Dr Stephen Hilton

Quality Report

7 Elvaston Road
Ryton
Tyne and Wear
NE40 3NT
Tel: 0191 413 3459
Website: www.elvastonroadsurgery.nhs.uk

Date of inspection visit: 7 December 2015
Date of publication: 10/03/2016

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	Requires improvement
Are services safe?	**Inadequate**
Are services well-led?	**Requires improvement**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection of this practice on 15 January 2015. Breaches of legal requirements were found. Although the provider did not submit an action plan following the publication of our report of that inspection, they did tell us about the improvements they intended to make to address the breaches of legal requirements, as set out in the Health and Social Care Act (HSCA) 2008. The provider did give us an action plan during our follow up focused inspection on 07 December 2015.

The breaches we identified when we carried out the inspection on 15 January 2015 were in relation to:

- Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control (which corresponds to Regulation 12 (2) (h) of the HSCA 2008 (Regulated Activities) Regulations 2014);
- Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines (which corresponds to Regulation 12 (f) & (g) of the HSCA 2008 (Regulated Activities) Regulations 2014.)

We undertook this focused inspection on 7 December 2015 to check whether the provider had taken steps to comply with the above legal requirements. This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Dr Stephen Hilton on our website at www.cqc.org.uk.

Our key findings were as follows:

- Improvements to patient safety had been made following our last inspection on 15 January 2015. For example, action had been taken to improve the arrangements for assessing the risk of, and controlling and preventing the spread of infection. Suitable arrangements had been made for the safe handling of prescriptions. There was a more effective system for monitoring vaccine expiry dates and we found that vaccines held at the practice were all within their expiry dates. The provider had carried out a comprehensive review of the practice's Legionella risk assessment. A business continuity plan had been prepared and staff had been provided with access to a child protection policy.
- However, we identified further concerns that some of the arrangements for protecting patients against the

Summary of findings

risk of receiving ineffective vaccines were not always reliable or effective. For example, the arrangements for protecting vaccines requiring refrigeration during transportation and storage off site were not adequate. Ineffective arrangements had been made to carry out daily temperature checks of the vaccines stored at the practice.

The areas where the provider must make improvements are:

- Improve the arrangements for the storage and handling of vaccines, and ensure that national guidelines are fully implemented.

The areas where the provider should make improvements are:

- Make improvements to the quality of minute taking of meetings held within the practice.
- Consider using a second thermometer to check the accuracy of the temperature readings displayed on the thermometer installed in the dispensary refrigerator. The provider should also arrange for annual calibration checks to be carried out of the thermometers installed in the practice's refrigerator.
- Develop an adult safeguarding policy.
- Carry out a risk assessment to determine how often electrical equipment used at the practice should be checked for safety.
- The practice's designated infection control lead should complete more advanced training to enable them to carry out this role more effectively.

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 safe?

Inadequate

The practice is rated as inadequate for providing safe services.

We found that medicine management systems and practices were not always reliable or effective, and this placed patients at risk of receiving unsafe care. Following our last inspection, we found the provider had made improvements to address the concerns that had led us to issue two requirement notices. Suitable arrangements had been made to ensure the safe handling of prescriptions. A more effective system for monitoring vaccine expiry dates had been put in place and we found that vaccines held at the practice were all within their expiry dates. However, we identified further concerns that some of the arrangements for protecting patients against the risk of receiving ineffective vaccines were not always reliable or effective. For example, the arrangements for protecting vaccines requiring refrigeration during transportation and storage off site were not adequate. Ineffective arrangements had been made to carry out daily temperature checks of the vaccines stored at the practice. These failures placed patients at risk of being given ineffective vaccines. We found action had been taken to improve the arrangements for assessing the risk of, and controlling and preventing the spread of infection

The provider had taken action to make improvements to patient safety which we said should be made following our last inspection. These improvements included: making oxygen available on the premises for use in an emergency; providing staff with access to a business continuity plan and a child protection policy; and carrying out a comprehensive review of the provider's Legionella risk assessment. However, we identified other areas in which action could be taken to further improve the safety of patients and staff. For example, we found that staff did not have access to an adult safeguarding policy.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well led services.

The arrangements for governance were not always effective, and improvements required were not always actioned promptly. For example, shortfalls in the monitoring of the daily temperatures of vaccines, and the recording of these temperatures, had not been identified and addressed. This had placed patients at risk of receiving ineffective vaccines. The provider had also failed to take prompt action to address some of the concerns we referred to in the

Summary of findings

report of our last inspection. For example, action was only taken to review the practice's Legionella risk assessment, and obtain a Disclosure and Barring Service check for a member of the clinical team, when we notified staff of our forthcoming follow up inspection.

Summary of findings

What people who use the service say

We did not speak to any patients during this focused inspection. However, as part of our inspection we asked practice staff to invite patients to complete Care Quality Commission (CQC) comment cards. We received 16 completed comment cards, all of which were positive about the standard of care and treatment provided by Dr Stephen Hilton and his team. Words used to describe the service included: more than helpful; always respond with care and the right treatment; staff are always polite, discreet and informative; a first class surgery; the doctors really listen to what you have to say; helpful, professional and so very friendly. None of the patients who completed comment cards raised any concerns about the care and treatment they received at the practice.

Areas for improvement

Action the service MUST take to improve

- Improve the arrangements for the storage and handling of vaccines, and ensure that national guidelines are fully implemented.

Action the service SHOULD take to improve

- Make improvements to the quality of minute taking of meetings held within the practice.
- Consider using a second thermometer to check the accuracy of the temperature readings displayed on the thermometer installed in the dispensary refrigerator. The provider should also arrange for annual calibration checks to be carried out of the thermometers installed in the practice's refrigerator.
- Develop an adult safeguarding policy.
- Carry out a risk assessment to determine how often electrical equipment used at the practice should be checked for safety.
- The practice's designated infection control lead should complete more advanced training to enable them to carry out this role more effectively.

Dr Stephen Hilton

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and a GP.

Background to Dr Stephen Hilton

Dr Stephen Hilton is registered with the Care Quality Commission to provide primary care services. The practice provides services to approximately 2,291 patients from one location and we visited this as part of the inspection:

- 7 Elvaston Road, Ryton Village, Tyne and Wear, NE40 3NT.

Dr Stephen Hilton is a small practice providing care and treatment to patients of all ages, based on a General Medical Services (GMS) contract. The practice is situated in the Ryton area of Gateshead and is part of the NHS Newcastle Gateshead clinical commissioning group (CCG.) The health of people who live in Gateshead is generally worse than the England average. Deprivation is higher than average and life expectancy for both men and women is lower than the England average.

Dr Stephen Hilton is located in an adapted residential building and provides patients with accessible treatment and consultation rooms on the ground floor. There is no lift to the first floor, so only mobile patients can access this area of the practice. The practice provides a range of services and clinics including services for patients with asthma and heart disease. The team consists of a single GP provider (male) and a salaried GP (female), a practice manager, a practice nurse, a healthcare assistant, and a small team of administrative and reception staff.

The practice is open: Monday, Wednesday and Friday between 9am and 12pm and 2pm and 6pm; Tuesday between 9am and 12pm and 1:30pm and 7pm and Thursday between 9am and 12pm.

Appointment times were as follows:

Monday: 9am to 11am and 3pm to 5pm (two GPs).

Tuesday: 9am to 11am (two GPs) and 5pm to 7pm (one GP).

Wednesday: 9am to 11am (two GPs) and 2:30pm to 4:30pm (one GP).

Thursday: 9am to 10:30am (one GP).

Friday: 9am to 11am and 3pm to 5pm (one GP).

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Northern Doctors Urgent Care Limited (NDUC).

Why we carried out this inspection

We undertook an announced focused follow up inspection of Dr Stephen Hilton on 7 December 2015. This inspection was carried out to check whether the provider had taken the action they said they would take to address shortfalls in relation to legal requirements which had been identified during our comprehensive inspection on 15 January 2015. We inspected the practice against two of the five questions we ask about services: is the service safe; and is the service well-led. This is because the service was not meeting some legal requirements relating to safety and governance at the time of the previous inspection.

Detailed findings

How we carried out this inspection

We carried out an announced visit on 7 December 2015. We spoke with, and interviewed, the practice manager. We also spoke with the GP provider during and shortly after the inspection. We looked at a sample of records the practice maintained in relation to the provision of services.

Inadequate

Are services safe?

Our findings

Overview of safety systems and processes

When we last inspected the practice, in January 2015, we identified that some aspects of medicines management were not safe. We also found that the practice's infection control arrangements were not fully effective. In particular, we identified that:

- Patients had not been fully protected against the risk of acquiring infections because effective infection control systems had not been put in place.
- Blank prescription forms were not handled in accordance with NHS Protect guidance.
- The arrangements for maintaining the 'cold-chain' for vaccines transported a short distance from the practice to a local church on annual 'influenza days' were not effective.
- The arrangements for monitoring the expiry dates of vaccines held at the practice were not effective.

We also informed the provider that they should:

- Carry out regular reviews of the practice's Legionella risk assessment.
- Prepare a business continuity plan and make this accessible to all staff.
- Carry out a risk assessment to determine which emergency drugs, including oxygen, were required by the practice.

In addition, we identified that a Disclosure and Barring Service (DBS) check had not been obtained for a member of the clinical team. The practice manager told us that a DBS check would be obtained without delay for this member of staff. In our report of the inspection, we also noted that staff did not keep minutes of the daily lunch time meetings they held.

During this focused inspection, carried out on 7 December 2015, we found :

- Staff had carried out an infection control audit shortly after our inspection in January 2015. They had devised an action plan to address the shortfalls they identified and had taken steps to address them. For example, at the time of the last inspection, the practice did not have a cleaning schedule for domestic staff to follow. We were told this had been put in place following the audit. The practice had also purchased specialist packs to deal with any potentially hazardous spills. This meant the provider had complied fully with the requirement notice we set following our inspection in January 2015.
- During this inspection, we found the designated infection control lead had not completed the advanced training that would help them to carry out this role more effectively. The practice manager confirmed shortly after our inspection that they had taken steps to make sure that this member of staff received this advanced training.
- Blank prescription forms were handled in line with national guidance. A system had been put in place which ensured that records were kept of the serial numbers of prescription pads and prescription boxes received into the practice and of when blank prescriptions were issued to the GPs. However, the name of the GP receiving the blank prescriptions was not recorded. The practice manager told us they would do this. This meant the provider had complied fully with this part of the requirement notice we set following our inspection in January 2015.
- The provider had not complied fully with national guidance regarding the transportation and storage of vaccines off site. There was evidence that the provider had taken some steps to improve the arrangements for transporting and storing the vaccines they needed to administer during the practice's recent annual 'influenza day'. Staff had also purchased a thermometer to help them monitor the temperature of the cool box. We saw staff had kept a log of the hourly temperature checks they had carried out on the domestic cool box used to transport and store the vaccines. The log showed the temperature of the cool box had been maintained between +2°C to and +8°C.

  However, we also identified some other concerns. The practice manager told us the domestic cool box that had been used to transport and store the vaccines during the 'influenza day' was a domestic one and not a validated medical grade cool box. Also, staff had not carried out a check of the maximum/minimum temperature of the domestic cool box in line with national guidance. The failure to comply with the national guidance regarding how vaccines should be

transported and stored off site placed patients who attended the 'influenza day' at risk of receiving potentially ineffective vaccines. This meant the provider had not complied fully with this part of the requirement notice we set following our inspection in January 2015.

- There was an effective system for monitoring the expiry dates of vaccines held at the practice. We checked a sample of the vaccines held in both of the refrigerators used to store them and found they were all within their expiry dates. This meant the registered provider had complied fully with this part of the requirement notice we set following our inspection in January 2015.

  However, we identified a number of additional concerns which indicated that the arrangements for handling and storing vaccines at the practice were not fully satisfactory. During the period from 1 July to 4 December 2015 daily temperature checks of the practice's large vaccine refrigerator had not been recorded correctly in the log book being used for this purpose. Instead of recording that the 'actual temperature' at the time of the checks was 5°C they were recording that it was '0.5'. The inaccurate temperature readings meant that the records in the log book indicated the temperature of the refrigerator was consistently below the minimum temperature of +2°C, as specified in the national guidance on the storing and handling of vaccines. When we raised this concern with the practice manager, they decided not to allow the administration of any further vaccines until they could assure themselves that vaccines were being stored between +2°C and +8°C. The practice manager explained that staff had been recording the temperature as '0.5' but should have been recording it as '05', as displayed on the digital temperature gauge of the large vaccine refrigerator.

  Whilst the inspection was underway, the practice manager contacted the manufacturer of the large vaccine refrigerator to confirm whether, if the digital temperature gauge indicated '05', this equated to 5°C. Staff later received an email from the manufacturer confirming this was the case. This confirmation was made available to us.

  We also found that, when daily temperature checks of the large vaccine refrigerator had been carried out, these checks had consistently recorded that the maximum and minimum temperatures were either '0.2' to '0.5' or '0.2' to '0.8'. The practice manager told us that this part of the log book had not been completed correctly. They said the actual maximum and minimum temperatures displayed on the digital thermometer gauge of the large vaccine refrigerator were not recorded at the time of the check. Instead staff had been recording what they had been told was the temperature range within which vaccines had to be stored.We looked at the records that had been kept of the daily temperature checks that staff had undertaken of the large vaccine refrigerator. The log book covered the period from 1 July 2015 to 7 December 2015. We saw that daily checks had usually been carried out when the practice was open, but there were exceptions to this. Daily temperature checks had not been carried out on 1, 2, 3, 4, 7, 8, 9 and 10 September 2015. The practice manager told us this was because the member of staff responsible for carrying out these checks was on holiday at the time. In addition, daily temperature checks had not always been carried out each Wednesday during the period the log book covered. The practice manager said this was because the member of staff was not at work on the Wednesdays concerned. The practice manager also confirmed that there were no arrangements in place for another member of staff to carry out these checks out, when the person usually responsible for doing them was on holiday or not at work.

- Arrangements had not been made to carry out periodic checks of the internal thermometers in both vaccine refrigerators, to ensure they were working correctly. The practice manager told us both vaccine refrigerators were purchased in 2006, and that since then, arrangements had not been put in place to calibrate the internal digital thermometers to make sure they were accurate. Failure to make sure that the calibration of the internal thermometers was accurate placed patients at risk of receiving potentially ineffective vaccines. The practice manager took immediate action to address this concern, and arranged for calibration checks to be carried out. In addition, an electrical safety check of the practice's vaccine refrigerators had not been carried out. The practice manager took immediate action following the inspection to arrange for a check of all electrical equipment used at the practice to undergo a safety test. We have since received confirmation that all of these checks have been completed.

Inadequate

Are services safe?

- Staff did not have written guidance regarding the checks that must be carried out to ensure that vaccines are stored correctly, or on how to ensure the safe transportation and storage of vaccines off site. The lack of clear written guidance to staff had increased the risk that patients might potentially receive ineffective vaccines. There was guidance about how to carry out daily temperature checks of the vaccines held by the practice. We saw that guidance in the form of a poster had been placed on the side of the large vaccine refrigerator. This poster had been produced by an external agency.
- The practice had developed a business continuity plan which provided guidance to staff about the steps they should take to ensure patients continued to receive a service in the event of an emergency.
- The GP team had considered what emergency medicines they needed to hold at the practice in case of an emergency, and for use in acute situations when carrying out routine home visits. Following our focused inspection, the provider forwarded to us a copy of the risk assessment they had completed which demonstrated how they had reached the decisions they had made about what emergency medicines to hold.
- Action had been taken to provide staff with a written policy setting out what they should do to protect children from neglect and abuse. However, although the provider had set up a file for staff which contained up-to-date national and local safeguarding information, the practice did not have their own adult safeguarding policy.
- An independent contractor had recently carried out a full Legionella risk assessment of the practice, and the provider was waiting for the report to be sent to them. (Legionella is a bacteria which can increase the risk of contracting Legionnaires' disease.) The practice manager told us no significant concerns had been identified. However, this had only been carried out following our pre-inspection notification telephone call to the practice.
- The practice manager had only recorded brief minutes of the daily lunch time staff meetings when they judged a summary of the discussion was required. Apart from these, and the minutes of the three monthly multi-disciplinary meetings held at the practice, no other records were kept of any meetings held between staff. We recognise that this is a very small practice, where the staff work together very closely every day. However, keeping minutes of staff meetings means that there is a record of any discussions, and of how decisions are made, why and by whom. We shared this feedback with the practice manager who responded positively and agreed to look at how they could make improvements.
- The provider had not taken prompt steps to obtain a DBS check for a member of the clinical team. However, an application had been made to obtain a DBS check for this member of staff shortly before we carried out this inspection. We saw evidence confirming this. The provider has since provided evidence confirming that a DBS has now been obtained.

Are services well-led?

Requires improvement

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

Our findings

Governance arrangements

When we last inspected the practice in January 2015, we found that the practice's governance arrangements did not always operate effectively. During this inspection, carried out on 7 December 2015, we found evidence that prompt steps had been taken to address some of the concerns we identified during our previous visit. For example, the provider had prepared a business continuity plan which provided guidance to staff regarding what they should do to ensure patients continued to receive a service in the event of an emergency. The provider had also taken action to strengthen their governance arrangements for preventing and controlling the spread of infection. However, with regards to some of the other concerns we identified in January 2015, we found that action to address these had only taken place when we notified the provider of the date of our follow up inspection. Also, the lack of effective governance in relation to the management of vaccines meant that shortfalls in relation to the monitoring and recording of the daily temperatures had not been identified and addressed.

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 Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have appropriate arrangements for the storage and handling of vaccines to minimise the risk of compromising the effectiveness of vaccines given to patients. **Regulation 12 (1) (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**