Sutherland Lodge Surgery

Quality Report

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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.

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced, comprehensive inspection of Sutherland Lodge on 7 December 2017. At this inspection, we found a number of areas of serious concern relating to risk management and patient safety. We spoke with the provider about our findings and asked them to send us an action plan to assure us that the areas of high risk that we found on inspection were being managed effectively and the risks to patients reduced.

As a result of the action plan sent to us on 22 December 2017, we found that the provider had identified measures to reduce the risks to patients.

We then carried out an unannounced focused inspection on 10 January 2018 to check whether the service had implemented their action plan effectively and made sufficient progress to reduce the risk to patients, since the last inspection on 7 December 2017 and to enable us to assess the level of enforcement action we needed to take. This report covers our findings.

The practice was not rated as part of this inspection and we only looked at areas where risk was assessed as high, as a result of the last inspection.

Our key findings were as follows:

Summary of findings

- Not all clinical staff had received safeguarding training at a level required for their role.
- There was an effective system to manage infection prevention and control.
- Letters from secondary care were acted on in a timely manner.
- Medicines are being stored safely in accordance with manufacturer's instructions.
- Staffing levels and skill mix had been reviewed; however staffing levels and skill mix did not compare with the planned levels identified by the provider.
- An audit had been completed on medicines that were known to be open to misuse. A protocol to assist GPs in reviewing patients on these medicines had been implemented.
- The practice had acted on the fire risk assessment recommendations.
- The practice had reviewed some significant events, however actions and lessons learnt were not being cascaded to all staff.
- Patients continued to have trouble in accessing the practice and receiving urgent clinical advice.
- There was a lack of systems to identify, escalate and action clinical risk. This included ill children and those who were seriously unwell.
- Patients who made a complaint were receiving a timely response.
- There remained a lack of oversight of clinical performance and some risks were not identified or managed effectively.
- Medicines audits had been completed although there had been no clinical audits scheduled for the next 12 months.
- Audits and processes were in place to monitor patients on high-risk medicines.
- Information cascades were not effective. Not all staff attended practice meetings or received minutes of these.
- Procedures in relation to patient medicine alerts had been reviewed, and appropriate action taken to ensure patients were safe.
- The practice had not implemented their own action plan within the timescales they identified in their action plan.

We were satisfied that the findings at this inspection reduced the risk to patients to a level where significant enforcement action was not required. The provider was continuing to make improvements as identified in their action plan.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Sutherland Lodge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP specialist adviser.

Background to Sutherland Lodge Surgery

- Sutherland lodge is a GP practice located in Chelmsford and is part of the Mid Essex Clinical Commissioning Group.
- Services are provided from: 113-115 Baddow Road, Chelmsford, Essex, CM2 7PY
- Online services can be accessed from the practice website: sutherlandlodgesurgery.co.uk
- Sutherland Lodge Surgery is managed by the provider organisation Virgin Care Services Limited. The company took over the contract to provide NHS primary care services at Sutherland Lodge on 1 July 2016. The company manages 19 GP practices across the country.
- The practice provides primary medical services to approximately 11,000.
- The practice has a slightly higher elderly population than the national averages with 32% of the practice list aged over 65 years compared to the national average of 27%.
- The practices population is in the fourth decile for deprivation, which is on a scale of one to ten. The lower the decile the more deprived an area is compared to the national average.
- Ethnicity based on demographics collected in the 2011 census shows the patient population is predominantly white British with; 1.8% mixed, 3.4% Asian, 1.4% black.

Why we carried out this inspection

We undertook a comprehensive inspection of Sutherland Lodge on 7 December 2017 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We undertook an unannounced follow up focused inspection on 10 January 2018. This inspection was carried out to review in detail the actions taken by the service to improve the quality of care and to confirm that the service was now operating safely.

Are services safe?

Our findings

At our inspection on 10 January 2018, we found that some improvements had been made to reduce the risks to patients but further progress was required in order to be compliant with the regulations.

Safety systems and processes

At our previous inspection, we found that equipment and medicines were not always in date or stored at the correct temperature. Safeguarding systems, processes and practices were not effective or implemented according to guidance. Some clinical staff had not received the recommended level of safeguarding training.

The system to manage significant events and patient safety risks was not effective. Requirements relating to the prevention and control of infection were not being met.

There were not enough clinical staff to keep patients safe. Information from secondary care and pathology results were not being managed. Patients who took high-risk medicines were not being reviewed to ensure their medicines were being prescribed safely. There was no system to ensure patient safety and medicine alerts were acted on.

The practice had failed to undertake recommended actions from an external company's fire risk assessment within the timeframes specified by this risk assessment. Some actions had a priority rating and a deadline of completion. The practice had completed most of these actions but not within the recommended timeframes. Some actions remained to be completed.

The practice had not acted upon the need to identify a fire marshal for the building and to provide training to all staff in fire safety. The risk assessment stated this was to be done as a priority and highlighted that a lack of staff knowledge of fire safety would be putting staff and patients at potential risk. The practice had not been completing fire evacuation drills as per their policy.

There had been improvements when we completed an unannounced focused follow up inspection on 10 January 2018.

- The practice continued to lack clear systems to keep patients safe and safeguarded from abuse. Whilst staff demonstrated knowledge of how to identify and report safeguarding concerns, not all staff, including GPs had received up-to-date safeguarding training at a level suitable for their role. The practice had not made it a priority to ensure training was undertaken as soon as possible.
- Patients on medicine that required monitoring were identified and sent appropriate test requests to ensure they were not at risk of developing side effects.
- Staffing levels and skill mix had been reviewed to ensure patients received safe care and treatment; however, on the day of the inspection staffing levels and skill mix did not compare with the planned levels previously identified. The provider told us they were continuing to review staffing levels.
- System to highlight vulnerable patients on records, such as children on child protection plans, looked after children, patients diagnosed with mental health had not been highlighted as vulnerable on the practice system.
- Effective standards of cleanliness and hygiene were maintained. There were reliable systems in place to prevent and protect people from a healthcare-associated infection.
- We reviewed the fire risk assessment, and the practices progress on the outstanding actions. The practice provided evidence that identified how they were able to complete all actions identified from the fire risk assessment.
- All staff had received fire safety awareness training. Fire marshals had been appointed for the practice and received additional training for this role.
- All staff spoken to on the day of the inspection demonstrated a clear understanding of what their roles and responsibilities would be in the event of a fire. They were able to provide the names of the newly appointed fire wardens.

Risks to patients

At our previous inspection, we identified that information received by the practice from secondary care was not being acted on in a timely way as there were 343 letters waiting to be actioned by clinicians. These letters included changes in medicines, requests to refer to different specialists and blood monitoring requirements.

The practice frequently relied on locum GPs. Despite their irregular working patterns, administrative staff continued to allocate tasks to them to complete, even though they

may not be back in the practice for some time. There were 108 pathology results and 32 of them required clinical attention and further contact with the patients concerned. These had not been actioned in a timely manner.

There had been improvements when we completed an unannounced focused follow up inspection on 10 January 2018.

- We saw there was a reduction in the number of outstanding letters to be reviewed. At the first inspection there were 343 outstanding letters; at this inspection there were 99 letters that were actioned by the end of the inspection. However, there remained no clinical oversight and letters were not being actioned in a timely manner. For example, a letter received in the practice on 17 November 2017 was scanned into the system on 6 December 2017 only allocated to be processed on 10 January 2018. That represented a delay of over seven weeks. A letter received on 12 December was scanned into the clinical system on 22 December. This letter was from a children's consultant requesting the practice continue with a certain medicine. We reviewed their notes and saw the medicine had stopped being prescribed.
- We saw from the outstanding task list that GPs who did not work frequently at the practice, had outstanding requests allocated to them. For example, one GP who was not allocated any sessions for the next two months had two outstanding tasks allocated to them from 27 December 2017. There was no process to oversee outstanding tasks.

Safe and appropriate use of medicines

At our previous inspection, we found that the service did not always follow national guidelines for the storage of medicines. For example; we viewed the daily temperature log in the room where emergency medicines were stored and we identified the temperature had exceeded to higher recommended level on three consecutive days. The policy was within the log it stated to inform the practice manager if limits were exceeded. There was no evidence this had been done.

Patients did not always receive specific advice about their medicines. Some patients told us they did not get clear, understandable information about their medicines. This would include what the medicine was for, how to use it, possible unwanted effects and how to report them also what the expected duration of treatment would be.

During the inspection, the GP specialist identified two prescribing errors that presented a high risk to patients. The first involved a child that was prescribed medicine not licenced for children. The second was an over prescribing issue with a medicine that was known to be open to misuse, abuse and dependence. Clinicians failed to identify that a patient had been seen five times over 21-day period. On each appointment, the patient was given a prescription that should have lasted between 14 and 28 days.

There had been significant improvements when we completed an unannounced focused follow up inspection on 10 January 2018.

- Medicine advice leaflets had been developed and staff had been made aware to discuss new medicine with patients.
- Medicine that was known to be open to misuse, abuse and dependence had been audited. The practice had developed a protocol to assist GPs to review patients on these medicines and assess suitability for reduction of dosage.
- Action to ensure storage of medicine was safe had been discussed and all staff were aware of their responsibilities to report any recording outside the recommended guidance.
- The practice had investigated a prescribing error for a child. The pharmacist undertook the investigation; however, the clinicians involved were not included in the investigation or the discussion about actions to mitigate reoccurrence. The issue was discussed at the clinical governance meeting where five prescribing clinicians attended.

Lessons learned and improvements made

At our previous inspection, we found that there was a process for receiving and acting on Medicines and Healthcare products Regulatory Authority (MHRA) and Central Alerting System (CAS) safety alerts that was not being followed. There were no systems in place to ensure the alert was actioned by a competent staff member. We checked a recent alert that would have affected 42 patients registered with the practice. There was no evidence that appropriate action had been taken.

Are services safe?

There had been significant improvements when we completed an unannounced focused follow up inspection on 10 January 2018.

- The lead pharmacist had fully reviewed and updated the statement of purpose relating to safety alerts received into the practice. There was a clear flow of information. Staff had been trained and they were monitoring the process.
- A lead clinician and pharmacist had reviewed all patient safety notifications and relevant notifications to GP practices were disseminated to staff with clear instructions about the action required. These actions were reviewed weekly.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection on 10 January 2018, we found that some improvements had been made to reduce the risks to patients but further progress was required in order to be compliant with the regulations.

Timely access to the service

At our previous inspection, we found that patients had trouble in accessing the practice: the next routine appointment with a GP was in eight days' time. By 9am on the day of our inspection of 7 December 2017, there were no emergency appointments available. This included appointments for sick children or those who needed a same day consultation. We heard patients being advised to attend A&E when no appointments were available.

There had been little improvement when we completed an unannounced focused follow up inspection on 10 January 2018.

- We arrived at 8.15am there were no on the day appointments available.
- The practice had increased the appointment slots by 24 slots a day. Their action plan stated they would increase by 48 slots to be implemented by 5 January 2018.
- We heard a receptionist talking to a mother stating there were no available appointments for her child to be seen on the same day. A telephone appointment was not offered.
- At our previous inspection, we found that no consideration had been given to reviewing the appointment system in light of a patient safety alert in April 2016. This alert required general practices to have a system in place to assess whether a home visit was clinically necessary and the urgency of need for medical attention. At our most recent inspection, we found that effective consideration had yet to be given to this patient safety alert. We saw that one patient had a home visit booked in for that day. There was a note on the practice computer system stating the patient was extremely short of breath and was not able to complete a sentence. This visit was not escalated to a clinician to be reviewed or treated as a potential medical emergency.

Listening and learning from concerns and complaints

At our previous inspection, we found that the practice did not have an effective system in place for handling complaints and concerns. Written complaints were seen to be dealt with however feedback from patients and NHS choices stated that the complainant was not always contacted. There was no evidence the practice learned lessons from individual concerns and complaints or from analysis of trends. We looked at 18 complaints received in the last 12 months and found that 12 of these were clinical, three were a mixture of clinical and non-clinical and three were non-clinical. We identified six of the complaints should have been dealt with as a serious incident.

There had been some improvement when we completed an unannounced focused follow up inspection on 10 January 2018.

- The practice manager was now responding within three days to the complainant.
- A staff meeting had taken place and we saw complaints were discussed.

Serious complaints did not have a policy that identified how to escalate to a serious incident.

Are services well-led?

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

Our findings

At our inspection on 10 January 2018, we found that some improvements had been made to reduce the risks to patients but further progress was required in order to be compliant with the regulations.

Leadership capacity and capability

At our inspection of 7 December 2017, we found that not all leaders had the necessary experience, knowledge or capacity to lead effectively. We found that there was a lack of oversight from corporate leaders and systems and processes were not being followed. There was a lack of review and monitoring of patients and performance generally. We were informed that a salaried GP was in the process of being recruited to oversee clinical performance.

At our recent inspection we found that this role had been fulfilled and as this person was away on a period of annual leave on the day of the inspection, an interim clinical lead was in place, until their return in February.

Whereas the practice manager had previously been employed to work across both Sunderland Lodge and another of the provider's locations, this had been reviewed and the practice manager now worked full-time only at Sunderland Lodge. She was being supported by the primary care GP quality lead from the provider.

Governance arrangements

During the previous inspection of Sutherland Lodge on 7 December 2017, we found that the provider could not demonstrate effective leadership. We identified significant concerns relating to governance and managing risk.

At our inspection of 7 December 2017, we found there were no structures, processes or systems of accountability to support the delivery of good quality, sustainable services. Staff were unable to describe the governance or the processes to manage current and future performance arrangements for the practice. There were no programmes of clinical or internal audit to monitor quality. There was a shortfall in the delivery of GP appointment sessions proportionate to the registered list size of 10,000. There was no detailed policy for the management of patients on medicines that required monitoring.

At our inspection on 10 January 2018, we found that some improvements had been made.

- Whilst we saw that two meetings had taken place since 7 December 2017 (one clinical and one staff), staff that we spoke with were not aware that these had taken place, nor had they received the minutes of these so that they could see what had been discussed and how this impacted on them. There continued to be a lack of effective structures, processes and information cascades to support good governance.
- Staff at all levels were clear about their roles and they understood what they were accountable for, and to whom.
- Arrangements with partners and third-party providers were being established to ensure appropriate interaction, sharing of information and to promote coordinated, person-centred care.
- Some staff spoken with remained unaware of any changes to the governance or the processes to manage current and future performance arrangements for the practice.
- There was a sustained shortfall in the delivery of GP appointment sessions, despite this being highlighted in our earlier inspection. Patients continued to have trouble in accessing appointments, even where there was an urgent clinical need. The provider had not made effective improvements, despite assurances.
- There were processes being embedded to manage current and future performance. Regular reviews and identified improvements were to be discussed at the governance meetings.
- A policy had been developed and a pharmacist was checking on all patients that required monitoring while on high-risk medicine.
- We found that the leadership structure for the practice was being developed.

Managing risks, issues and performance

There continued to be a lack of clear and effective processes for managing risks, issues and performance.

Following our previous inspection, we requested that the provider send to us an action plan detailing how they would mitigate immediate risks identified at the practice. At our most recent inspection, we found that the provider had failed to adhere to their own action plan and deadlines. According to their action plan, the provider would have completed most of their actions by the 10

Are services well-led?

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

January 2018. However, we found that not all of these actions had been implemented. We were advised by the practice that feedback had started in an informal way. There were no examples for us to see.

- There was not an effective process to identify, understand, monitor and address current and future risks, including those to patient safety.
- The practice did not have adequate processes to manage current and future performance. Whilst procedures in relation to safety alerts had been reviewed, we found evidence that previous alerts had not been actioned and therefore, continued to have the potential to adversely impact on patient care.
- We saw that the system for reviewing and responding to complaints had been improved, although it was unclear how these were being shared due to the lack of systems to ensure effective information cascade.
- Quality and sustainability continued to receive insufficient coverage in relevant meetings at all levels. The practice had commenced investigation of complaints and significant events but these were not being cascaded to all staff.
- Some audits had begun which considered the prescribing of medicines that required blood monitoring. There was a programme that identified four medicine audits over the year. There had been no further clinical audits identified for the next 12 months.
- There remained no practice based clinical oversight; the practice continued to rely on locum staff although we were advised that it had been difficult to recruit GPs to permanent posts. There were no processes in place to review referral letters to ensure they contained the right information and were sent by the most appropriate route.
- Actions identified in the Fire Risk assessment actions were being completed. Staff had fire marshal training and on the day of the inspection, a fire drill was conducted.
- Effective policies and procedures were yet to be implemented, cascaded and followed by all staff. There continued to be a lack of understanding and awareness of how to respond to immediate risks. This included patients who presented with symptoms indicating with severe illness and responding to outstanding and overdue tasks.