Hastings Old Town Surgery

Quality Report

Roebuck Surgery
26-27 High Street
Hastings
East Sussex
TN34 3EY
Tel: 01424 452800
Website: www.hastingsoldtownsurgery.co.uk

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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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Key findings

Contents

Letter from the Chief Inspector of General Practice

This practice is rated as inadequate overall.

The key questions are rated as:

Are services safe? – Inadequate

Are services well-led? - Inadequate

Hastings Old Town Surgery was last inspected on 8 December 2016 and was found to be good in all of the key questions. This inspection was an unannounced focused inspection and was carried out on 3 October 2018 in response to concerns that were reported to us. A CQC medicines manager visited the practice on 8 October 2018 to review the management of medicines.

The inspection focused on the key questions – are services safe and well-led.

At this inspection we found:

- The practice did not have a clear system in place to track significant events nor learn from these.
- Pre-employment checks undertaken by the practice were not thorough.
- Arrangements for the tracking and security of prescription forms was not sufficient.
- Fire doors were were found to be propped open within the practice.
- 37% of patients who required a medication review had not had one done between October 2017 and October 2018.
- Test results for 495 patients were found to be outstanding, 221 of which had been flagged as abnormal.
- The practice held incomplete records of the temperature of the medicines fridge.
- Complaint response letters written to patients had not been dated and the complaints policy was not followed appropriately.
- The practice did not have a functioning patient participation group.
- The practice's overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement.
- The lack of leadership and oversight in the practice resulted in ineffective systems to identify and proactively manage risks, issues and performance.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish and operate effectively a system for identifying, receiving, recording, handling and responding to complaints.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Summary of findings

- Ensure that staff receive appropriate support, training professional development, supervision and appraisal as is necessary to carry out the duties they are employed to perform.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

Where a service is rated as inadequate for one of the five key questions or one of the six population groups or overall, it will be re-inspected within six months after the report is published. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any key question or population group or overall, we will place the service into special measures. Being placed into special measures represents a decision by CQC that a service has to improve within six months to avoid CQC taking steps to cancel the provider's registration.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Hastings Old Town Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team on 3 October 2018 was led by a CQC lead inspector**.** The team included a GP specialist adviser, a practice manager adviser and two CQC inspectors. A CQC medicines manager visited the practice on 8 October 2018.

Background to Hastings Old Town Surgery

Hastings Old Town Surgery is a dispensing practice which offers general medical services to the people of the Old Town area of Hastings. There are approximately 10,862 registered patients. Services are provided at Roebuck House, 26-27 High Street, Hastings, TN34 3EY.

Services are also provided from a branch practice at Guestling Surgery, Chapel Lane, Guestling, Hastings, TN35 4HN. The branch surgery holds the dispensary for the service. This was visited on the day of inspection.

Hastings Old Town Surgery is run by a sole GP lead. The practice is also supported by four further GPs (two male and two female). One of these GPs is a long-term locum GP. Additionally, there are three practice nurses, an advanced nurse practitioner, two health care assistants, a physiotherapist and a clinical pharmacist. The team also includes a practice manager, a deputy practice manager, a business manager, medical secretaries and reception staff most of whom also have some additional responsibilities. The practice currently teaches FY2 doctors (doctors in their second year after qualifying) and medical students[GM1]. [MC2]

The practice runs a number of services for its patients including asthma clinics, child immunisation, diabetes clinics, contraception services, antenatal clinic, flu vaccine clinic and travel vaccinations (not Yellow fever). The practice runs an ear micro suction service and accepts referrals from other local GPs for this. There is a counselling service available in the building.

The provider is registered with the Care Quality Commission (CQC) to provide the following regulated activities: Diagnostic and screening procedures, Treatment of Disease, Disorder and Injury, Maternity and midwifery services, Family planning services and Surgical procedures.

The practice is run from three floors and has lift access. The practice is open from 8.30am on Monday, Wednesday and Friday and 7.30am on Tuesday and Thursday. The surgery is closed between and 1.00pm and 2.00pm. The practice closes at 6.30pm on Monday, Tuesday, Wednesday and Thursday and at 5.00pm on Friday. There is access for emergencies between 8.00am and 8.30pm Monday to Friday and 5.00pm to 6.30pm on Friday. Extended hours appointments are offered from 7.30am to 8.00am on Tuesday and Thursday, from 6.30pm to 7.15pm on Monday and 6.30pm to 8.00pm on Tuesday and Wednesday.

In addition to pre-bookable appointments that could be booked up to six months in advance, urgent appointments are also available for people that need them. When the surgery is closed patients can access out of hours care via the 111 telephone number. Urgent calls between 8.00am and 8.30am are put through to the duty GP.

The practice population has a higher than the national average number of patients aged over 65 although this is lower than the local average. There is a slightly higher than average number of patients with a long standing health

condition than the local and national average. The percentage of registered patients suffering deprivation (affecting both adults and children) is higher than both the local average and national average.

Inadequate

Are services safe?

Our findings

We rated the practice as inadequate for providing safe services.

The practice was rated as inadequate for providing safe services because:

- There was limited evidence of the management, tracking and learning from significant events.
- Safety systems and processes were not always operated effectively.
- Not all risks to patients were identified and addressed.
- Medicines were not managed safely.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff.
- Training for staff acting as chaperones was not evidenced in the training matrix supplied by the practice.
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice had not always carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was not an effective system to manage infection prevention and control. Cleaning schedules were not always completed or adhered to in order to aid infection control.
- The practice had some arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were not adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were not in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was not an effective induction system for temporary, or permanent, staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. However, the practice did not hold Naloxone (a medicine used to reverse the effects of opioid medicines) in their emergency medicines supply. A risk assessment was not in place for not having this medicine available.
- Not all emergency medicines were found to be in date. No rolling log was kept of emergency medicines checks. Checks for the current month only were seen.
- Fire doors were found to be propped open at the practice.
- Clinicians knew how to identify and manage patients with severe infections including sepsis. However, there was no evidence that non-clinical staff had been trained to recognise potential life-threatening conditions including sepsis.

Information to deliver safe care and treatment

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

- The care records we saw showed that information needed to deliver safe care and treatment was not consistently available to staff. There was not a documented approach to managing test results and there were significant delays in processing these.
- The practice had approximately 1,100 patient care records waiting to be summarised which had been outstanding since approximately September 2017.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols. However, we saw six significant events relating to two week wait referrals that had the same identical learning comments over a five month period.

Appropriate and safe use of medicines

The practice did not have reliable systems for appropriate and safe handling of medicines.

Inadequate

Are services safe?

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, did not always minimise risks. For example, the temperatures of the medicine fridges outside of the dispensary were not always within range and there was no evidence that the cause of this had been identified. There were also gaps seen in the records of fridge temperature checks.
- Staff did not prescribe, administer or supply medicines or give advice to patients in line with current national guidance.
- The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- We found that 37% of patients requiring a medicines review had not had one undertaken, this equated to 2,102 patients. Medicines were being repeatedly issued and prescriptions passed the number of times allowed on the patient's record. This included the repeat prescribing of controlled drugs.
- The tracking system in place to ensure prescription safety was not reliable. Prescription forms could be removed from open consulting rooms and there was no tracking of forms in place. At the branch site, consulting rooms were accessible with prescription forms stored in unlocked printer trays.

Track record on safety

The practice did not have a good track record on safety.

- Legionella and fire safety risk assessments were not readily accessible on the day of inspection.
- The practice had not monitored and reviewed activity. The practice lacked an understanding of risks and were unable to provide a clear, accurate and current picture of safety improvements.
- Safety was not a sufficient priority and there was limited monitoring of safety issues.

Lessons learned and improvements made

The practice did not learn and make improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were inadequate systems for reviewing and investigating when things went wrong. The practice did not learn and share lessons, identify themes or take action to improve safety in the practice. There was little evidence of learning from events or other action being taken to improve safety. Due to this, opportunities to minimise or prevent harm were missed.
- The practice acted on and learned from external safety events as well as patient and some medicine safety alerts. However, it was found that patients who were prescribed Sodium Valproate (a drug used mainly used to treat epilepsy) that were of child bearing age had not had the risks discussed and documented within their patient notes.

Please refer to the Evidence Tables for further information.

Are services well-led?

Inadequate

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

Our findings

We rated the practice as inadequate for providing a well-led service.

The practice was rated as inadequate for providing well-led services because:

- The practice overarching governance framework was not effective and did not support the practice to identify and act upon areas for improvement.
- The lack of leadership and oversight in the practice resulted in ineffective systems to identify and proactively manage risks, issues and performance.

Leadership capacity and capability

Leaders did not have the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The leaders did not always maintain an accurate overview and understanding of key quality and risk areas within the practice, for example in relation to health and safety, training and ensuring learning was shared from complaints, meetings and other incidents.
- Leaders at all levels were visible and approachable and worked closely with staff.
- There was no effective system in place for identifying, capturing or managing risks and issues. Significant issues that could threaten the delivery of safe and effective care were not identified or adequately managed.

Vision and strategy

The practice had a clear vision but no credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values and staff understood their role in achieving these.
- The governance arrangements at the practice were not sufficient to deliver the vision of the service.
- The practice planned its services to meet the needs of the practice population and had worked collaboratively with other local services to deliver extended hours care.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients, however, it was seen that there were lapses in this area in relation to monitoring test results and reviewing medicines.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints
- The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Processes were not in place for providing all staff with the development they needed. There were gaps evidenced in training that the practice deemed mandatory, for example fire safety training. There had been no appraisals undertaken since 2016 at the time of inspection. Staff were supported to meet the requirements of professional revalidation where necessary.
- Not all staff, including clinical staff, had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and we were informed that staff enjoyed the teamwork that took place at the practice.

Governance arrangements

There were not clear responsibilities, roles and systems of accountability to support good governance and management.

- The structures, processes and systems did not support good governance and management were not effective.

Are services well-led?

Inadequate

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

- The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities in respect of safeguarding.
- Infection prevention and control processes were not always sufficient and evidence was seen that the cleaning schedule was not always adhered to.
- Practice leaders had not established policies, procedures and activities to ensure safety.

Managing risks, issues and performance

There was no clarity around processes for managing risks, issues and performance.

- There was not an effective process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance.
- Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had an impact on quality of care and outcomes for patients.
- The practice had plans in place for business continuity in case of a major incident or disruption. However,

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice did not involve patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was not an active patient participation group at the time of inspection.
- There was a patient survey undertaken in 2018 by the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was no evidence of systems and processes for learning, continuous improvement and innovation.

- There was not a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice had not made use of internal and external reviews of incidents and complaints. Learning was shared but no evidence was seen that this was used to make improvements. For example, documenting the exact learning areas in relation to significant events which had similar features over a five month period would indicate that there was no, or insufficient, learning undertaken from these events.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Are services well-led?

Inadequate

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

Please refer to the evidence tables for further information.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered persons 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: • The provider failed to ensure that prescription forms were monitored and stored securely throughout the practice. • Cleaning schedules were not always being completed or adhered to in order to aid infection prevention. • Processes for reviewing patient's medicines were not sufficient. • Processes for managing test results were not sufficient. • There was no proper and safe management of medicines. In particular, the recording of medicine fridge temperatures was not always undertaken or action taken when out of range. Rolling logs were not kept of emergency medicines checks and there were no risk assessments in place for emergency medicines which were not available. This was in breach of regulation 12(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

There were no systems or processes that enabled the registered person to assess, monitor and improve the quality and safety of the services being provided or mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- **The provider did not have an adequate process in place for recording, managing and learning from significant events.**
- There were no systems or processes that enabled the registered person to evaluate and improve their practice in respect of the processing of the information obtained throughout the governance process.
- 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, approximately 1,100 patient records needed to be summarised to the providers computer system.
- There were no systems or processes that enabled the registered person to seek and act on feedback from relevant persons and other persons on the services provided in the carrying on of the regulated activity, for the purposes of continually evaluating and improving such services. In particular, the provider did not have a patient participation group functioning at the time of inspection.
- The registered person had failed to establish and operate effectively an accessible system for identifying, receiving, recording, handling and responding to complaints by service users and other persons in relation to the carrying on of the regulated activity. In particular, response letters were being sent to complainants with no dates upon them and the practice did not follow their own complaints policy.

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

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Family planning services	

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The service 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: • Not all training had been undertaken as expected by staff, for example, but not limited to, fire safety, information governance, major incidents and infection control training. • Appraisals for staff had not been regularly undertaken. This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • Insufficient pre-employment checks had been undertaken including not obtaining sufficient references. This was in breach of regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.