access was temporarily limited. We found that there was no significant backlog in reviewing and actioning of the electronic communications coming in to the practice and that action had been taken within appropriate time frames to keep patients safe.

There was a system in place for the receiving, distributing, actioning and scanning of paper communications coming in to the practice. Requests for private reports were logged in a book and retained for a designated GP to complete. Once completed they were logged and scanned in to the

computer system. General paper communications were taken by scanning staff and distributed according to guidance outlined in a workflow guidance document. Clinical letters were distributed to the appropriate GP and urgent letters passed to the duty GP. If action was required this was carried out and then the letters were returned to the pile to wait scanning in to the patients' electronic notes. Communications not requiring clinical input were put straight in to the pile to wait scanning in to patients' electronic notes.

We did however see that there was a significant backlog of paper communications some of which dated back to 1 February 2018 (approximately 25 working days) awaiting scanning in to patient notes. Most, but not all had been date stamped. We also looked at ten letters chosen from the pile awaiting scanning that contained clinical information that may have been useful to a clinician during a consultation. None of the letters were in the patients' electronic notes. Of these, two patients had been seen at the practice since being seen in an external clinic and the appropriate adjustments in medications mentioned in the letters had been made. Another two patients had been seen at the practice since their external clinic appointment without the letter from the clinic being available in the notes. We also found one letter awaiting scanning date stamped 9 February 2018 which had not been seen by a clinician and was flagging up a safeguarding concern for the practices' information.

Clinical staff told us that they were unaware that the backlog was so long. We were also told by staff that there was the potential for the distribution of workflow to be circumvented if staff placed documents directly on the scanning pile without handing them to a member of the scanning team first.

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 17 HSCA (RA) Regulations 2014 Good governance
Family planning services	Regulation 17 HSCA (RA) Regulations 2014 Regulation: Good governance
Maternity and midwifery services	How the regulation was not being met: The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to ensure that accurate, complete and contemporaneous records were being maintained securely in respect of each service user. In particular: there was a backlog of paper correspondence that had not been digitised in to the electronic records. This meant that they could not ensure that the most recent information in respect to the service user was always available to staff.
Surgical procedures	This was in breach of Regulation 17(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Treatment of disease, disorder or injury	