Boundary Court Surgery

Quality Report

1-2 Boundary Court
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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Boundary Court Surgery on 01 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, safe, effective, caring and responsive services. It was also good for providing services for older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people whose circumstances make them vulnerable; and people experiencing poor mental health (including people with dementia).

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

- Shortfalls we identified at our last inspection of the practice in July 2014 had been remedied by the new provider since it took over Boundary Court Surgery on 01 October 2014.
- There was a clear leadership structure and revised operational policies and procedures in place. Staff felt supported by the new management team. The practice proactively sought feedback from staff and patients, which it acted on.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including safeguarding, infection control, medicines management and staffing.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. The provider had increased staffing levels. Staff had received training appropriate to their roles and were supported to continue their professional development and training.
- Patients were treated with courtesy and respect and they said they were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available and easy to understand. Complaints were dealt with in a timely manner and the practice took learning points from complaints to improve the service.
- Patients said they found it much easier to make an appointment since the new provider took over the practice; that urgent appointments were available the same day; and that there was continuity of care.
- The practice was well equipped to treat patients and meet their needs.

We saw one area of outstanding practice:

- Since the new provider took over Boundary Court Surgery on 01 October 2014 there had been marked improvements in the practice's patients' access to primary care resulting in fewer A&E attendances and emergency admissions to hospital, and more planned admissions. The practice achieved a Quality and Outcomes Framework (QOF) score of 92.7% in 2014-15 compared with a score of 90.2% in 2013-14, despite the new provider taking over the practice half way through the year. QOF is a voluntary incentive scheme for GP practices in the UK. It rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

- Further raise patients' awareness of the availability of the telephone translation service.
- Ensure the name of the designated Health and Safety representative for the practice is displayed.

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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Patient outcomes were improving. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Patients communicated that they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We saw that staff treated patients with courtesy and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they found it much easier to make an appointment and that there was continuity of care. Urgent appointments were available the same day. The practice had made the best of inadequate premises and provided a safe environment for patient care. It was well equipped to treat patients and meet their needs.

Summary of findings

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear purpose and aims and objectives. Staff were clear about the purpose and their responsibilities in relation to it. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions and appraisal and attended staff meetings.

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

Good

The practice is rated as good for the care of older people. Since taking over the practice, the number of A&E attendances for people aged over 65 years had reduced significantly. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia. It was responsive to the needs of older people, and offered home visits and telephone consultations to improve access to a GP. Longer appointments were available for patients with complex medical needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions (LTC). The practice was taking proactive action to identify patients with undiagnosed LTCs and patients at high risk of avoidable hospital admission. It was establishing a recall system to ensure regular and timely reviews of all patients with LTCs took place. The GPs and the nurse offered patients designated LTC appointments as part of the planned initiative to bring all patients' reviews up to date. Longer appointments and home visits were available when needed. The practice worked with relevant health and care professionals to deliver a multidisciplinary package of care to those people with the most complex needs. It was taking part in borough wide initiatives, for example to improve services for people with diabetes.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice's GP Lead was the Clinical Commissioning Group's (CCG) clinical lead for maternity, children, young people and safeguarding children, and was a member of the CCG's Safeguarding Board. He brought this experience and expertise to the development of systems at the practice to identify and follow up children living in disadvantaged circumstances and who were at risk, for example children and young people who had a high number of A&E attendances. Immunisation rates were much improved and the practice was meeting the target for child immunisations for children aged 24 months, which had not been reached previously. This success was due to the practice's Turkish speaking immunisations coordinator. Appointments were available outside of

school hours and the premises were suitable for children and babies. The practice was taking part in a borough wide public health project to address child poverty through improved engagement with health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. It had introduced extended opening hours. The practice was proactive in offering online services, including appointments, medication requests, and contact and summary care record updates. It was in the process of promoting health checks. Cervical screening rates were much improved and the practice was meeting the target, which had not been achieved previously. A full range of information about health conditions and diseases, and about the prevention of ill health was available on the practice website. The website allowed translation of this information in to 87 different languages.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with a learning disability. It offered longer appointments for people with a learning disability and involved carers in decisions about their treatment and care when necessary. The practice was in the process of promoting health checks. There was a system in place for a GP to review the patient's records if they did not attend for their appointment.

The practice regularly worked with other services in the case management of vulnerable people for example district nurses and health visitors, and the local alcohol and drug dependency service. It had told vulnerable patients about how to access various support groups and voluntary organisations, for example local support groups for Asian women and women affected by domestic and sexual violence.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, for example Improving access to psychological therapies (IAPT) and the community mental health team. The practice was in the process of promoting regularised annual health checks to ensure people's physical health needs were also met. There was a system in place for a GP to review the patient's records if they did not attend for their appointment.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations, for example MIND.

Summary of findings

What people who use the service say

Patients completed CQC comment cards in the two weeks prior to our inspection to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service they had experienced. Patients said the practice was caring and they were treated with dignity and respect; they were seen quickly; and the practice responded to them with the right care and treatment. Some patients commented on the recent improvements in the service. A few of the comments were less positive but there were no common themes. They referred to an issue with booking appointments online, a wait for appointments, and test results that had not been received by the practice.

We spoke with 12 patients on the day of our inspection. All expressed satisfaction with the way staff treated them and with the care they received. They told us that the appointment system worked well on the whole. A few patients told us about language barriers which they tried to overcome by bringing along a friend or relative to act as interpreter, but that this was not always possible.

The results of the national GP patient survey published on 02 July 2015 showed Boundary Court Surgery compared well with other practices in Enfield in the following areas:

- Respondents say the last GP they saw or spoke to was good at treating them with care and concern (83% compared with the Enfield average of 80%).
- Respondents say the last GP they saw or spoke to was good at involving them in decisions about their care (78% compared with the Enfield average of 77%).
- Respondents say the last GP they saw or spoke to was good at listening to them (85% compared with the Enfield average of 85%).

Boundary Court Surgery compared less well in the following areas:

- Respondents usually wait 15 minutes or less after their appointment to be seen (35% compared with the Enfield average of 56%).
- Respondents were able to get an appointment to see or speak to someone the last time they tried (65% compared with the Enfield average of 82%).
- Respondents say the last nurse they saw or spoke to was good at giving them enough time (76% compared with the Enfield average of 88%).

This was based on a 27% survey completion rate (385 surveys sent out and 105 surveys sent back).

Areas for improvement

Action the service SHOULD take to improve

- Further raise patients' awareness of the availability of the telephone translation service.
- Ensure the name of the designated Health and Safety representative for the practice is displayed.

Outstanding practice

- Since the new provider took over Boundary Court Surgery on 01 October 2014 there had been marked improvements in the practice's patients' access to primary care resulting in fewer A&E attendances and emergency admissions to hospital, and more planned admissions. The practice achieved a Quality and Outcomes Framework (QOF) score of 92.7% in 2014-15 compared with a score of 90.2% in 2013-14, despite the new provider taking over the practice half way through the year. QOF is a voluntary incentive scheme for GP practices in the UK. It rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

Boundary Court Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included a second CQC Inspector and a GP Specialist Advisor. Specialist Advisors are granted the same authority to enter the registered persons' premises as the CQC inspectors.

Background to Boundary Court Surgery

Boundary Court Surgery is located in Upper Edmonton, in the London Borough of Enfield in North London. The practice has approximately 3,000 registered patients. Its opening hours are:

- Monday – 8.00am to 8.00pm (extended opening hours)
- Tuesday to Friday – 8.00am to 6.30pm

Since 01 October 2014 GP services have been provided by a registered Organisation, Evergreen Surgery Limited, under a General Medical Services (GMS) contract with NHS England on a caretaking basis.

Prior to this arrangement GP services at Boundary Court Surgery had been provided by a registered Partnership. Both GPs in the Partnership suffered ill health before retiring from the practice in 2014, and patient care suffered in their absence. When we inspected the practice in July 2014 we found improvements were required in respect of regulations relating to Care and welfare of people who use services, Safeguarding service users from abuse, Cleanliness and infection control, Management of medicines, Staffing, Assessing and monitoring the quality of service provision, and Complaints (HSCA 2008 (Regulated Activities) Regulations 2010).

At our inspection on 01 July 2015 we found shortfalls had been remedied and that the new provider, Evergreen Surgery Limited, was providing services that are safe, effective, responsive, caring and well-led.

Services are provided by two male GPs, one full time and one part time; and by one part time female GP. The full time GP is the GP Lead for the practice and is on secondment from the provider's other GP practice in Enfield, Evergreen Surgery Limited. The others are long term locum GPs. The practice also employs a part time female practice nurse on a long term locum basis and receptionist and administrative staff. Further support for the practice is provided by Evergreen Surgery Limited's clinical director, medical director, practice manager, deputy practice manager and childhood immunisations and cervical smears coordinators.

The caretaking arrangement was in place initially until 30 June 2015 and was recently extended to 31 December 2015. NHS England has judged the premises in which the practice is housed unfit for purpose and suitable alternative premises are being looked for.

Boundary Court Surgery serves a deprived population. It is located in the most deprived ward in Enfield and falls within the most deprived ten per cent of all areas in England. It serves a highly mobile and ethnically diverse population, and a significant number of patients speak English as an additional language. The population in Enfield overall is younger than the England average, yet there is a comparatively high prevalence of long term conditions such as diabetes, hypertension and severe enduring mental illness. Childhood immunisation rates and

participation in national cancer screening programmes in Edmonton are lower than the Enfield and London averages. Life expectancy in Edmonton is 8.65 years less than life expectancy in the more prosperous areas in the borough.

Evergreen Surgery Limited is registered with the Care Quality Commission to carry on the following regulated activities at Boundary Court Surgery, 1-2 Boundary Court, Snells Park, Upper Edmonton, London N18 2TB: Treatment of disease, disorder or injury; Diagnostic and screening procedures; Maternity and midwifery service.

Patients are cared for by an external out of hours GP service when Boundary Court Surgery is closed.

Why we carried out this inspection

We inspected this service as part of our new 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. This 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.

We also wanted to check that shortfalls we had identified at our inspection of Boundary Court Surgery under the previous provider in July 2014 had been remedied.

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.

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice. We carried out an announced visit on 01 July 2015. During our visit we spoke with a range of staff, including directors, the GP Lead, practice nurse, practice manager, deputy practice manager and administrative and reception staff. We spoke with patients who used the service and a member of the Patient Participation Group. We observed how people were being cared for and talked with carers and/or family members. We reviewed the personal care or treatment records of patients. We reviewed documentation the provider gave us about the operation, management and leadership of the service.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety, for example reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed incident reports and minutes of meetings where safety concerns were documented and discussed going back to when the provider took over the practice in October 2014. They showed the practice had managed safety concerns consistently and was establishing a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of four significant events that had occurred since October 2014 when the provider took over the practice, and saw this system was followed appropriately. Significant events was a standing item on the provider's weekly clinical meetings. There was evidence that the practice learned from significant events and that the findings were shared with relevant staff. For example, following a near miss when it was identified that the practice did not have the correct contact information for a patient, an alert was put on the appointments screen prompting reception staff to check and update each patient's address and telephone number.

Staff, including receptionists, administrators and nursing staff, knew how to raise a concern with the practice manager or the GP and incident forms were available for them to use on the practice intranet. Staff felt encouraged to report when something went wrong or when patient treatment and care could be improved.

National patient safety alerts were disseminated by the practice manager to practice staff. Alerts were a standing item on the provider's weekly clinical meetings, and were disseminated more widely through email, practice meetings and changes in operational procedures to ensure all staff were aware of changes relevant to the practice and where they needed to take action. Papers from clinical meetings showed, for example, that the recent Alert on Middle East Respiratory Syndrome Coronavirus (Mers-Cov) Outbreak in South Korea was discussed at the clinical meeting on 25 June 2015.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. GPs and the practice nurse had Level three child protection training. Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information and contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a safeguarding lead GP. All staff we spoke with were aware who the lead GP was and who to speak with in the practice if they had a safeguarding concern. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. Systems were in place for identifying and following up children and young people with a high number of A&E attendances. The lead GP was also a member of the Clinical Commissioning Group's Safeguarding Board.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to a child protection plan, patients who were very frail or very elderly, housebound patients, and those who needed their medication without delay.

There was a chaperone policy and guidelines available for staff. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Non clinical staff called on to act as chaperones had been trained and had received Disclosure and Barring Service (DBS) checks. 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. Staff we spoke with demonstrated they understood their responsibilities when acting as chaperones.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out and that appropriate action was taken when the temperature exceeded the recommended upper limit, to ensure patients did not receive medicines that were not suitable for use.

Processes were in place to check medicines were within their expiry date. All the medicines we checked were within their expiry dates. The provider disposed of expired and unwanted medicines in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as they were tracked through the practice and kept securely at all times.

We saw records of clinical meetings that noted the actions taken in response to a review of prescribing data. For example, the provider was tracking the prescribing of certain broad spectrum antibiotics (Cephalosporins and Quinolones), to ensure they were prescribed only when clinically necessary because of the risk of antibiotic resistance using them poses to public health.

The nurse used up to date Patient Group Directions (PGDs) that had been produced in line with legal requirements and national guidance to administer vaccines and other medicines. The nurse worked for the practice on a long term locum basis and the provider had arrangements in place to ensure the nurse was appropriately trained and assessed as competent by the agency.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Clinical waste was handled, stored and disposed of appropriately.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

The clinical director and medical director completed an infection control audit in January 2015 to address issues at the practice concerning cleanliness and infection control. We saw that the improvement action plan arising from that audit had been completed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We were told that legionella testing was due to be undertaken shortly after our inspection on 02 July 2015, and shortly after this the provider sent us the completed risk assessment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained. A schedule of testing was in place and we saw evidence of calibration of relevant equipment, for example blood pressure and temperature measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff, including locum appointments. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. These 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. It was the provider's policy to DBS check all staff.

Staff told us about the arrangements for planning and monitoring the number of staff and the mix of staff needed to meet patients' needs. The provider had recruited

additional frontline staff capacity when it took over the practice in October 2014, and deployed staff so that a practice nurse was available every day of the week and a female GP every day except Fridays. Staff we spoke with said this had much improved the smooth running of the practice, and told us they felt well supported by the new practice manager arrangements. We saw there was a rota system, locum and cover arrangements in place for all the different staffing groups to ensure there were enough staff on duty. Clinical and non-clinical staff from the provider's other practice were sometimes called upon to provide additional capacity as well.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see; however it did not include the name of the practice's designated Health & Safety representative.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

An appropriate range of emergency medicines was easily accessible to staff in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice, for example loss of the computer system or incapacity of GPs. In response to a significant event in November 2014 the provider had purchased mobile phones for the practice for back up in the event the telephone server went down so that calls could be diverted.

Records showed that staff had received fire safety training since the provider took over the practice in October 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The provider held weekly clinical meetings where guidelines and improving and maintaining the practice's performance in relation to them was discussed. These clinical meetings also provided a forum for discussing the care of patients with complex needs.

One of the long term locum GPs was the practice's lead for diabetes, in recognition of the comparatively high prevalence of this condition amongst patients, and had certification in diabetes. The GP Lead had completed an obstetrics update to meet unmet demand amongst patients and was the practice's lead for long term conditions. The GP Lead was part of the larger pool of GPs working for the provider which included leads in other specialist clinical areas. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice was beginning to use computerised tools to identify patients who were at high risk of admission to hospital. Such patients were discussed in the weekly clinical meetings and referred for multidisciplinary team discussion to coordinate care to meet their needs and reduce the likelihood of them having to go to hospital.

Discrimination was avoided when making care and treatment decisions. Clinical and non-clinical staff demonstrated patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. For example the learning point from one significant event analysis was the importance of the aggressive management of risk factors, especially so in certain ethnic groups, for example South Asian men who are more likely to develop cardiovascular disease at a younger age.

Management, monitoring and improving outcomes for people

The practice was developing its systems for using information about people's care and treatment, and their outcomes, to improve care. This included searching the clinical IT system for uncoded or undiagnosed patients with long term conditions (LTC) and installing new software so that there was a robust recall system for patients with LTCs for reviews and blood tests where required.

The practice showed us two completed clinical audits that had been undertaken since the provider took over the practice in October 2014, with a focus on patient safety. The first was a repeat prescribing audit with the aim of assessing current prescribing practice and assessing the changes needed to improve performance. The target list was patients with four or more medicines on repeat. Following the initial audit, a number of leadership and systems changes were identified to improve the numbers of patients receiving medication reviews. The repeat audit showed that the proportion of patients on the target list with a Read code indicating that a medication review had been carried out in the previous six months had risen from 11% to 63%. The audit also showed that prescribing was safe, relatively few patients had redundant medication on repeat, that comprehensive instructions appeared on medicines and most medicines were prescribed generically in line with CCG guidance. The audit was reviewed by the GP Lead and directors and further recommendations were made to meet the target of carrying out medication reviews for 80% of patients on multiple medication, and a repeat audit was planned in six months.

The second audit reviewed antipsychotics prescribing in dementia. The initial audit in October 2014 identified a total of seven patients with dementia. None were prescribed any antipsychotic medication. The provider was implementing a new system to ensure patients with dementia received appropriate treatment and care and so decided a repeat audit should be carried out to assess whether the NICE guidance was still being adhered to. The repeat audit in April 2015 identified a total of five patients. None had received or been prescribed antipsychotic medication in the preceding six months. As a result it was recommended that searches be implemented to identify as yet undiagnosed or uncoded patients with dementia in line with national and local guidance, and to carry out a repeat audit in six months to reassess performance.

There was a protocol for repeat prescribing which followed national guidance. The protocol provided guidance to staff about processing requests for a repeat prescription efficiently, and set out the clinical review process that

Good

Are services effective?

(for example, treatment is effective)

ensured a patient's medication continued to be safe and effective for them. The protocol also set out the systems in place for drugs that require regular monitoring, where dosing must be carefully monitored to avoid potentially dangerous side-effects.

The practice was also using automated quality and outcomes framework (QOF) audits to focus on re-engaging with patients with LTCs, which it had determined would generate the greatest benefit for its patients in terms of health outcomes. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

Comparative QOF data was not available because the practice had only been in existence with the new provider since October 2014. However, the practice was able to provide us with the following information:

- It had reversed the 40% increase in emergency admissions between 01 April and 30 September 2014 on the previous year, and achieved a further 1% reduction, showing it was more responsive to patients' needs and more accessible.
- The number of A&E attendances for patients aged over 65 years had fallen by 14% compared with a 35% increase in the preceding 6 months, although the number of admissions had increased slightly.
- A&E attendances overall had fallen by 34%, reversing the 15% increase between 01 April and 30 September 2014 on the previous year and achieving a further 19% reduction. A&E attendances had been the highest of any surgery in Enfield. Currently, A&E attendances during surgery hours were below the CCG average.
- Outpatient referrals spiked in October 2014 and the number of planned admissions increased, showing the practice was addressing previously unmet demand. Despite a 31% increase in referrals the practice's referral rates remain below the CCG average, and other measures show GPs are making appropriate referrals (the Referrals for Procedures of Limited Clinical Effectiveness measure is low).
- The practice achieved a QOF score of 92.7% in 2014-15 compared with a score of 90.2% in 2013-14, despite the new provider taking over the practice half way through the year.

Effective staffing

Practice staffing included medical, nursing, managerial, reception and administrative staff. The practice was also supported by the provider's childhood immunisations and cervical cytology coordinators to improve uptake of these prevention services. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

It was the provider's policy that all staff undertook annual appraisals that identified learning needs from which action plans were documented. Not all staff records we looked at contained appraisal meeting records, however. Staff we spoke with said they had had an appraisal or induction recently and that the new provider had been very supportive of their further training and development.

There was a job description for the practice nurse role. The nurse worked for the practice on a long term locum basis and the provider had arrangements in place to ensure the nurse was appropriately trained and assessed as competent by the agency. Training needs were identified to meet gaps in the practice staff skills set, for example the nurse was going to complete spirometry training so that in future GPs would not have to conduct this test of lung function.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and to manage patients with complex needs. Its operational procedures for dealing with faxes and referrals had been revised and staff had been given additional training to ensure all correspondence and test results were dealt with properly and in a timely way. This enabled clinical staff to act on incoming information and to

Good

Are services effective?

(for example, treatment is effective)

make referrals to other services without delay. Staff we spoke with were able to explain the procedures for dealing with post, emails, and faxes, and tasks assigned to them by the GP.

Emergency hospital admission rates for the practice were much improved since the provider took over the practice in October 2014 reflecting improved access to the practice's services. The practice was commissioned to provide the unplanned admissions enhanced service and was putting systems in place to identify patients most at risk of an avoidable unplanned admission. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice held weekly clinical meetings to discuss patients with complex needs, for example those with multiple long term conditions or end of life care needs. There were additional meetings as necessary attended by district nurses, health visitors and the community matron where necessary.

The practice was based in Enfield near to the border with Haringey and had highlighted difficulties with the different access arrangements to physiotherapy for patients living in the two boroughs. These difficulties had been resolved, smoothing the patient pathway for patients regardless of where they lived.

Information sharing

The practice used several electronic systems to communicate with other providers, for example there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Also, the practice participated in the Summary Care Records scheme. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or unplanned care situation.

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. Add-on software enabled staff to process and workflow clinical hospital letters sent to the practice, and to automate recall processes to ensure patients attended for routine tests and reviews in a timely way.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling this legislation. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented them.

When interviewed, staff described how a decision was made in a patient's best interests when they did not have capacity to make a decision, by involving the patient's carer in deciding how best to meet the patient's needs. All clinical staff demonstrated a clear understanding of Gillick competency and assessing when a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions.

Health promotion and prevention

Comparative QOF data was not available because the practice had only been in existence with the new provider since October 2014. However, the practice was able to provide us with the following information:

- The practice was consistently attaining the 90% immunisations target for 2 year olds and was close to the same for 5 year olds. It was achieving the higher 80% cervical cytology target. These targets had been missed in previous years.
- It was working hard to increase flu vaccination rates in both children and adults, including endorsement in face-to-face consultations, and communication by letter, SMS text, telephone, prescription reminders and posters. It had succeeded in vaccinating 66% of the target group and did not achieve the 75% target. A large proportion of patients consistently declined vaccination, and a proportion of Muslim patients declined the childhood intranasal influenza vaccine as it contains pork gelatine.

There was a wide variety of patient information available to help patients manage and improve their health including patient information leaflets at the surgery and online resources on the practice's website. The website allowed translation of information in to 87 different languages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published 02 July 2015 and NHS Choices users' ratings. Both these sources showed there had been significant improvement in patients' experience of the care and treatment they received since the new provider took over the practice. For example, data from the national patient survey showed 62% respondents would recommend this surgery to someone new in the area compared with 44% in January 2015. Three of the four user's reviews posted on NHS Choices since the provider took over the practice in October 2014 commented very favourably on the improvements at the surgery since the new doctors took over.

Other areas where the practice compared well with the Enfield average included:

- The last appointment the patient got was convenient was 85% compared with the Enfield average of 89%.
- The last GP the patient saw or spoke to was good at listening them was 85% compared with the Enfield average of 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority showed patients had a positive experience of the practice. Patients said the practice was caring and they were treated with dignity and respect, they were seen quickly, and the practice responded to them with the right care and treatment. Some patients commented on recent improvements in the service. A few comments were less positive but there were no common themes to these.

We also spoke with 12 patients on the day of our inspection. All expressed satisfaction with the way they were treated.

Consultation and treatment room doors were closed when patients were being treated and conversations taking place in these rooms could not be overheard. There were curtains in the consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments.

We saw that staff were careful to keep confidential information private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient conversations private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour and this was stated also in the practice leaflet. Reception staff described how they tried to diffuse difficult situations and to calm patients who were agitated or distressed. The practice kept policy and practice in this area under review, for example it had treated the removal of a patient from its list for abusive and potentially violent behaviour as a significant event.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 80% said the last GP they saw or spoke to was good at explaining tests and treatments compared to the Enfield average of 82% and the national average of 86%.
- 78% said the last GP they saw or spoke to was good at involving them in decisions about their care compared to the Enfield average of 77% and national average of 81%.

A few patients told us about language barriers to fully understanding what the doctor or nurse was telling them which they tried to overcome by bringing along a friend or relative to act as a translator, but which was not always possible. Staff told us that telephone translator services were available for patients who wanted them. The practice leaflet explained that a double appointment should be booked if the telephone translation service was going to be used, and information about the translation service was on display in reception and in consulting and treatment rooms.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

Good

Are services caring?

- 83% said the last GP they spoke they saw or spoke to was good at treating them with care and concern compared to the Enfield average of 80% and national average of 85%.
- 81% said the last nurse they saw or spoke to was good at treating them with care and concern compared to the Enfield average of 85% and national average of 90%.

Notices in the patient waiting room and practice website also told patients how to access a number of support groups and organisations. Information for carers was available on the practice website including the contact details for Carers Direct which provides free, confidential information and advice for carers.

The GP told us that sometimes they contacted the family when there had been a bereavement and / or that relatives could be referred to the bereavement service at the local district general hospital.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood and systems were being put in place to address identified needs in the way services were delivered, including:

- Dedicated long-term condition (LTC) appointments, rather than clinics, to enable the practice to respond more flexibly and opportunistically to patients who need regular reviews.
- New specialist software to identify patients with LTCs and develop effective recall systems.
- Work with a CCG initiative to improve the care of patients with diabetes, focussing on improving diabetes control in complex, poorly controlled patients and increasing the rate of new diagnoses.
- Involvement in a public health project to address child poverty through improved engagement with health visitors.
- Childhood vaccination and cervical cytology coordinators employed to increase the practice's child immunisation and cervical screening rates.

It was too early to measure the impact of most of these initiatives; however the practice was now meeting child immunisations at 2 years of age and cervical screening targets.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients who needed the telephone translator service. The website provided comprehensive information about the practice and the services it offered, including the additional languages spoken by staff. It provided information about a wide range of health problems and diseases, and about health topics including childhood vaccines, stopping smoking, contraception, mental health and get fit for free. The website allowed translation of information in to 87 different languages.

The premises had been judged unfit for purpose by NHS England and a suitable alternative was being looked for. The provider had improved how the available space was used and the service was accessible to people with mobility disabilities.

There were male and female GPs in the practice and staff told us they could usually accommodate patients' GP gender preferences.

An alerting system was used to flag patients with additional needs, for example patients made vulnerable by social isolation or a learning disability.

Access to the service

When the provider took over the practice in October 2014 it met with the patient participation group and the clinical commissioning group to prioritise areas for improving the service. Improving the availability and mix of appointments was identified as the top priority. Since then the system had been completely overhauled to increase clinical availability and access to booked appointments. The practice had recently introduced extended opening hours.

The surgery opened extended hours on Mondays, from 8:00am to 8.00pm. Appointments were available from 9.30am to 7.30pm. On Tuesday to Friday the surgery was open from 8.00am to 6.30pm, and appointments were available from 9.30am to 5.30pm. A mixture of bookable appointments was available, including on-the-day, advance, long term condition appointments; double appointments, for example for patients with language or other communication needs, or complex medical needs; urgent appointments; and telephone appointments. Staff told us patients waited no more than one week for a routine appointment and that they could usually accommodate patients' preferences for a female doctor. They said the new appointment system worked much better than the old one and that as a result staff faced much less hostility from patients.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. It included how to arrange urgent appointments and home visits and how to book appointments online. Arrangements were in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring to access out of hours advice and attention. Information on the out-of-hours service was provided to patients.

Data from the national patient survey data published 02 July 2015 showed marked improvement in patients' experience of access to the service:

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Satisfaction with the practice opening hours was 72%, up from 61% in January 2015 and comparing well with the Enfield average of 74%
- Finding it easy to get through to the surgery by phone was 66%, up from 47% and comparing well with the Enfield average of 67%
- Experience of making an appointment described as good was 67%, up from 45% and comparable with the Enfield average of 70%

Patients told us through comment cards and interviews that they were satisfied with the appointments system and it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent and that they did not have to wait too long for a routine appointment.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints procedure was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information was included in the practice leaflet and on the website, and there was a separate patient complaint form.

We looked at two complaints received since the provider took over the practice in October 2014. The provider worked hard to resolve the complainants' concerns and took learning points away from the process to improve the service.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear purpose to provide people registered with the practice with personal health care of high quality and to seek continuous improvement on the health status of the practice population overall. We found details of the practice purpose and the practice aims and objectives in the provider's Statement of purpose.

When the provider took over the practice in October 2014 it identified immediate priorities for improving the service through increasing frontline staff capacity, increasing clinical availability, replacing the phone system and other equipment where necessary, and making the best use of the available space within the practice. The provider made decisions about clinical staffing that would maximise continuity of care for patients and provide stability and certainty during a time of change over a relatively short fixed term arrangements. It seconded a GP Lead to Boundary Court Surgery from its other practice and employed an additional long term locum GP and locum nurse. The changes the provider made have had a significant impact on the safety and effectiveness of the service, and addressed the concerns we identified at our inspection in July 2014 of the practice under the previous provider.

We spoke with seven members of staff and they all knew and understood the purpose, aims and objectives and what their responsibilities were in relation to them. They were positive about the way the practice worked and committed to providing patients with a safe, effective and responsive service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the computer system. We looked at seven of these policies and procedures and they provided staff with appropriate guidance and instruction. A few policies were past their review date and had not yet been made specific to Boundary Court Surgery, for example the infection control policy. However we saw that the provider had prioritised policies for review immediately necessary to the operation of the practice, for example the Guidelines for locum doctors.

Staff had ready access to, and daily contact with the deputy practice manager for guidance and support, who was based at the provider's other surgery. The deputy practice manager also spent one day a week at Boundary Court Surgery. Staff could work across the provider's two locations because they shared the same computer system. This meant for example that the childhood vaccination coordinator could contact parents registered with Boundary Court Surgery while based at the other location.

There was a clear leadership structure with named members of staff in lead roles. For example the GP Lead was the lead for safeguarding and for long term conditions and the practice manager was the lead for complaints. The practice was developing the clinical lead role for infection control although this currently rested with the practice manager. All of the staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued and well supported and were confident that they could go to the GP, practice manager or deputy practice manager for help.

The provider's directors and the GP Lead, practice manager and deputy practice manager took an active leadership role in overseeing that the systems in place to improve and monitor the quality of the service were being used consistently and were effective, including using the Quality and Outcomes Framework (QOF) to measure performance. Early gains included reducing A&E attendances so that Boundary Court Surgery had dropped from having the highest rate in Enfield to below the average for the CCG, reflecting the greater responsiveness of the service the practice provided. The practice had also used clinical audit to strengthen assurance around safe and effective prescribing.

Leadership, openness and transparency

The GP Lead was visible in the practice and staff told us that he was approachable and always took the time to listen. Staff were involved in discussions about how to run the practice and how to develop the practice and the provider encouraged staff to identify opportunities to improve the service delivered by the practice.

The practice aimed for monthly whole practice meetings. In addition there were weekly clinical meetings and non-clinical staff met on an ad hoc, more informal basis

Are services well-led?

Good

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

when needed, for example over lunch. Regular email communication between the deputy practice manager and the administrative and reception staff showed governance issues were raised, discussed and resolved regularly.

Staff demonstrated there was an open culture within the practice and that they felt confident to raise any issues and felt supported when they did.

Seeking and acting on feedback from patients, public and staff

The practice valued feedback from patients and was seeking ways of getting more feedback from a wider range of its patients, especially younger people. There was a clear invitation to join the patient participation group (PPG) on the practice website, or to submit comments, suggestions and complaints online. There was a dedicated email address for patients to contact the chair of the PPG direct to share their views, and the practice offered patients the opportunity to take part in the NHS friends and family test. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The PPG was active and in March 2015 had seven members, three men and four women, ranging in age from 35 to 64 years. Their ethnic backgrounds were diverse and representative of the ethnic background of the practice population. We spoke with one member of the PPG and they were very positive about the role the group played and its engagement with the practice. The group had been consulted by the new provider early on in the process and its concerns about the appointment system and uncertainty about the future of the service had been understood and appreciated. The interviewee confirmed the new provider had invested in the premises to make them safe and more presentable, and in staff training and development around customer service. They said patients were finding it easier to get an appointment.

The provider had also gathered feedback from staff through interviews in the early days of it taking over the practice, as part of its initial assessment of the practice. It used this feedback to plan staffing levels and training and to develop operational policies and lines of accountability. Staff told us changes had been for the better and that they could raise issues with the new management. The operation of the practice was discussed in meetings, most recently prescriptions and home visits for example. Staff were also asked for their ideas and suggestions as part of the appraisal process.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring, and there was weekly protected learning time.

Non clinical staff told us appraisals were taking place and that the practice was supportive of training.

The practice had completed reviews of significant events and other incidents and shared learning with staff at meetings and one-to-ones to ensure the practice improved outcomes for patients.