Northbourne Surgery

Quality Report

Northbourne Surgery
Bournemouth
Dorset
BH10 7AR
Tel: 01202 574100
Website: www.northbournesurgery.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Northbourne Surgery was previously inspected by the Care Quality Commission in May 2015. when we rated the practice as requires improvement overall. Specifically, the practice was rated as requires improvement for providing safe care, for providing responsive services and for being well-led. The practice was rated as good in the caring and responsive domains. Shortfalls were found in relation to infection control, recruitment processes, staff deployment, medicines management and governance.

We carried out an announced comprehensive inspection at Northbourne Surgery on 3 March 2016. Overall the practice is rated as inadequate.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment. Action had not been taken to improve identified shortfalls in infection control procedures.
- There was more than one version of some of the policies and procedures. Policies contained out of date information referencing dissolved organisations or entities such as primary care trusts and criminal record bureau checks.
- Staff could not identify the safeguarding lead at the practice.
- Staff were clear about reporting incidents, near misses and concerns but there was no evidence of learning and communication with staff.
- Patient outcomes were hard to identify as little or no reference was made to audits or quality improvement. There was limited evidence that the practice was comparing its performance to others; either locally or nationally.
- Most patients were positive about their interactions with staff and said they were treated with compassion and dignity.
- Appointment systems were not working well and did not provide patient choice, so patients did not receive timely care when they needed it.

Summary of findings

- The practice had no clear leadership structure and limited formal governance arrangements.

The areas where the provider must make improvements are:

- Introduce robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.
- Take action to address identified concerns with infection prevention and control practice.
- Ensure recruitment arrangements include all necessary employment checks for all staff as detailed in the regulations.
- Implement formal governance arrangements including systems for assessing and monitoring risks and the quality of the service provision.
- Provide staff with appropriate policies and guidance to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- Ensure that blank prescription forms are handled in line with current national guidance, tracked through the practice and kept securely at all times.
- Ensure that patient group directives and patient specific directives are signed and dated on an individual record by each member of staff who is carrying out the delegated role.
- Ensure there are sufficient numbers of staff available to ensure there are no delays in scanning or coding documentation.
- Ensure regular checks of medicines and emergency equipment are in place to ensure they are in date, maintained and fit for use.
- Ensure there is proactive engagement with patients and staff.

The areas where the provider should make improvement are:

- Improve processes for making appointments to provide patients with real choice.
- Improve the range of clinical audits.

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

Special measures will give patients who use the practice 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 and improvements must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when there were unintended or unexpected safety incidents, reviews and investigations of incidents were not always completed. For example meeting minutes highlighted that information was discussed but there was no evidence that recording of actions took place or that lessons were learned to ensure patient safety was improved. Patients did not always receive a written or verbal apology when required.
- Patients were at risk of harm because systems and processes were not implemented in a way to keep them safe. For example, investigation results and other reports were not acted upon in a timely way to identify any abnormal results or urgent actions required.
- There was no formal repeat prescribing policy in place that ensured patients received appropriate and relevant medicines. Some medicines had expired and emergency equipment was missing or not packaged securely to ensure it was clean and safe to use.
- The practice did not have a procedure to identify who was working in the building in the event of an evacuation.
- There was insufficient attention to safeguarding children and vulnerable adults. Policies relating to safeguarding had not been reviewed since 2009.Staff were unable to identify the lead for safeguarding.Up to date information on local safeguarding teams was however available in consultation rooms.
- Deployment of staff did not ensure that the practice ran smoothly when staff were on annual leave or off sick.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services as there are areas where improvements should be made.

- Data showed that patient outcomes were above or similar to the locality and nationally. For example, the percentage of patients with high blood pressure having regular blood pressure tests in the preceding 12 months was 83% in comparison to the national average of 84%.

Summary of findings

- The practice decided to exempt patients from the Quality and Outcomes Framework assessment when they were housebound and could not attend the practice for appointments.
- 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.
- There was engagement with other providers of health and social care.
- There was no overarching training matrix in place for the practice to identify when staff training needed updating and demonstrate what training had been given.
- There was limited recognition of the benefit of an appraisal process for staff and little support for any additional training that may be required.
- Staff told us about the arrangements for monitoring the number of staff and skill mix to meet patient needs. We saw the rota system in place for different staffing groups but there was no system to monitor staffing levels on a regular basis.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- Data from the National GP Patient Survey showed patients rated the practice lower than others for some aspects of care. For example, 79% of patients said the last GP they saw or spoke to was good at explaining treatment and tests in comparison to the Clinical Commissioning Group average of 90% and a national average of 87% of patients.
- The majority of patients said they were treated with compassion, dignity and respect. However, not all felt cared for, supported and listened to.
- Information for patients about the services was available but not readily available in accessible formats such as easy read or in other languages apart from English.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.as there are areas where improvements should be made.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.

Summary of findings

- 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.
- There was inflexibility around clinic times for reviews of patients with long-term conditions. Practice nurse meeting minutes from January 2016 evidenced the discouragement of seeing patients outside of the set clinic times.
- The practice did not proactively seek other ways to enable patients to have reviews of their condition.
- Feedback from patients reported that access to a named GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day.
- The practice was equipped to treat patients and meet their needs.
- Consulting rooms were mainly on the ground floor. There was no lift to the upstairs rooms but patients could be seen downstairs if needed.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that learning from complaints had been shared with staff and an apology provided if needed.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led, as there are improvements that must be made.

- The practice did not have a clear vision and strategy. There was no clear leadership structure and staff did not feel supported by management.
- The practice had a number of policies and procedures to govern activity, but these were over out of date or contained incorrect information.For example, policies referred to obsolete organisations. The infection control policy did name the correct lead staff member but was dated before this staff member had commenced employment.
- The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- The practice had not proactively sought feedback from staff or patients. There was a patient participation group however their engagement with the practice was limited.
- Some staff told us they had not received regular performance reviews and did not have clear objectives.There was no formal appraisal policy in place.

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 the care of older people. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The safety of care for older patients was not a priority and there were limited attempts at measuring safe practice. For example home visits were only organised or offered for those considered to be extremely frail rather than on patient need.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older patients were similar to national data. However, if a patient could not attend the practice for health checks the practice chose to exempt them from Quality and Outcome Framework reporting.
- Over 75 health checks were conducted by health care assistants.
- The practice had little understanding of the needs of older patients and were not attempting to improve the service for them. Services for older patients were therefore reactive, and there was a limited attempt to engage this patient group to improve the service.

People with long term conditions

Inadequate

The practice is rated as inadequate for people with long term conditions. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

- The performance related indicators for both diabetes and asthma were similar to or better than national averages.However, exception reporting for these was significantly higher than local and national averages.Patients were exempt if they were unable to attend the practice for an appointment or had not responded to three verbal or written notifications.
- Longer appointments and home visits were not consistently available when patients needed them.
- Very few of these patients had a named GP and personalised care plan.

Summary of findings

- Structured annual reviews were not undertaken to check that patients' health and care needs were being met.
- There was a lack of flexibility around chronic disease clinic timings and appointments.Meeting minutes from January 2016 evidence the discouragement of nurses from seeing patients outside of these clinic times.

Families, children and young people

Inadequate

The practice is rated as inadequate for the care of families, children and young people. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice including this population group.

- There were no systems to identify and follow up patients in this group who were living in disadvantaged circumstances and who were at risk of harm.
- There was an allocated Safeguarding lead, however, staff were unclear as to who this was.
- Immunisation rates for the standard childhood immunisations were comparable to national averages.
- A telephone triage appointment system was in place reducing the need to visit the practice unnecessarily.
- GPs reviewed telephone appointments and determined whether a child under 10 years of age was to be given priority.
- The practice was accessible for pushchairs.

Working age people (including those recently retired and students)

Inadequate

The practice is rated as inadequate for the care of working-age people (including those recently retired and students). The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice including this population group.

- The age profile of patients at the practice is mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group.
- Appointments could only be booked by telephone. A GP would call back before a face to face appointment was given. Pre-bookable appointments were not available.
- The extended opening hours on a Monday had temporarily been suspended due to staff shortages but signs in the waiting area still advertised this service.

Summary of findings

- Reception staff reported that working age individuals were not happy with the new appointment system as staff were unable to provide patients with a time that the GP would call them back.
- Health promotion advice was offered but there was limited accessible health promotion material available through the practice.

People whose circumstances may make them vulnerable

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice including this population group.

- There were no policies or arrangements to allow patients with no fixed address to register or be seen at the practice.
- The practice worked with multi-disciplinary teams in the case management of vulnerable patients.
- Some staff knew how to recognise signs of abuse in vulnerable adults and children, but they were not aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies out of normal working hours.
- Not all staff had received adult safeguarding training.Staff were unclear of who the safeguarding lead was at the practice, listing two different staff members.

People experiencing poor mental health (including people with dementia)

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia). The provider was rated as inadequate for safe, effective, responsive and well-led and requires improvement for caring. The concerns which led to these ratings apply to everyone using the practice including this population group.

- The practice was unable to identify patients experiencing poor mental health or those with dementia.
- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health but not always those with dementia.The practice was part of a locality program to become a dementia friendly practice.This was in its infancy at the time of inspection.

Summary of findings

- The practice did not carry out advance care planning for patients with dementia.
- Nurses administered injectable medicines for patients with mental illness but there was no system in place to follow up with patients who did not attend for the medicines.

Summary of findings

What people who use the service say

The national GP patient survey results published on 7 January 2016. The results showed the practice was performing in line with local and national averages. 257 survey forms were distributed and 106 were returned. This represented a response rate of 41% and was representative of approximately 2% of the practice's patient list.

- 86% found it easy to get through to this surgery by phone compared to a national average of 73%.
- 81% were able to get an appointment to see or speak to someone the last time they tried compared to a national average of 76%.
- 88% described the overall experience of their GP surgery as fairly good or very good compared to a national average of 85%.
- 76% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards, the majority of which were positive about the standard of care received. Patients said that staff respected them and maintained their dignity.

We spoke with one patient during the inspection. The patient was unhappy with the new appointment system of telephone triage prior to being seen by a GP if needed. This system had been introduced in September 2015. There were no pre-bookable appointments available. The patient said that they would rather see a GP face to face than have to receive a phone call first to determine if this was necessary.

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, a second CQC inspector, and a practice manager 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 locum GPs when needed. At the time of our inspection the practice was further supported by a GP registrar. Support is also provided by two practice nurses and a health care assistant. The practice is further supported by a 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. There used to be extended hours until 8pm on Mondays, but this had 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. However details of how to access out of hours care was not detailed on the practice website.

Northbourne Surgery was previously inspected by the Care Quality Commission in May 2015. when we rated the practice as requires improvement overall. Specifically, the practice was rated as requires improvement for providing safe care, for providing responsive services and for being well-led. The practice was rated as good in the caring and responsive domains. Shortfalls were found in relation to infection control, recruitment processes, staff deployment, medicines management and governance.

Detailed findings

Why we carried out this inspection

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

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.

Northbourne Surgery was previously inspected by the Care Quality Commission in May 2015 when we rated the practice as requires improvement overall. Specifically, the practice was rated as requires improvement for providing safe care, for providing responsive services and for being well-led. The practice was rated as good in the caring and responsive domains. Shortfalls were found in relation to infection control, recruitment processes, staff deployment, medicines management and governance. We carried out the inspection on 3 March 2016 to follow up on previous breaches of regulation.

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 3 March 2016.

During our visit we:

- Spoke with a range of staff, including GPs, the practice manager and admin staff.There were no nurses available to speak with us due to staff training.We also spoke with patients 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.

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

Northbourne Surgery was previously inspected by the Care Quality Commission in May 2015 when we rated the practice as requires improvement overall. Shortfalls were found in relation to recording and tracking outcomes in relation to significant events and complaints.

At this inspection we found the practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, there was limited improvement in how information was recorded and whether action had been taken.

Records were kept of significant events that had occurred and a record of the last 12 months was made available to us. We saw that significant events and complaints were discussed at weekly meetings held with the GPs and practice manager. This provided GPs and the practice manager the opportunity to discuss any incidents and to record any actions to improve patient care. However, the system of recording, analysis and monitoring of significant events, incidents and complaints was not consistently robust. We saw from practice meeting minutes that these had been recorded as being discussed; but the minutes did not give full details. It was not always possible to track the actions or lessons learnt as some of the dates on the event analysis forms or complaints record did not match those recorded in meeting minutes.

Medicines and healthcare products regulatory agency safety alerts were received by the practice via fax and distributed to GPs and acted upon when needed. When needed, they were discussed at practice meetings if the concerns were relevant to the practice, for example, when there had been the recall of medicines.

When there were unintended or unexpected safety incidents, patients sometimes received reasonable support, truthful information and were told about any actions to improve processes to prevent the same thing happening again. Patients did not always receive this support or a written or verbal apology.

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. We found:

- 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. We found a number of results concerning blood tests and investigation results, which had been received at the practice in February 2016, had not been actioned. This included both those phoned through to the practice as well as those arriving electronically into the patient record management system. There was a lack of understanding by staff of what process ensured that the absence of a GP did not delay review of results received. This put patients at potential 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. We found a backlog of results from 17 February 2016 which had not been actioned. We noted that there were abnormal blood tests results which had not been actioned and some of these patients were on high risk medicines which required routine monitoring.
- 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.
- We requested a copy of the repeat prescribing policy. The information we were given did not reflect what occurred in the practice. The policy consisted of screen shots of the process staff had to undertake to generate prescriptions on the electronic prescribing system. There were no details of safety netting to ensure patients were receiving appropriate and relevant medicines and had had regular reviews.
- Arrangements were in place to safeguard children and vulnerable adults from abuse and policies were accessible to all staff. There was a nominated lead for safeguarding in the practice but staff we spoke with gave the names of different members of staff who they thought were responsible. We found that the policies and procedures which were dated in 2009 contained relevant information on what to do if a member of staff

suspected a vulnerable adult or child was at risk of harm. We noted that consultation rooms had up to date contact details of the safeguarding teams in the local authority and clinical commissioning group.

- The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities but not all staff had received training relevant to their role. We found that seven members of the administration staff had not received any training on safeguarding adults. GPs and nurses were trained to Safeguarding level 3.
- The practice's induction programme indicated that safeguarding training would be provided for new members of staff, but not the timescales for when this should be completed by.
- 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 check (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 policy lack instruction for staff when carrying out chaperone duties. The policy stated that chaperones would either be practice nurses or health care assistants who were competent in this role and had been appropriately checked. However, an earlier part of the policy indicated that this role could be carried out by a parent or an interpreter. We were not clear what arrangements where followed when patients needed a chaperone.
- 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 who liaised with the local infection prevention teams to keep up to date with best practice. Cleaning checks were not recorded as being completed on a daily basis as per the practice policy; this had been identified as a shortfall at our inspection in May 2015.
- The practice records did not demonstrate whether nebulisers and ear syringe equipment was routinely cleaned.
- There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The infection control policy was dated 2014, however stated that the infection control lead, was a member of staff who did not start employment until 2016.
- The arrangement for managing medicines including emergency medicines and vaccines, in the practice was not sufficient to keep patients safe (including obtaining prescribing, recording, handling and storing security). For example whilst we saw records that showed the vaccine fridges were maintained within the correct temperature range. However the fridges were overcrowded which did not allow air to circulate and one fridge had a broken seal. Not all medicines listed as being present in the emergency drugs box were in the box and other medicines were out of date. For example, Salbutamol (a medicine to relieve shortness of breath) expired in October 2015. We found that packaging on the oxygen masks was open, which could compromise hygiene and patient safety.
- At our inspection in May 2015 we found that prescription printer paper was not stored securely and their use was not tracked through the practice. At this inspection we found that prescription printer paper and pads were securely stored. There was a system in place to log the serial numbers of electronic prescription paper. There was no log for hand written prescription pads once these had been taken from the locked filing cabinet.
- Patient Group Directions (PGD) had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions (PSD) to enable Health Care Assistants to administer vaccines after specific training when a doctor or nurse was on the premises. We found that both the PGDs and PSDs these had not been dated when signed by staff members and all the signatures were on one page.
- A GP said that a receptionist had been trained to search and arrange GP led prescribing reviews, either on the telephone or at a face to face appointment.
- The recruitment policy was implemented in August 2014 as a result of a previous CQC inspection in July 2014

which found gaps in the records of checks made of new employees. The practice had employed new staff since the last inspection in May 2015. We reviewed four personnel files and found that the practice did not gain satisfactory evidence of conduct in previous employment. For example, one staff member had a clinical reference from another practice but this practice was not listed as a former employer on their curriculum vitae. Two other staff members did not have any record of references obtained prior to employment in their files. The recruitment policy is unclear as to how many references should be collected for each employee sometimes stating "the references" and other times "the reference". Two personnel files for nursing staff had copies of criminal records checks but these were obtained when working with previous employers. There was no evidence that a new criminal record check had been completed by Northbourne Surgery.

Monitoring risks to patients

Risks to patients were assessed and managed but this was not consistent.

- There were procedures in place for monitoring and managing risks to patient and staff safety, but these did not keep patients and staff consistently safe.
- The practice had up to date fire risk assessments and had carried out regular fire drills and there was a record of the call points checked. However, staff were not always aware of who was in the building in the event of an emergency.
- 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). The monthly Legionella checks were of the hot water only. There were no cold water checks as part of the process as detailed in the risk assessment. Legionella bacteria multiply when water is at a temperature of 20 to 50 degrees Celsius. Therefore if cold water is not delivered under 20 degrees Celsius there is a risk of contamination which is harmful to health.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

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 all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult masks.There were no child defibrillator pads available with the emergency equipment.The adult and paediatric airway and tubing stored with the oxygen were out of date, having expired in 2015. This meant that the equipment could not be guaranteed to be in good working order which placed patients at risk.
- 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 fit for use.Some emergency medicines listed as being present in were missing.

The practice had a business continuity plan in place for major incidents such as power failure or building damage. However, the plan was not updated to reflect staffing changes in the past six months and did not include emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and 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 were 100% of the total number of points available.

Exception reporting for all areas was higher than the clinical commissioning group (CCG) 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).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed:

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes, on the register, in whom the last average blood sugar was acceptable in the preceding 12 months was 87% compared to the national average of 78%.
- The percentage of patients with high blood pressure having regular blood pressure tests was similar to the national average of 84%. The practice achieved 83% in the preceding 12 months.
- Performance for mental health related indicators was better than the national average. For example the percentage of patients with Schizophrenia, Bipolar Affective Disorder and other psychoses who had a comprehensive agreed care plan documented in their records in the preceding 12 months was 94% compared to the national average of 88%.
- QOF exception reporting was higher than CCG and national averages for several indicators.
- For example 24% of patients were exempt from Peripheral Arterial Disease monitoring in comparison to a CCG average of 7% and a national average of 6%.
- For cancer patients, the practice has 44% exception reporting in comparison to the CCG average of 17% and a national average of 15%.
- Patients were exempt if they have not responded to three letter or phone prompts to attend the practice for review.Patients were also exempt if they were housebound and not able to attend the practice.

Clinical audits demonstrated quality improvement.

- There had been three clinical audits completed in the last 12 months such as an audit on the prescribing of Non-steroidal Anti-inflammatory drugs (NSAID). These completed audits were required and supported by the CCG.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, there were no timescales identified for when new members of staff should complete their induction training to demonstrate they were competent.
- There was no overarching training matrix in place for the practice to identify when staff training needed updating and demonstrate what training had been given. Staff were responsible for monitoring and updating their own training through an on-line training system. Seven of the administration staff had not completed safeguarding adult training. Records showed that no staff had completed the Information Governance training module and only one staff member completed the equality and diversity training. The practice had protected learning afternoons every three months which would be for role specific training. For example the nursing staff attended the local hospital for training on ear syringing techniques.

Inadequate

Are services effective?

(for example, treatment is effective)

- The learning needs of staff were not consistently identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to training to meet their learning needs and to cover the scope of their work, but they were not fully supported to achieve this. Support staff told us that there was limited opportunity for training due to time constraints and the demands of the practice. Three administration staff said that they had received an appraisal within the past 12 months; however there was no record of this in their files or elsewhere. There was no formal appraisal policy in place.
- Arrangements were in place for revalidation of GPs.
- Staff told us about the arrangements for monitoring the number of staff and skill mix to meet patient needs. We saw the rota system in place for different staffing groups but there was no system to monitor staffing levels on a regular basis. Staff raised concerns around the planning of staff to cover holiday and the impact on skill levels and abilities during these time periods. This had been an ongoing concern for staff and was identified at our inspection in May 2015.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services 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. We saw evidence that virtual multi-disciplinary team meetings took place on a regular basis and that care plans were routinely reviewed and updated.

At out inspection in May 2015 we found that there had been a backlog of coding and scanning of discharge letters which was due to a member of staff not being adequately covered whilst they were on leave. At this inspection we found there were no standard operating procedures in place for tasks such as scanning documents and adding clinical codes. This did not ensure that information was handled in a timely and effective manner. We were told by the practice that this was 'work in progress'.

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. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Supporting patients to live healthier lives

The practice's uptake for the cervical screening programme was 80%, which was comparable to the national average of 82%. The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates were comparable to CCG averages. For example, childhood immunisation rates given to under two year olds ranged from 96 -100 % in comparison to a CCG average of 94-97% and five year olds from 94% to 98% comparable to a CCG average of 92-98%.

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.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed that 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.
- The reception area lacked privacy. For example patients giving out their telephone number or address to receive a prescription or test results could be overheard. Evidence was seen that this issue was raised at the last two staff meetings but with no clear action plan for resolving the issue.
- The reception desk was noted to be too high for patients in a wheelchair. When dealing with a patient in a wheelchair the receptionist was observed to not stand up or come around to speak to the patient, instead directing the conversation towards a family member.

Nine of the ten patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, caring and treated them with dignity and respect.

Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. However, one patient said that when they had telephoned the practice the call was prematurely ended by a receptionist prior to them being able to make their request for an appointment. We were unable to speak to members of the Patient Participation Group (PPG) as they were not available. The PPG was virtual, but there had been limited engagement with the practice.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to other practices for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 94% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 87% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

Results from the Family and Friends tests in January 2016, indicated that patients were unhappy with the attitude of some staff. Comments related to rudeness of staff who worked in the practice, action to address these concerns was not evident.

Care planning and involvement in decisions about care and treatment

Patient feedback on the comment cards we received told us that they felt supported by staff and that they were able to make an informed decision about the choice of treatment available to them.

Results from the national GP patient survey showed patients responded positively to questions

about their involvement in planning and making decisions about their care and treatment. Results were worse than local and national averages. For example:

- 79% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 75% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 87% said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

Information for patients about the services was available but not readily available in accessible formats such as easy read or in other languages apart from English.

Requires improvement

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

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. We observed admin staff giving condolences to a family and offering appropriate advice on obtaining a death certificate and funeral director arrangements.

Inadequate

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. For example, the practice was working towards becoming a dementia friendly practice as part of the dementia friendly project run by the CCG. This development was in its infancy.

- The practice had offered extended opening hours on a Monday evening until 8.00pm aimed at patients who could not attend during normal opening hours. However, this had been suspended since September 2015 due to a lack of staff. Information advertising this service was still on display in the waiting room.
- A telephone appointment system was in place for all patients and the GP would determine whether a face to face appointment at the practice was required. Patients were only able to see a GP if they have received a telephone call from the GP first. This included children under 10 years of age.
- Northbourne Surgery did not offer female GP consultations and it was not clear what arrangements were in place of a patient requested this.
- Learning disability health checks were offered at either the practice or a patient's home.
- A phlebotomist from Poole hospital offered frequent clinics at the practice to reduce the need to travel to hospital for blood tests.
- 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.
- There was inflexibility around clinic times for reviews of patients with long-term conditions. Practice nurse meeting minutes from January 2016 evidenced the discouragement of seeing patients outside of the set clinic times.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were available on one level. Some GP consulting rooms were on the first floor; however there were arrangements in place for GPs to see patients in a ground floor room as required.
- There were automatic entrance doors and access enabled toilets with baby changing facilities. There was space in the waiting area for wheelchairs and prams. However we noted that the reception desk was at a high level which could create a barrier to people who use wheelchairs.
- The practice did not proactively seek others ways to enable patients to have reviews of their condition. For example, if a patient did not respond to three reminders which could either be by letter or a text reminder no further action was taken. We found an instance where a patient had not responded to one letter for a review and no attempt was made to facilitate this and no further reminders were sent.

Access to the service

The practice was open from 8am to 6.30 pm Monday to Friday. Appointments were available from 8.30am to 11.30am and from 2pm to 5.30pm on weekdays. The GPs provided telephone appointments between morning and afternoon surgeries.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages:

- 77% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 86% patients said they could get through easily to the surgery by phone compared to the national average of 73%.
- 32% patients said they always or almost always see or speak to the GP they prefer compared to the national average of 36%.

Some patients with long term conditions informed us they with were dissatisfied with the new appointment system in that they had to receive a call from the GP before an appointment was made.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- 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 on the practice website to help patients understand the complaints system along with signposting to Dorset Advocacy Services.Complaints leaflets were kept behind the reception desk screen and therefore were not easily accessible to patients.

We looked at all 15 recorded complaints received in the last 12 months. We found that the review of complaints lacked sufficient detail to confirm if dealt with in a timely way or if there was openness when dealing with the complaint. Although complaints were discussed in practice meetings there was little evidence that lessons had been learned from concerns and complaints or that actions were taken as a result to improve quality of care. For example, there was no evidence that themes had been identified around the complaints to identify areas of concern. There was no evidence of verbal complaints being logged or discussed by the practice.

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 did not have a vision and strategy displayed in the practice or on its website. We were provided with a statement of purpose which stated that the practice aims to provide high quality primary care to the patient population. It also included references to understanding, meeting and involving patients in their care and treatment. However, there was no information visible for staff on how the vision and values would be achieved in the practice.
- The practice did not have a formal written business plan to support its values and vision and to demonstrate how the practice was performing and how it wished to develop.

Governance arrangements

The practice did have governance arrangements; however, we found that they were not always effective.

At our inspection in May 2015 we found shortfalls in governance arrangements. This included: clinical audits, review of policies and procedures to ensure information was relevant and current and acting on feedback from staff. The practice had produced an action plan in response to the requirement notices made after our inspection in May 2015. The timescale for completing all actions was the end of January 2016. However, we found that this had not been achieved. The practice manager stated that there had been issues with staff sickness and one of the partners retiring which resulted in actions not being completed.

This meant that shortfalls in governance arrangements were still evident. This included risks to patient safety and led to ineffective practices and missed opportunities to improve patient care because the delivery of care had not been planned for or monitored in many areas.

For example we found that:

- Risk assessments had been completed but had not been acted upon. This also exposed patients to risks of harm. For example, Legionella checks.
- Staff training had not been planned and completed by all members of staff.
- We found 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. For example, we noted that there were duplicates of policies such as the recruitment policy and infection control policy. The infection control policy had been reviewed by a non-clinical member of staff and lacked sufficient detail of how infection control risk would be assessed and addressed. We also noted that the recruitment policy had two review dates. Some staff had signed to indicate they had read the policies but the practice could not confirm if all staff had read the policies and procedures.
- Version controls of polices were not in place, for staff to determine what the current policy was. Other policies did not accurately reflect the current situation at the practice or had not been updated to ensure they were relevant. For example, a policy referred to obsolete organisations such as primary care trusts and the recruitment policy mentioned criminal records bureau checks.
- There was a staffing structure, and evidence that staff were aware of their own roles and responsibilities. However, staff were not 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 openness and transparency.

Leadership and culture

- Staff told us they could offer suggestions about how to run the practice and how to develop the practice, but usually discussed any ideas with the practice manager. We noted in meeting minutes that any concerns or ideas were to be addressed to the practice manager in the first instance who would discuss them with the GP partners. 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.

We found that leadership was reactive rather than proactive. For example, clinical audits were not planned for in advance and only carried out in response to external guidance. Recruitment protocols were in place, but these were not consistent with the requirements of the regulations, for example, ensuring all relevant checks were carried out.

The GPs were aware of the requirements of the Duty of Candour and encouraged a culture of openness and

Are services well-led?

Inadequate

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

honesty but communication barriers throughout the practice meant this was not promoted or demonstrated fully. The practice had systems in place for knowing about notifiable safety incidents.

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

The practice did not have suitable systems in place to gather feedback from patients to demonstrate that their views were valued and changes were made when possible to the service provided.

Staff concerns were not always acknowledged and there was no clear action planning from staff feedback. We saw that minutes from a staff meeting in January 2016 recorded some items of concern raised by staff regarding holiday cover; the response documented was that holiday cover was not an issue for a staff meeting. Another concern related to reception staff not being aware of who was in the building. Meeting minutes also identified many issues that had been raised a number of times with no resolution.

There was also a discussion workflow when staff were on leave in the staff meetings. At the time of our inspection, the issue with workflow had not been fully addressed as a member of staff had not been adequately covered when they were on leave. This had created a backlog of scanning and coding of discharge letters. Another concern was that reception staff did not know when GPs were in or out of the building. Reception staff we spoke with were not aware which staff were in the building which meant they could not effectively direct patient queries or be able to account for all staff should there be an emergency evacuation.

The practice did not proactively seek patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received although there was no evidence of this provided on the day. 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.
- The practice had gathered feedback from staff through staff meetings.However, some staff spoken to on the day felt that the issues raised as agenda items were not listened to or acted upon.For example one staff member raised concerns about prescriptions being completed by reception staff at the front desk and asked for this to be an agenda item.The staff member felt discussions were not always followed through and are preventing staff from being motivated to raise concerns.

Continuous improvement

There was no clear evidence to demonstrate that the practice was engaging in pilot programmes or initiatives to generate innovative service improvements.

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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** The registered person had not ensured that staff received suitable training and appraisals to enable then to carry out the duties they were employed to perform. • Staff training had not been planned for and completed by all members of staff. • Appraisals for staff were not consistently carried out. This was in breach of regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person did not ensure that persons employed for the purposes of carrying on a regulated activity were of good character. The registered person did not have regard to the matters outlined in Schedule 3 of the regulations. • Recruitment arrangements did not include all necessary employment checks for all staff as detailed in the regulations. This was in breach of regulation 19 (1) (a) 2 (a) (3) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The registered provider did not have suitable systems in place to ensure care and treatment was provided in a safe way. The provider had not ensured that patients were protected by means of assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated. The provider had not ensured that the proper and safe management of medicines was in line with current legislation and guidance. • The practice's chaperone policy did not show how the patients and staff members would be protected. • Risk assessments on staff had been completed but had not been acted upon, which exposed patients to risks of harm. • 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. • 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. • 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.

This section is primarily information for the provider

Enforcement actions

- **There were no details of safety netting to ensure patients were receiving appropriate and relevant medicines and had had regular reviews.**
- The practice records did not demonstrate whether nebulisers and ear syringe equipment was routinely cleaned.
- There were no children's masks or defibrillator pads available with the emergency equipment. The adult and paediatric airway and tubing stored with the oxygen were out of date, having expired in 2015. We found that packaging on the oxygen masks was open, which could compromise hygiene and patient safety.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccines after specific training when a doctor or nurse was on the premises. These had not been dated when signed by staff members.
- Medicines were not stored safely and appropriate checks had not been carried out to ensure they were in date and fit for use. The fridges were overcrowded which did not allow air to circulate and one fridge had a broken seal. Not all medicine listed as being present in the emergency drugs box were in the box and other medicines were out of date.
- **Action had not been taken to address identified concerns with infection prevention and control practice.**
- **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 lack of robust processes for reporting, recording, acting on and monitoring significant events, incidents and near misses.**

This was in breach of regulations 12 (1) (2) (a) (b) (d) (e) (f) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

Regulated activity	Regulation

This section is primarily information for the provider

Enforcement actions

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

How the regulation was not being met:

The registered person did not have appropriate systems, processes and policies in place to manage and monitor risks to the health, safety and welfare of patients, staff and visitors to the practice.

The registered person did not have systems in place to ensure they were able to maintain an accurate and complete record in respect of each service user at all times.

- There were no robust systems for ensuring that the staff were aware of the number of people working in the building. 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.
- Quality and outcome framework reporting exceptions were significantly higher than national and clinical commission group averages, but not action had been taken to engage patients in their care and treatment.
- We found 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. This did not enable staff to carry out their roles in a safe and effective manner which are reflective of the requirements of the practice.
- 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. This did not ensure that information was handled in a timely and effective manner.
- The registered provider did not proactively engage with patients and staff and acted on their comments and concerns when needed.
- Training arrangements did not demonstrate that all staff had the necessary skills and competencies to carry out their role.

This section is primarily information for the provider

Enforcement actions

- The practice did not operate effectively an accessible system for identifying and receiving complaints by service users and other persons.
- The practice's complaints policy and procedures did not contain current information.
- No information was visible or for patients to take away to help them to understand the complaints process.
- No systems were in place for recording informal or verbal complaints.

Regulation 17 (1) (2) (a) (b) (c) (e) (f)

of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance