Northbourne Surgery

Quality Report

Northbourne Surgery
Bournemouth
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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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced inspection at Northbourne Surgery on 26 July 2016 to monitor whether the registered provider had met the requirements of the warning notices which were served following an announced inspection in March 2016. The timescale given to meet the requirements was 30 June 2016.

Two warning notices were served which related to regulations 12 Safe care and treatment; and 17 Good governance respectively of the Health and Social Care Act 2008.

Areas which did not meet the regulations were:

- Policies to ensure there were appropriate staff trained and checked to act as chaperones did not protect patients from harm.
- Investigation results and other reports were not reviewed and acted upon in a timely way to ensure patient received appropriate treatment and were not placed at risk of harm.
- Patients on high risk medicines did not have these reviewed at regular intervals with required blood tests being carried out, to ensure they were being prescribed appropriately.
- Processes for medicines management including handling, administration, storage and prescription did not protect patients from harm.
- Infection control processes and cleaning regimes of equipment and the premises did not protect patients form harm.
- Checks and storage of emergency equipment and medicines were not robust and placed patients at risk of harm.
- There was a lack of formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision. This placed patients and others at risk of harm. This included managing significant events, incidents and near misses; systematic updating of policies and procedures to ensure they were current and relevant; ensuring there were suitable numbers of staff who were competent to carry on the regulated activities; engaging with staff and patients about how the practice was run; and ensuring the complaints system was accessible for all patients and concerns were responded to in a comprehensive manner. Patients were not proactively engaged in their care and treatment and appointments were not tailored to meet patient need.

Summary of findings

At this inspection we found that the provider had taken action to meet the requirements of the warning notices.

Key findings:

- Emergency equipment and medicines were suitable for use and regular checks were in place.
- The infection control processes were now in place , which included maintaining records and audits of cleaning regimes to ensure patients were protected from harm.
- Governance arrangements had been reviewed and systems and processes were in place for assessing and monitoring risk and the quality of the service provision. These included managing significant events and complaints; reviews of policies and procedures and proactive engagement with staff and patients on the running of the service.

The Care Quality Commission is satisfied that the areas within the warning notices have been addressed adequately and the practice is now compliant with regard to the notices.

The full report published on 5 May 2016 should be read in conjunction with this report. The practice remains in special measures until a full comprehensive inspection is carried out by the Care Quality Commission. Therefore the overall rating remains inadequate.

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 until a further comprehensive inspection takes place. However, there are areas of good practice:

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- Emergency equipment and medicines were suitable for use and regular checks were in place.
- The infection control processes were now in place, which included maintaining records and audits of cleaning regimes to ensure patients were protected from harm.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led until a further comprehensive inspection takes place. However, there are areas of good practice:

- Governance arrangements had been reviewed and systems and processes were in place for assessing and monitoring risk and the quality of the service provision. These included managing significant events and complaints; reviews of policies and procedures and proactive engagement with staff and patients on the running of the service.

Northbourne 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.

Background to Northbourne Surgery

Northbourne Surgery is located at 1368 Wimborne Road, Dorset BH10 7AR. The practice is located in a residential area of north Bournemouth. Northbourne Surgery is part of the Dorset Clinical Commissioning Group. The practice operates from a building which is owned by the GP partners. The practice building has five consulting rooms and two treatment rooms. A physiotherapist and a local counselling service also use the building.

The practice has two male GP partners and used additional locum GPs when needed. Support is also provided by two practice nurses and a health care assistant. The practice is further supported by a locum practice manager, reception and administrative staff. Northbourne Surgery is a training practice and has trainee GPs supporting the practice and working alongside the partner GPs.

The practice provides a range of primary medical services to approximately 5870 patients and has a general medical services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

The practice is open on Monday to Friday between 8am and 6.30pm. Extended hours have been suspended due to GP shortages.

The Care Quality Commission draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework, the National Patient Survey and data from Public Health England. This data shows that the practice provides care and treatment to a higher than average number of patients who are over the age of 65 compared with the average for England. This includes care and treatment to people who are living in a large nursing home and other care homes in the area.

The GPs at this practice have opted out of providing out of hours services to their patients. When the practice is closed out of hours care and treatment is provided by South Western Ambulance Trust. Patients can access this service through the NHS 111 telephone number.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out a focussed 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.

Detailed findings

How we carried out this inspection

We carried out an announced visit to the practice on 26 July 2016 and looked specifically at the shortfalls identified in the warning notices served to the practice after our inspection in March 2016.

We did not look at population groups or speak with patients who used the service.

We spoke with the lead GP, the locum practice manager, nursing staff and reception and administration staff.

We looked at policies and procedures and inspected records related to the running of the service. These included minutes of staff meetings, significant events and action plans produced by the practice to address concerns and complaints.

Inadequate

Are services safe?

Our findings

Safe track record and learning

At our inspection on 3 March 2016 we found shortfalls in identifying and acting on significant events. Reporting processes did not ensure that significant events were reported, recorded appropriately and monitored when action points had been identified.

At the inspection on 26 July 2016 we found that the processes for managing significant events had been improved. The practice had implemented an action plan to manage all shortfalls identified in the warning notices served. These actions were rated red, amber and green to show when action had been taken and completed. The action which related to significant events had been completed on 19 July 2016. The action taken included standardising agendas for partner and staff meetings to ensure that significant events were a standing item to be discussed.

Minutes from staff and GP partner meetings showed that all significant events which had occurred since the inspection in March had been identified, appropriately recorded and discussed in meetings. Actions points were made and minutes demonstrated ongoing monitoring of remaining actions needed. Discussion with staff confirmed that significant events were discussed in meetings and they were able to describe changes in practice as a result of significant events. For example, a GP had been requested to contact a parent about a child. The task had not been completed. This was noted as a significant event and action was taken to ensure urgent tasks were identified on the system and acted upon.

Overview of safety systems and processes

At the inspection in March 2016 we found that investigation results and other reports were not reviewed and acted on in a timely way to identify any abnormal results or other urgent actions required. The process in place to ensure these tests and result were acted on had not been followed by staff employed for the purpose of carrying out the regulated activity which placed patients at risk of harm.

- There was not an effective process to ensure that tests required for the monitoring of higher risk medicines including disease modifying anti rheumatic drugs (DMARDs) and others such as lithium and warfarin were undertaken.
- There were no details of safety netting to ensure patients were receiving appropriate and relevant medicines and had had regular reviews. Systems for ensuring that repeat prescriptions and those for DMARDs were only authorised by a clinician did not protect patients from harm. We found that GPs signed prescriptions which had been generated by an administrator even when blood tests results had not been obtained and/or checked.

Since the inspection in March 2016 the practice had change the system for managing investigation result, reports and management of high risk medicines. There was a lead GP who was responsible for authorising prescriptions for DMARDs. This GP ensured that there were no remaining actions from hospital investigations or other tests; blood tests or other relevant investigations had been carried out and the results were available for these, prior to the prescription being authorised.

Medicines

At our inspection in March 2016 we found shortfalls in the arrangements for managing medicines, including vaccines, including obtaining, prescribing, recording, handling, storing, security and disposal.

- The repeat prescribing protocol did not clearly show what arrangements were in place for ensuring that medicines were necessary, relevant and appropriate checks were in place prior to prescriptions being produced line with current legislation and guidance.
- We found that medicines held in the practice had expired and vaccines were stored in overcrowded fridges.
- Patient Group Directions and Patient Specific Directions were in place. However, these had not been individually signed and dated on individual sheets by the members of staff who administered vaccines and medicines.
- Blank prescription forms were not handled in line with current national guidance, tracked through the practice and kept securely at all times. There was a system in place to log the serial numbers of electronic

prescription paper, but no record of which printer the electronic prescription paper was being used in. There was no log for hand written prescription pads once these had been taken from the locked filing cabinet.

At the inspection on 26 July 2016 we found that the arrangements for managing medicines, including vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The repeat prescribing policy had been reviewed and updated to reflect safe practice and the standards staff were expected to maintain when handling repeat prescriptions. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient group directions had been checked to ensure they were in date and staff had signed them appropriately.

Chaperoning

At our inspection in March 2016 we found that the chaperone policy dated 1 August 2015 did not show clearly who was an appropriate person to chaperone patients when they were receiving an examination. The policy stated that chaperones would either be practice nurses or healthcare assistants due to the need that chaperones should have had a criminal records check and some clinical knowledge and training. However, in paragraphs three and four of the document the information stated that interpreters and parents or an adult relative could act as a chaperone.

At our inspection in July 2016 we found the chaperone policy had been rewritten and clearly showed who could act as a chaperone and how this would be recorded and carried out. The practice was currently using practice nurses only, until other staff such as healthcare assistants and receptionists had received appropriate training. The practice informed us that all staff were currently having their Disclosure and Barring Service (DBS) checks carried out again; records we saw confirmed this. 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.

Infection control

At our inspection in March 2016 we found shortfalls in infection control measures. Records kept for cleaning of equipment did not show that this was carried out on a regular basis. There were no instructions for staff on how to carry out effective cleaning of equipment, such as ear syringes and nebulisers.

Areas in the practice did not allow for thorough cleaning and reduce the risk of cross infection. For example, waterproof sheeting near a sink was not effectively sealed.

At this inspection we found that the practice had undertaken a complete infection control audit with the assistance of the infection control lead from the clinical commissioning group (CCG) on 9 June 2016. The practice had scored 92% and had developed an action plan to address shortfalls identified. All actions from the audit had been actioned and the practice were awaiting a re-audit by the CCG. We found that the waterproof sheeting above the sink area had been sealed to enable it to be cleaned effectively. The practice had had floors and the waiting area deep cleaned. Desks and surfaces had been de-cluttered and cleaning schedules had been reviewed. Records showed that equipment was cleaned on a regular basis and recorded. There were also records to show that clinical areas and other areas in the practice were regularly cleaned and audits carried out on the quality of cleaning undertaken.

Arrangements to deal with emergencies and major incidents

At the inspection in March 2016 we found shortfalls in the amount of emergency equipment and medicines kept in the practice. We also found that some of these items had expired or were not in a safe condition to be used. The practice did not have a suitable business continuity plan in place in case of a disruption to the service provided.

- In July 2016 we found that emergency equipment had been replaced. There were new adult and child masks and airways; oxygen tubing had been replaced and was stored in sealed packaging; and paediatric defibrillator pads were available for use, in addition to adult pads. We found that the lists of emergency equipment and medicines that the practice considered necessary were present in the practice and the amounts tallied, for example the number of airways to be kept.

Are services well-led?

Inadequate

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

Our findings

Governance arrangements

At our inspection in March 2016 we found the practice did not have suitable systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities, including the quality of the experience of service users in receiving those services. Systems in place to monitor or mitigate risks were not operated effectively to ensure that risks to patients were minimised as far as possible.

Shortfalls related to:

- The system to manage complaints did not ensure that complaint themes were identified and action was taken to improve the quality of care and treatment when needed.
- Arrangements for annual leave and other absences did not ensure that there were appropriate numbers of staff with the skills and competencies to carry on the regulated activity.
- There were no standard operating procedures in place for tasks such as scanning documents and adding clinical codes. Patients' records were not fully maintained, up to date and accurate.
- Staff spoken with during this inspection were concerned that training for scanning and coding had not been completed to a sufficient standard to enable effective cover to be provided for planned periods of annual leave.
- There were no systematic processes in place to ensure that practice policies and procedures were appropriately reviewed and updated to ensure their content was current and relevant. There were duplicate copies of policies and procedures which did not provide sufficient information to ensure patients and staff were protected from risk.
- The business continuity plan was not up to date and accurate. It was not clear whether the buddy GP practice or GP partners were aware of the actions that they would need to take if there was an unplanned interruption to the service.
- There were no arrangements to show which members of staff were on the premises when the practice was open for patients. Therefore staff were unable to ascertain who to contact in the event of an emergency situation.
- Quality and outcome framework reporting exceptions were significantly higher than national and clinical commission group averages. The practice were unable to demonstrate how it planned to improve its exception reporting rate.
- The practice was not proactive in engaging patients in their care and treatment. There was inflexibility around clinic times for reviews of patients with long-term conditions. The practice did not show evidence of actively supporting patients who were housebound. Home visits were only organised or offered for those considered to be extremely frail, rather than based on patient need.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement and there was no evidence that the practice was comparing its performance to others; either locally or nationally.

At this inspection on 26 July 2016 we found that action had been taken:

- To ensure all complaints whether they were received verbally or in writing had been addressed and responded to openly. An analysis had taken place on all concerns received and action plans showed that improvements were being made and monitored.
- Each staff group had an annual leave planner which showed when staff were absent and arrangements were in place to skill staff in carrying out coding and scanning duties. The member of staff responsible for scanning and coding had been given protected time to clear the backlog of documentation to ensure patients' records were up to date and accurate.
- All policies and procedures related to the running of the practice were in the process of being reviewed. Each policy had a date for further review and a version control number. We noted that the practice had prioritised policies on infection control, recruitment and repeat prescribing. The policies on recruitment and infection control clearly stated what the processes and systems were in place to ensure patients received safe care and treatment. The policy on repeat prescribing was awaiting review by the pharmacist who worked for the clinical commission group prior to being signed off; the draft copy that we saw was comprehensive and detailed

Are services well-led?

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the processes for repeat prescribing and management of high risk medicines. These aligned with how prescriptions and medicines were now being handled in the practice.

- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included up to date emergency contact numbers for staff. Copies of the business continuity plan were kept off site by the partners and key staff members.
- The practice had implemented a signing in and out book for all staff members to complete. The locum practice manager reported that this had been useful when a fire alarm went off and they were able to account for all staff members.
- Appointment times were now more flexible and the practice worked with the over 75 team in the area to ensure that housebound patients were offered reviews in their home. The practice had also employed a practice nurse who was to be responsible for carrying out home visits to undertake reviews on long term conditions.
- The GPs were now responsible for coding patient interactions for QOF; we were shown unverified figures for 2015-16 which showed some improvements.
- We reviewed audits which had been undertaken since our inspection and found that the practice had commenced an audit on use of analgesics (painkillers) used in slow release patch form to ensure they were use appropriately.

Leadership and culture

At our inspection in March 2016 we found that improvements were needed to ensure that staff were enabled to take ownership of the work they carried out, as there were strict lines of communication and processes which had to be followed, which did not allow for openness and transparency.

At this inspection in July 2016, staff informed us that delegation of tasks had started to occur and they were being supported to be autonomous in their roles. We found that support and training was being given to a member of staff who had recently been made the practice support manager, to enable them to become responsible for the day to day running of the practice. The lead nurse told us they had assumed all responsibility for nursing matters in the practice and had put some systems into place. For example, a healthcare assistant was now responsible for ordering supplies of equipment and had protected time to carry out weekly checks on equipment in the practice. A full infection control audit had been undertaken and a hand hygiene audit had taken place.

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

At our inspection in March 2016 the inspection team found that processes for seeking and acting 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 were inadequate.

- The registered provider did not proactively engage with patients and staff and acted on their comments and concerns only when these were raised directly with them.
- Staff told us that they did not consider they were able to approach the GP partners directly because of this and were uncertain whether they were being listened to.
- Staff concerns were not always acknowledged and there was no clear action planning from staff feedback.
- Meeting minutes identified many issues that had been raised a number of times with no resolution and there were strict lines of communication, which did not encourage staff to speak with the GP partners directly.
- A staff member felt discussions were not always followed through and were preventing staff from being motivated to raise concerns.
- A patient we spoke with was concerned that only telephone triage appointments were offered and this aligned with views on NHS Choices, the Friends and Family test and comments from patient who completed Care Quality Commission patient comment cards. Patients considered that this did not allow choice.
- The provider stated that feedback had been gathered from patients through the patient participation group (PPG) and surveys and complaints received. PPG meeting minutes showed that a discussion of the recent Family and Friends Test (FFT) results had taken place. However, this lacked information about any actions to be taken from this feedback. There was no evidence provided to demonstrate how the practice has made improvements as a result of patient feedback.

Are services well-led?

Inadequate

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

At this inspection we found that regular staff meetings had been held and minuted. Meetings were held on a weekly basis and all staff were invited to attend. In addition nurses were able to have specific meetings for their staff group. Meetings for the whole practice had a set agenda which included complaints, significant events and sickness and absence cover. We saw that staff were encouraged to raise any concerns they had or make comments on how the practice was managed. There were clear actions plans developed when needed, which were monitored.

The practice had reviewed the appointment system and patients were now able to attend for reviews outside of set clinic times. When patients had specific needs, for example were hearing impaired then an alert was place on their record to show that telephone triage was not appropriate and they were able to book a face to face appointment. The practice had registered to respond to comments on NHS Choices and was in the process of replying to comments received. We found there was an action plan in place to address concerns raised by patients when needed.