Hawthorn Drive 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.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Good
Are services well-led?	Inadequate

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Hawthorn Drive Surgery on 14 November 2016. Overall the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- There was an effective system for recording and reporting of significant events. However the process for the sharing of learning and ensuring that actions had been completed was not effective.
- The patients and practice staff were at risk of harm, as the practice had not undertaken the recommended action from the Health and Safety and Legionella risk assessment to ensure that they would be kept safe. Non-clinical staff were expected to clean body fluids without their Hepatitis B immunity being checked and not all staff had completed infection control training.
- The process for ensuring that MHRA alerts were actioned for patients affected was not adequate.
- The practice could not evidence a programme of completed audits that had been re-run to monitor and improve outcomes for patients or to ensure quality of record keeping. Inaccurate coding had been identified as an issue in March 2015 and had not been resolved at the time of the inspection.
- Some areas of the practice performance were insufficiently supported to ensure safe and effective care and treatment for patients. For example, data from the quality and outcome framework was significantly lower than the CCG and national averages in some areas and the exception reporting was significantly higher than the CCG and national averages in many areas.
- The practice told us that multidisciplinary meeting were held to discuss and review vulnerable patients, the elderly, children with safeguarding needs and patients with palliative care needs. We saw agendas for these meetings, but there were no minutes to

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ensure that any relevant information was shared with the appropriate clinical staff. We did not see any evidence that the actions from these meetings were recorded in patient's notes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns. However there was no formal process for the sharing of learning and checking that actions identified had been completed.
- The majority of patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Appointment requests for children, vulnerable patients, the elderly and those with palliative care needs were prioritised.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had established good working relationships with other agencies. The Citizens Advice Bureau (CAB) held a drop in clinic at the practice on Thursdays.

The areas where the provider must make improvement are:

- Ensure there is an effective process for sharing and checking that actions have been completed in relation to patient safety alerts, for example MHRA alerts and NICE guidance.
- Ensure there is an effective process for checking that agreed actions identified as a result of significant events and complaints have been implemented.
- Review the arrangements for cleaning of body fluids by ensuring they meet the requirements as detailed in the Health and Social care Act (2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- Ensure that the actions from the Legionella risk assessment and Health and Safety risk assessment undertaken in July 2016 are completed.
- The practice must record agreed actions from meetings to evidence their working in partnership with other relevant agencies and ensure patients records reflected information shared to keep patients safe.
- Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Ensure there is clinical leadership capacity to deliver all improvements.
- Ensure that the CQC registration of the practice and Registered Manager is up to date.

The areas where the provider should make improvement are:

- Maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data.
- Agree and implement a process for checking uncollected prescriptions, ensuring that GPs are aware of patients who may not be compliant with their medicines.
- Review the recording and coding of medical records to ensure accurate and reflective care and treatment of patients.
- Implement a practice specific safeguarding adults and children policy.
- Ensure that annual health reviews are offered for those patients with a learning disability who have not yet received one.
- Ensure that a copy of the business continuity plan is kept off site.
- Ensure that internal audits of the cleaning are undertaken.
- The practice management should implement systems to give oversight and assurance that staff receive all training appropriate to their roles and needs.
- Review systems and process to ensure that complaints and feedback are managed effectively and safely. Minutes of meetings should contain sufficient detail to ensure shared learning by practice staff.
- The practice should seek to increase the number of patients who attend for a cervical screen.
- Chaperones should themselves record any duties carried out on the practice system.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take

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action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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.

- There was an effective system in place for reporting and recording significant events, but no formal process for sharing learning and ensuring that actions identified had been completed, to make sure safety in the practice was improved.
- Patient safety alerts were not logged, shared and searches were not completed to ensure the changes were implemented.
- Patients on high risk medicines were identified and reviewed.
- When things went wrong patients received reasonable support, detailed information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice followed the CCG guidance for safeguarding children and adults. Staff were aware of their role in order to keep patients safe and safeguarded from abuse. However there was no practice policy to detail the in house arrangements and not all staff had completed training appropriate to their role and deemed mandatory by the practice.
- Risks to patients and staff were assessed but not well managed. Actions from the Health and Safety and Legionella risk assessment had not been completed. Non-clinical staff were responsible for cleaning spilt body fluids, when their Hepatitis B immunity was not known and not all staff had received infection control training. There were no audits of the cleaning undertaken by the practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or below average compared to the CCG and national average. The exception reporting for the majority of clinical domains was above the CCG and England average.
- Staff assessed needs and delivered care in line with current evidence based guidance, although this was proactive, as NICE guidance was not shared formally with in the practice.
- Clinical audits had not been undertaken at the practice. Inaccurate coding of patients' medical records had been

Summary of findings

identified during an audit in March 2015. No actions had been undertaken to improve this and this was repeated in December 2015, showing similar results. Inaccurate coding remained an issue at the time of the inspection.
- There was evidence of appraisals and personal development plans for all staff.
- The practice told us that multidisciplinary (MDT) working was taking place but this was informal and record keeping was limited or absent.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey showed patients rated the practice in line with or lower than other practices for most aspects of care. Patients and their representatives who we spoke with and comments we received were positive in relation to the caring, friendly and helpfulness of all the staff at the practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had developed an information and resource folder which detailed the contact details of a number of organisations who could provide advice and support to patients.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.
- Data from the national GP patient survey showed patients rated the practice in line with or higher than other practices for satisfaction with accessing the practice.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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- Information about how to complain was available and easy to understand. The practice did not have a process for sharing the learning from complaints and checking that identified actions had been completed.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision and strategy, although this seemed misaligned to the way in which the practice was running on the day of the inspection. The GPs told us they had to prioritise patient demand, but also provided a rationale that patients did not engage with the practice, hence the high exception rate.
- The GPs did not demonstrate that they had sufficient clinical and management oversight of the practice. For example, governance arrangements were insufficient. The practice did not operate a systematic recall system for all patients, as the coding on patients' medical records was not always accurate. Patients were contacted by telephone or by letter at the request of the GP.
- The practice staff told us that they did hold various meetings; however the management team meetings were not minuted and were informal. There was scope for this to be improved for the practice to be assured of shared learning and that identified actions had been completed.
- Although practice staff told us they felt supported by the GPs, some staff reflected that they would benefit from more clinical leadership and guidance.
- The practice had a number of policies and procedures to govern activity and these had been reviewed.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had approximately 150 patients registered in three local nursing and residential homes. Each home had an allocated clinician, with the largest having two allocated clinicians in order to provide continuity of care to patients. Regular and as required home visits were planned according to patients' needs.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis, dementia and heart failure were above the local and national averages. The exception reporting was higher than the CCG and national averages for the majority of the outcomes.

People with long term conditions

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Nursing staff had lead roles in chronic disease management and had received training in the appropriate area.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that performance for diabetes related indicators was 84%, which was below the local average of 93% and national average of 90%. This was an improvement of 3% from the 2014/2015 data. 2015 to 2016 exception reporting for diabetes related indicators was 16% which was above the local average of 9% and the national average of 11% (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Summary of findings

- Longer appointments and home visits were available when needed.
- The practice did not operate a systematic recall system for all patients, as the coding on patients' medical records was not always accurate.
- For patients with the most complex needs, the named GP worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- There were some systems in place to follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations and comparable to the CCG and national averages.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Any contact made by the parents or carers of young children were highlighted to the duty GP to ensure this group of patients were dealt with swiftly.
- The practice offered a full range of contraception services and chlamydia screening.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments were available every Saturday morning from 8.40am to 12 noon.
- Patients were able to book evening and weekend appointments with a GP through Suffolk GP+ (Suffolk GP+ is for patients who urgently need a doctor's appointment, or are not able to attend their usual GP practice on a weekday.)

Summary of findings

- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice's uptake for the cervical screening programme was 70% which was below the CCG average of 75% and the national average of 74%. The practice encouraged patients to have cervical screening.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice offered longer appointments for patients who needed one. For example those with a learning disability or translation needs.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Patients who were deemed to be vulnerable were added to the duty GP list if no routine appointments were available.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations. The Citizens Advice Bureau ran a weekly clinic at the practice.
- Staff were aware of their role in order to keep patients safe and safeguarded from abuse. However there was no practice policy to detail the in house arrangements and not all staff had completed training appropriate to their role and deemed mandatory by the practice.
- The practice had 51 patients on the learning disabilities register. 24 of these patients had received a health review in the previous year. The practice were aware that they needed to plan reviews for those who had not yet had an annual review.
- The practice had a link worker on site once a week to support patients who were vulnerable.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for safe, effective and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- 93% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the CCG average of 85% and national average of 84%. The exception rate was 16% which was 8% above the CCG average and 9% above the national average.

Summary of findings

- 87% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months. This was in line with the CCG average of 85% and national average of 88%. The exception rate was 42% which was above the CCG average of 16% and national average of 13%.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice had a link worker on site once a week, to support patients as appropriate.
- The practice offered a daily and weekly prescription service where appropriate.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing in line with or below local and national averages. 288 survey forms were distributed and 109 were returned. This represented a 38% response rate, which was the same as that for England.

- 75% of patients found it easy to get through to this practice by phone compared to the CCG average of 80% and the national average of 73%.
- 74% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 88% and the national average of 85%.
- 79% of patients described the overall experience of this GP practice as good compared to the CCG average of 87% and the national average of 85%.
- 59% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received 13 comment cards which were all positive about the standard of care received from the entire staff team. Staff were reported to be friendly, helpful and took the time to listen. Two comments related to difficulty in getting an appointment, but one commented positively on how quickly the GP called back to discuss their need.

We spoke with representatives from three care homes where residents were registered at the practice. The feedback was positive, particularly in relation to responsiveness of home visits, involving patients and families in their care and the helpfulness of all staff at the practice.

We spoke with three patients during the inspection. They were satisfied with the care they received, were involved in decisions about their care and treatment and thought staff were approachable, committed and caring. The practice engaged with the Friends and Family Test. The most recent data which was published in August 2016, showed that no data had been submitted by the practice. We asked for the most recent data from the practice but this had not been provided to us by the practice at the time of writing the report.

Areas for improvement

Action the service MUST take to improve

- Ensure there is an effective process for sharing and checking that actions have been completed in relation to patient safety alerts, for example MHRA alerts and NICE guidance.
- Ensure there is an effective process for checking that agreed actions identified as a result of significant events and complaints have been implemented.
- Review the arrangements for cleaning of body fluids by ensuring they meet the requirements as detailed in the Health and Social care Act (2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance.
- Ensure that the actions from the Legionella risk assessment and Health and Safety risk assessment undertaken in July 2016 are completed.
- The practice must record agreed actions from meetings to evidence their working in partnership with other relevant agencies and ensure patients records reflected information shared to keep patients safe.
- Ensure that an accurate, complete and contemporaneous record is maintained for every patient.
- Ensure there is clinical leadership capacity to deliver all improvements.
- Ensure that the CQC registration of the practice and Registered Manager is up to date.

Action the service SHOULD take to improve

- Maximise the functionality of the computer system in order that the practice can run clinical searches, provide assurance around patient recall systems, consistently code patient groups and produce accurate performance data.

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- Agree and implement a process for checking uncollected prescriptions, ensuring that GPs are aware of patients who may not be compliant with their medicines.
- Review the recording and coding of medical records to ensure accurate and reflective care and treatment of patients.
- Implement a practice specific safeguarding adults and children policy.
- Ensure that annual health reviews are offered for those patients with a learning disability who have not yet received one.
- Ensure that a copy of the business continuity plan is kept off site.
- Ensure that internal audits of the cleaning are undertaken.
- The practice management should implement systems to give oversight and assurance that staff receive all training appropriate to their roles and needs.
- Review systems and process to ensure that complaints and feedback are managed effectively and safely. Minutes of meetings should contain sufficient detail to ensure shared learning by practice staff.
- The practice should seek to increase the number of patients who attend for a cervical screen.
- Chaperones should themselves record any duties carried out on the practice system.

Hawthorn Drive Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, and a practice management specialist adviser.

Background to Hawthorn Drive Surgery

The practice area covers the Chantry Estate, in Ipswich, with a few patients from the nearby villages of Copdock, Washbrook, Sproughton and Burstall. The practice offers health care services to around 8250 patients. It is located in a building which was purpose built in 1984 and has consultation space for GPs and nurses.

The practice holds a Personal Medical Service (PMS) contract with the local CCG.

There are three GP Partners at the practice (two male and one female). There are two advanced nurse practitioners, two nurses and three healthcare assistants. A team of ten administration and reception staff support the practice manager.

- The practice is open between 8am and 6:30pm Monday to Friday. Appointments are usually from 8.30am to 11.20am and from 3pm to 5.20pm for GPs and from 8am to 12.40pm and 2pm to 5.40pm for nurses. Extended hours appointments are offered between 8.40am and 12 noon every Saturday. Patients are able to book evening and weekend appointments with a GP through Suffolk GP+.
- During out-of-hours GP services are provided by Care UK via the 111 service.
- The practice has a larger number of patients between the ages of 0 to 34 and those over 85 than the national average. There are fewer patients between the ages of 35 to 84 than the national average. Income deprivation affecting children is 28%, which is higher than the CCG average of 14% and national average of 20%.
- The practice has a higher percentage of patients who are unemployed (9%) compared to the CCG average of 4% and the national average of 5%.
- Male and female life expectancy in this area is in line with the England average at 78 years for men and 83 years for women.

The CQC registration of the Partnership members and the Registered Manager was not up to date. he practice had been informed of this and need to ensure the relevant statutory notifications and applications are submitted.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 November 2016. During our visit we:

- Spoke with a range of staff including the practice manager, GPs, nurses, health care assistants, reception and administration staff and spoke with patients and their representatives, who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke with representatives from three of the five care homes where residents were registered at the practice.

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?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

- There was a system in place for reporting and recording of significant events. Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, detailed information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- There was no formal system for discussing and identifying the learning from significant events and complaints and checking that the actions had been completed. This was undertaken informally by discussion with the management team and no minutes of these meetings were documented.
- We saw some evidence that changes were made following the reporting of significant events. For example, following a missed two week wait referral, the GP now checked with the secretary to ensure these have been acted upon. However, there was no formal system to check that the learning identified had been actioned and there was no analysis of the significant events every year in order to identify trends.
- The process was not sufficient for sharing Medicines and Healthcare Products Regulatory Authority (MHRA) alerts within the practice and for checking that any required action had been completed. For example a recent safety alert regarding the importance of advising women to check the positioning of a contraceptive implant had not been shared with the clinicians who undertake this procedure. Patients had therefore not been advised of this information. Another MHRA alert, regarding prescribing of sodium valproate for women of childbearing age, had not been acted upon.

Overview of safety systems and processes

The practice did not have clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

- Some arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. The practice referred to the Clinical Commissioning Group (CCG) policies for safeguarding which were accessible to all staff. However, the practice did not have their own safeguarding policy to inform staff of the in house arrangements for safeguarding. There was a lead member of staff for safeguarding. Staff we spoke with demonstrated they understood their responsibilities. The GPs responded to requests for information and provided reports where necessary for other agencies. We noted that due to the coding errors, approximately 300 patients were identified as having involvement with safeguarding, which the practice recognised was not accurate. We looked at three staff files and two staff had received training on safeguarding children and vulnerable adults relevant to their role. We reviewed the records of online training for staff and noted that six staff had not completed safeguarding training for children or vulnerable adults. GPs were trained to child protection or child safeguarding level three and nurses to level two. We noted that one of the nurses had been trained to level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The chaperones advised that they did not document when they had acted as a chaperone, as this was completed by the GP.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead, They liaised with the local infection prevention teams to keep up to date with best practice. The practice were in the process of identifiying an infection control and prevention course and further support in relation to audits to enable the lead to undertake their role effectively. There was an infection

control protocol in place. An infection control audit had been completed on 11 November 2016 and there was an action plan in place to address any improvements identified as a result. We saw evidence of staff cleaning checks by those staff employed by the practice. We were told that records of cleaning were kept by the external cleaning company. They also audited their own cleaning and sent reports to the practice. There were no audits of the cleaning undertaken by the practice. We were advised that staff reported any issues raised and these had been resolved. The practice used disposable curtains which were changed every six months and the date these were changed was recorded. The practice had guidance in place for cleaning up body fluids. However non-clinical staff were expected to undertake this and the practice had no record of the Hepatitis B immunity for non-clinical staff. Records were kept of the Hepatitis B immunity status of clinical staff. There were hand washing signs next to all sinks and alcohol hand gel was available for use. Clinical waste was stored and disposed in line with guidance. We looked at three staff files and one staff member had completed infection control eLearning. We reviewed the records of staff eLearning and noted that 13 staff, including both clinical and non-clinical, had not completed this training.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Records showed medicine refrigerator temperature checks were carried out to ensure medicines and vaccines requiring refrigeration were stored at appropriate temperatures. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. We looked at four high risk medicines and saw that patients had been appropriately reviewed. We noted that there were three prescriptions which had not been collected. These were dated 9 August and the 3 and 8 September 2016. There was no process for checking uncollected prescriptions. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Two of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They had received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. (Patient Specific Directions are written instructions, from a qualified and registered prescriber for a medicine, which includes the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. There was also a comprehensive process in place for checking locum GPs.

Monitoring risks to patients

Risks to patients were assessed but actions were not always completed and there was no formal process to check that actions had been completed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a GP lead for health and safety and a health and safety policy was available with a poster in the staff room. A health and safety risk assessment had been completed in July 2016. We noted that some of the actions had not been completed. For example having a raised toilet seat and a support structure around the disabled toilet. The practice had an up to date fire risk assessment dated July 2016. They had carried out a fire drill on 11 November 2016. There was no previous record of any fire drills. The fire alarm had been checked on 11 November 2016, with the previous check being completed on 19 March 2015. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and

infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).We noted that the actions from the legionella risk assessment had not been implemented.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in the practice which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. Records showed these were checked at least monthly.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Copies were not kept off the premises, but the practice manager agreed to ensure that a copy was held off site.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice did not have a formal system in place to keep all clinical staff up to date with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The clinicians accessed this information through the Clinical Commissioning Group website on a reactive basis; although the records we reviewed showed that current evidence based guidance was used in the delivery of care and treatment to meet patients' needs. We reviewed the records of seven patients. Two patients had been incorrectly coded as having diabetes. Two patients with diabetes and three patients with chronic obstructive pulmonary disease were receiving appropriate treatment. There was no evidence that the practice monitored that these guidelines were followed through risk assessments, audits or random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice received 94% of the total number of points available. This compared with the CCG average of 97% and the national average of 95%. The overall exception reporting rate was 13% which was 5% above the CCG average and 4% above the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014 to 2015, showed a similar level of exception reporting, with the practice receiving 92% of the total number of points available.

Data from 2015/16 showed:

- Performance for diabetes related indicators was 84% this was 9% below the CCG average and 6% below the national average. The exception reporting rate was 16%, which was higher than the CCG (9%) and national (11%) exception reporting rates. The practice explained that they sent written invitation to patients to attend for review, but the high exception reporting rate was due to patients who did not attend for their review. We reviewed a number of patient records and saw that reminder letters had been sent. The GPs told us that contacting patients by telephone could be difficult as often their contact details were not up to date.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was 150/90mmHg or less was 77%. This was lower than the CCG and national average of 80%. The practice explained that patients may have a higher blood pressure reading when they commenced treatment and then may not attend for review, where a lower blood pressure reading may be recorded.
- Performance for mental health related indicators was 100%. This was 4% above the CCG average and 7% above the national average. The exception reporting rate was 29% which was higher than the CCG average of 12% and national average of 11%. The practice explained the high exception reporting rate was due to patients choosing not to attend.
- Performance for asthma related indicators was 100% which was 1% above the CCG average and 2% above the national average. The exception reporting rate was 5% which was lower than the CCG average and national average of 7%.

There was some evidence of quality improvement as the practice participated in local audits and national benchmarking. Findings were used by the practice to improve services. For example, The practice participated in review of their A&E attendances using the CCG provided benchmarking data. They had prioritised access to the clinicians for some patient groups including children, the elderly and those with palliative care needs. This is reflected in the inpatient emergency admissions being less this year than in 2015/16. For patients who were above 75 years of age, the practice is still the third highest for emergency admissions, but it had improved this year compared to the previous year. The over 75 year old A&E attendances was less than the CCG average and much less this year compared to the previous year.

There was no evidence of any completed clinical audit cycles. We were shown one audit which was undertaken in March 2015. This identified 500 patients had an asthma diagnosis with no medication in the previous six months and that 478 patients were prescribed asthma medication,

but were not coded as having an asthma diagnosis. This was repeated in December 2015, however no actions had been undertaken to resolve the coding issues identified and the results were similar. The practice recognised that they did not have an effective system to ensure that a consistent and reliable approach to coding within the medical record was in place.

Effective staffing

- The practice had an induction programme for all newly appointed staff and the newly appointed staff we spoke with said they felt supported. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We noted that not all staff had completed all the training identified. A comprehensive induction was in place for locum GPs, which included training and competency on using the clinical system.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, clinicians providing contraception services had attended relevant update courses.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and attendance at study days.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, informal meetings, coaching and mentoring, clinical supervision and support for revalidating GPs. A number of staff had not completed e-learning training which was deemed by the practice to be appropriate to their role. The practice were aware of this and explained that staff were working at capacity and there was little time for this training to be completed. They had offered overtime to staff to undertake this, but this had not been successful in ensuring the learning had been completed. We reviewed three staff files and saw that staff had received an appraisal within the last 12 months. We noted that two of the GPs were not showing on the performers list. The practice manager was aware of this and had tried to get this resolved, but it was felt to be a system issue. During the inspection we viewed the appraisals for these two GPs and we checked they were registered with the GMC. Following the inspection we had confirmation from NHS England that they were on the performers list.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not always available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- The practice recognised that they did not have a consistent approach to the coding of patients and we found examples where patients were not coded correctly. This meant that there were both risks internally where patient diagnoses had been incorrectly recorded and also risks where external professionals accessed patients' records which held inaccurate information.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Multi-disciplinary meetings took place on a quarterly basis to discuss for example, patients with complex needs, those where there was a safeguarding need and those with palliative care needs. However decisions made and actions agreed at multidisciplinary meetings were not documented in multidisciplinary team minutes and we saw no evidence that they were recorded on the patients' medical record.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We looked at two week wait referrals and all relevant information had been included.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Inadequate

Are services effective?

(for example, treatment is effective)

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and worked with other agencies to ensure services were available for patients. For example

- Onelife Suffolk provided weekly clinics at the practice for stop smoking services, adult weight management, NHS health checks, child weight management and advice about physical activity.
- The Citizens Advice Bureau (CAB) held a drop in clinic at the surgery one day a week and referrals between CAB staff and clinicians at the practice were encouraged.

The practice's uptake for the cervical screening programme was 70% which was below the CCG average of 75% and the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and the practice also sent letters to patients. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available and by explaining the procedure in simple terms. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The breast cancer screening rate for the past 36 months was 75% of the target population, which was below the CCG average of 80% and above the national average of 72%. The bowel cancer screening rate for the past 30 months was 55% of the target population, which was below the CCG average of 63% and the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 75% to 97%. This was comparable to the CCG range of 74% to 97% and national range of 73% to 95%. Immunisation rates for the vaccinations given to five year olds ranged from 77% to 100% which was comparable to the CCG range of 71% to 97% and national range of 81% to 95%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Chlamydia testing was available for all patients under 25.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We spoke with representatives from three care homes who said they were satisfied with the service provided by the practice and had no concerns regarding dignity and privacy. Patients told us they were very satisfied with the care provided by the practice and staff were helpful, caring and treated them with dignity and respect. All of the 13 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring, treated them with dignity and respect. and provided support when required. We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed the practice was below average for its satisfaction scores on consultations with GPs and average in relation to nurses. For example:

- 84% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 68% of patients said the GP gave them enough time compared to the CCG average of 87% and the national average of 87%.
- 85% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 71% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey were below local and national averages in relation to patient's involvement in planning and making decisions about their care and treatment. For example:

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and the national average of 86%.
- 70% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and national average of 82%.
- 81% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw information was available informing patients this service was available.
- We asked if any information was available in easy read format, but we were not provided with any examples of this.

Patient and carer support to cope emotionally with care and treatment

Requires improvement

Are services caring?

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. The practice had developed a resource booklet of local and national groups and sources of advice. This included information on alcohol and drug support, domestic abuse, bereavement, cancer, carers, homelessness, mental health and wellbeing, parenting, social activities and sexual health.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 95 patients as carers (1.5% of the practice list). The practice manager advised that the number of carers was higher than this as some patients had been identified as carers but had not been coded correctly on the system, so they did not show up on the search for carers. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Information was available for bereaved patients on the practice website and in the resource folder developed by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- Telephone appointments were available for patients if required. The practice used a text message appointment reminder service for those patients who had given their mobile telephone numbers.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- There were disabled facilities, and a translation services available. The self check in screen had five languages.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The practice had 51 patients on the learning disabilities register. 24 of these patients had received a health review in the previous year. The practice offered longer appointments for patients with a learning disability. The practice were aware that they needed to plan reviews for those who had not yet had an annual review.
- When a secretary left, the practice undertook a review of staff roles and the practice needs. They identified a greater need for and employed a health care assistant to manage the increasing patient demand for clinical aspects of care.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.

Access to the service

The practice was open between 8am and 6:30pm Monday to Friday. Appointments are usually from 8.30am to 11.20am and from 3pm to 5.20pm for GPs and from 8am to 12.40pm and 2pm to 5.40pm for nurses. Extended hours appointments are offered between 8.40am and 12 noon every Saturday. Appointments could be booked in person, by telephone or online. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The practice was open on Saturday mornings from 8.30am to 12.30pm, for pre booked appointments. The practice had telephone triage by a GP where patients were called back and where necessary, appointments were offered on the same day. The practice offered online prescription ordering. Patients were able to book evening and weekend appointments with a GP through Suffolk GP+.

We spoke with three patients and reviewed 13 comments cards on the day of the inspection. The majority of patients told us were able to get appointments when they needed them. Two comments related to difficulty in getting an appointment, but one commented positively on how quickly the GP called back to discuss their need. Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was in line with or higher than local and national averages.

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and the national average of 76%.
- 75% of patients said they could get through easily to the practice by phone compared to the CCG average of 80% and the national average of 73%.

The practice had a system in place to assess whether a home visit was clinically necessary and

the urgency of the need for medical attention. Requests for home visits were triaged and allocated by the duty GP to all the GPs on duty. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. Any contact made by the parents or carers of young children, vulnerable patients, elderly patients and those with palliative care needs were highlighted to the duty GP to ensure this group of patients were dealt with swiftly. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

Listening and learning from concerns and complaints

The practice system for handling complaints and concerns needed to be improved. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system in the waiting room and on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We looked at documentation relating to four complaints received in the previous year and found that they had been investigated. Three of the complaints had been responded to in a timely and empathetic manner. However for one, there was no documented evidence that complainant had been responded to. We spoke with the practice manager who advised that the response had been made by telephone, however there was no record of this. We did see that changes were made as a result of complaints. For example a notice was displayed in reception to remind staff about their role in relation to patient confidentiality. However, there was no formal process for identifying the learning from complaints, ensuring that the learning had been shared and ensuring that any actions identified were completed.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice had a mission statement in their statement of purpose which was 'Working together to create an innovative and sustainable local primary care service delivering high quality healthcare for all.' The GP partners explained that their focus was on the encouragement of self-care. The practice staff we spoke with were aware of the mission statement.

The practice were planning to work with a number of other practices in order to share some of the back office functions and improve efficiency. Work was being undertaken at the practice to create space for an additional consultation room and additional clinical resource. The practice had a practice development strategy 2016 to 2019, 'Improving primary care through vision, commitment and integrated working.' This covered areas such as systems, workforce, patients, premises, communication and equipment. The action plan had been reviewed as we saw that some actions had been completed, for example the review of policies and procedures However, other identified actions had not been completed, for example the correct Read coding of patients' medical records.

Governance arrangements

The practice governance framework which supported the delivery of the strategy and good quality care needed to be improved.

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The GPs did not have a comprehensive understanding of the clinical performance of the practice.
- The practice did not use clinical and internal audit to monitor quality and to make improvements.
- The arrangements for managing risks were insufficient to keep patients and staff safe.
- The practice had policies and procedures in place to govern its activity, which were readily available to all members of staff. We looked at a number of policies and procedures. We found that they had been reviewed annually, the partners had been involved in their review, and checks were in place to ensure that staff had read and understood them.

Leadership and culture

Although practice staff told us they felt supported by the GPs, some staff reflected that they would benefit from more clinical leadership and guidance. There was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so. The practice manager had an open door policy. Staff told us the practice held reception meetings and nurse meetings but the management team mostly had informal conversations. Minutes of meetings were not always taken or in sufficient detail to ensure shared learning across the practice.

The management team told us that the GPs had to prioritise patients' needs and meeting the demand they presented with, which had resulted in not them not being able to prioritise the management of the practice. There was a lack of management oversight and coordination of the actions to be implemented in relation to significant events, complaints, patient safety alerts, NICE guidance, health and safety risk assessments and legionella risk assessments.

The practice was aware of and had systems in place to ensure compliance with the requirements of the duty of candour but these needed to be improved. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

- The practice gave affected people reasonable support, and a verbal and written apology.
- The practice kept written records of written correspondence but did not record verbal feedback.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. The practice engaged with the Friends and Family Test. They had not submitted data to NHS England for July and August, which was the most recently published information. We asked for the most recent data from the practice but this had not been provided to us by the practice at the time of writing the report.

The practice was trying to reinvigorate the Patient Participation Group (PPG), and had plans to collaborate

Are services well-led?

Inadequate

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

with other nearby practices in order to achieve this. We spoke to the proposed chair of the practice PPG, who was keen to be involved in the PPG to give something back to the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

The practice did have a desire to improve services and had established networks with a number of other agencies and had developed an information resource for patients and staff for a range of support groups and contacts for advice.

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 • The practice had not undertaken actions identified in the Health and Safety Risk Assessment (July 2016) and the Legionella risk assessment (July 2016). • The practice did not meet the requirements as detailed in the Health and Social Care Act (2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance, or have their own systems in place which were better. Staff had not received appropriate training. The Hepatitis B status of non clinical staff was not known and as non-clinical staff were responsible for cleaning spilt body fluids, this constituted a potential risk to both staff and patients. • The practice did not have a comprehensive process in place to ensure staff were informed of MHRA alerts and to check that these had been implemented for patients.

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 Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Ensure that an accurate, complete and contemporaneous record is maintained for every patient. • The practice did not evidence that there was clinical joint working with other professionals to ensure shared information and management of risk. • The practice did not have governance systems in place to ensure patients were identified and received timely, safe care and treatment. The practice did not have effective and systematic systems to recall patients that required regular monitoring.