Evergreen Surgery Limited

Quality Report

Evergreen Primary Care Centre
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Date of inspection visit: 3 February 2015
Date of publication: 06/08/2015

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?	Requires improvement
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 Evergreen Surgery Limited on 3 February 2015. Overall the practice is rated as good.

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

It was rated as requires improvement for providing safe services.

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

- 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, with the exception of those relating to recruitment checks.
- Nursing staff administered childhood vaccines under Patient Group Directives (PGDs - written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). However, a locum nurse working at the practice and giving vaccinations had no such authorisation and was therefore not legally able to give these injections.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and that they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

- In 2013, the practice identified that cervical screening and childhood immunisation rates were lower than the locality average. It was felt that the low immunisation rates were due to cultural reasons and a lack of awareness. We noted that the practice's local population was diverse and also that it had a high percentage of people aged under eighteen. Two coordinator posts were created (which included an element of community outreach) and we noted that both post holders were multi-lingual; recognising the diverse nature of the population. The practice told us that these posts had had a positive impact.
- For example, prior to the creation of the posts, the practice did not meet Department of Health 90% immunisation target for either two or five year olds. Following the introduction of the immunisation co-ordinator, we were told that the practice now routinely achieved immunisation targets for two year olds and was close to reaching the target for five year olds. The figures for the last complete quarters were 93.1% for two year olds and 84.1% for five year olds. For the first quarter of 2013, the equivalent figures had been 88.7% and 81.1% respectively. We were also told that in 2013, only 63% of women in the target age group had undertaken cervical screening. Latest available data showed that the practice's performance was 79.8%.
- After each consultation, patients were sent an SMS text asking them to rate their consultation. This data was collated and discussed at quarterly meetings.

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

Importantly the provider should:

- Ensure policies and procedure related to the recruitment of staff are fit for purpose.
- Ensure that all necessary pre-employment checks are retained on file for staff.
- Ensure that signed and valid PGDs are on file for all nursing staff.
- Undertake annual appraisals for practice nurses; to ensure that progress is reviewed, targets agreed and training needs identified.
- Consider translating patient information leaflet in reception into local community languages.
- Consider introducing building signage in local community languages.
- Ensure that all non clinical staff are up to date regarding basic life support training.
- Ensure that signed and valid PGDs are on file for all nursing staff.
- Ensure that the practice's emergency drugs protocol includes a list of the contents of the emergency trolley.
- Ensure that its medicines management policy includes a protocol for staff to follow in the event that the "cold chain" is disturbed (the cold chain refers to the continuous maintenance of low temperatures required for some medicines such as vaccines).
- Consider introducing a systematic programme of clinical audit to drive improvements in patient outcomes.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. The practice had recruitment procedures in place but we noted areas where these needed to be amended (for example regarding nurses' pre-employment checks). We also noted that some staff personnel records were missing pre-employment checks.

The practice carried out routine vaccinations and some travel vaccines. Nurses gave the childhood vaccines under Patient Group Directives (PGDs). These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. However, we noted that a locum nurse working at the practice and giving vaccinations had no such authorisation and was therefore not legally able to give these injections. We fed this back to the practice and were advised that the locum would not be offered further sessions until signed PGDs were on file. Shortly after our inspection we were advised that procedures had been amended so that any nurse working at the practice was given time to read and sign PGDs as part of their induction and before commencing their clinics.

We noted that patients were treated in a clean, hygienic environment. All clinical, communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment.

Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses including safeguarding concerns. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality in a number of clinical areas. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles (for example post graduate training in chronic disease management). We saw evidence of clinical audits being used to improve patient outcomes. Staff worked with multidisciplinary teams.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect. They also told us that doctors and nurses provided sufficient information to be able to make informed decisions about their care and treatment. Staff treated patients with kindness and respect, and maintained confidentiality. However data showed that the practice was rated lower than others regarding GPs involving patients in decisions about their care.

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 Enfield Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with clinical and administrative staff. Most complaints related to the practice phone system which was consistent with patient feedback. However, we saw evidence of how the practice worked with its Patient Participation Group to bring about improvements to the phone and wider appointment system. Urgent same day appointments were available.

Are services well-led?

Good

The practice is rated as good for being well-led. We did not see evidence of a business plan but discussions with staff and review of staff and clinical meeting minutes highlighted that the practice's focus was upon delivering a high standard of medical care with a commitment to addressing patient's needs. There was a documented leadership structure and staff felt supported by management. The practice proactively sought feedback from patients and had an active patient participation group (PPG). The practice had a number of policies and procedures to govern activity but some (such as recruitment) required amending to ensure they were fit for purpose.

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. Nationally reported data showed that the practice performed better than the Enfield and England average for assessment of conditions commonly found in older people such as dementia. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services such as a scheme to identify vulnerable older patients who may be at risk of falls or hospital admission. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. The practice had a dedicated GP clinical lead for long term conditions. Dedicated chronic disease clinics were run throughout the year, involving all doctors working in rotation under the supervision of the lead long term condition GP. People with long term conditions had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the practice worked with relevant health and care professionals to deliver a multidisciplinary package of care. Unplanned hospital admissions for long term conditions such as diabetes and lung disease were below the average for the locality.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people There were systems in place 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. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice provided dedicated clinics for children and under-fives in the afternoon and evening, when there was peak demand. The practice had also appointed an immunisations co-ordinator to

improve vaccination rates by contacting parents and arranging immunisation appointments. Systems were in place to follow up on missing vaccinations or for those who did not attend. Community outreach was also provided.

The practice had identified that cervical screening rates were lower than the locality average. It was felt that this was due to cultural reasons and a lack of awareness. A coordinator post was created (which included an element of community outreach). The practice told us that this post had had a positive impact and we noted that cervical screening rates were above the locality and England average.

In 2013, the practice identified that childhood immunisation rates were lower than the locality average. It was felt that this was due to cultural reasons and a lack of awareness. A childhood immunisations coordinator post was created (which included an element of community outreach) and we noted that the post holder was multi-lingual. The practice told us that these posts had had a positive impact. For example, prior to the creation of the post, the practice did not meet the Department of Health's 90% immunisation target for either two or five year olds. Following the introduction of the post, we were told that the practice now routinely achieved immunisation targets for two year olds and was close to reaching the target for five year olds. The figures for the last complete quarters were 93.1% for two year olds and 84.1% for five year olds. For the first quarter of 2013, the equivalent figures had been 88.7% and 81.1% respectively.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice was part of an initiative allowing people who worked in the area (but lived and were registered elsewhere) to be able to access primary care services at the practice. The practice had recently employed a heath care assistant with a special interest in health checks and smoking cessation. The heath care assistant proactively engaged patients to attend for health checks and

Summary of findings

identified patients at risk of developing long term conditions. They also delivered appropriate interventions including lifestyle advice. Patients were referred to clinicians to discuss risk reduction strategies.

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 including those with a learning disability. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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.

We noted that 18% of patients had a caring responsibility (above the England average) and were advised that the practice routinely signposted patients requiring support to a local carer support network. We also noted that carers information was provided in the practice reception and on the practice website.

We were told that many patients spoke English as a second language and that to aid effective communication the surgery offered consultations supported by interpreters. The practice website was available in a range of languages. However, we noted that there was a limited range of translated materials available in the practice reception.

In 2013, the practice identified that cervical screening rates were lower than the locality average. It was felt that this was due to cultural reasons and a lack of awareness. A screening coordinator post was created (which included an element of community outreach) and we noted that the post holder was multi-lingual. The practice told us that the posts had had a positive impact.

For example, prior to the creation of the post, we were told that only 63% of women in the target age group had undertaken cervical screening. Latest available data showed that the practice's performance was 79.8%.

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 was part of a scheme providing GP services to patients who had

been barred from other practices because of abusive or violent behaviour (often related to poor mental health). The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice invited mental health voluntary organisations to give presentations at practice staff meetings. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

GPs stressed the importance of reviewing patients' physical as well as mental health and we noted for example that 76% of women on the practice's mental health register had had a cervical screening test in the previous five years (better than the local and national averages). The practice offered flexible appointments such as evening appointments (when the practice was less busy) as we were told that this was preferred by many patients experiencing poor mental health.

Summary of findings

What people who use the service say

During our inspection, we spoke with six patients who were generally positive about the care they received and the practice environment. One of the patients was also the chair of the practice's Patient Participation Group (PPG: a group of patients registered with the practice who worked with the practice to improve services and the quality of care).They spoke positively about how the practice acted upon patients' concerns.

We also reviewed twenty patient comment cards. These had been completed by patients in the two week period before our inspection and enabled patients to record their views on the practice. Feedback was also generally positive with key themes being that staff were respectful, that they listened and were compassionate.

However, three patient comment cards highlighted problems regarding telephone access. The NHS England 2014 GP national patient survey results noted that from 457 surveys sent out, 98 patients had responded, of whom only 39% had found it easy to get through to the practice by telephone. This was worse than the average of 71% for Enfield practices. Some patients we spoke with also expressed concerns in this area. However, during our inspection we saw evidence of how the practice had worked with its PPG to improve telephone access.

Patients told us that they felt involved in decisions about their care and treatment and that their questions were answered. This was consistent with national patient survey feedback which highlighted that 82% of respondents had said that the last nurse they saw or spoke to was good at explaining tests and treatments. We also noted that 78% of the 229 respondents to the practice's in house patient survey had fed back that doctors listened to their concerns.

Areas for improvement

Action the service SHOULD take to improve

- Ensure policies and procedure related to the recruitment of staff are fit for purpose.
- Ensure that all necessary pre-employment checks are retained on file for staff.
- Ensure that signed and valid PGDs are on file for all nursing staff.
- Undertake annual appraisals for practice nurses; to ensure that progress is reviewed, targets agreed and training needs identified.
- Consider translating patient information leaflet in reception into local community languages.
- Consider introducing building signage in local community languages.
- Ensure that all non clinical staff are up to date regarding basic life support training.
- Ensure that signed and valid PGDs are on file for all nursing staff.
- Ensure that the practice's emergency drugs protocol includes a list of the contents of the emergency trolley.
- Ensure that its medicines management policy includes a protocol for staff to follow in the event that the "cold chain" is disturbed (the cold chain refers to the continuous maintenance of low temperatures required for some medicines such as vaccines).
- Consider introducing a systematic programme of clinical audit to drive improvements in patient outcomes.

Outstanding practice

- In 2013, the practice identified that cervical screening and childhood immunisation rates were lower than the locality average. It was felt that this was due to cultural reasons and a lack of awareness. Two coordinator posts were created (which included an element of community outreach) and we noted that both post holders were multi-lingual. The practice told us that these posts had had a positive impact.

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For example, prior to the creation of the posts, the practice did not meet the Department of Health's 90% immunisation target for either two or five year olds. Following the introduction of the immunisation co-ordinator, we were told that the practice now routinely achieved immunisation targets for two year olds and was close to reaching the target for five year olds. The figures for the last complete quarters were 93.1% for two year olds and 84.1% for five year olds. For the first quarter of 2013, the equivalent figures had been 88.7% and 81.1% respectively. We were also told that in 2013, only 63% of women in the target age group had had a cervical screening test. Latest available data showed that the practice's performance was 79.8%.

- After each consultation, patients were sent an SMS text asking them to rate their consultation. This data was collated and discussed at quarterly meetings.

Evergreen Surgery Limited

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, practice nurse specialist advisor, practice manager specialist advisor and pharmacy inspector. They were granted the same authority to enter the registered person's premises as the CQC lead inspector.

Background to Evergreen Surgery Limited

Evergreen Surgery Ltd. is located in Edmonton, North London and has a patient list of approximately 18,400 (the largest in the borough of Enfield). Only seven percent of patients are aged 65 or older (compared to the England average of 16%) and 32% are aged under 18 years old (compared to the England average of 21%). Forty four percent have a long standing health condition and 18% have carer responsibilities. The area is extremely diverse with over eighty languages spoken in the borough. The practice holds a General Medical Service (GMS) contract with NHS England. This is a contract between general practices and NHS England for delivering primary care services to local communities.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8:30am to 6pm daily. Extended hours surgeries are offered weekdays from 6.30pm to 8pm. Outside of these times, patients are referred to a local out-of-hours provider. Details of how to access the service are displayed in reception and on the provider's website. The provider also hosts an 8am to 8pm weekend walk in centre.

The services provided include child health care, ante and post natal care, immunisations, sexual health and contraception advice, management of long term conditions and smoking cessation clinics. The staff team comprises ten salaried and four partner GPs (overall six female, eight male), practice nurse (female), two health care assistants (female), practice manager and a range of administrative staff including immunisation and screening coordinators.

Public Health England's Enfield 2014 Health Profile notes that the health of people in Enfield is generally better than the England average. Deprivation is lower than average, however about 19.9% (14,200) of children live in poverty. Life expectancy for both men and women is higher than the England average.

Twenty four percent of children at age ten are classified as obese (worse than the average for England). Levels of breastfeeding and smoking at time of delivery are better than the England average. In 2012, 26% of adults were classified as obese. The rate of Tuberculosis is worse than average. Rates of sexually transmitted infections are better than average.

In Enfield, strategic improvements in health and wellbeing are led by the borough's Health & Wellbeing Board; comprised of Enfield Council, Enfield Clinical Commissioning Group, Enfield Healthwatch and other health stakeholders. Priorities in Enfield include tackling childhood obesity, reducing the gap in life expectancy and improving diagnosis of hypertension (high blood pressure) and diabetes.

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

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 February 2015. During our visit we spoke with a range of staff (GPs, practice nurse, practice manager, reception manager) and spoke with patients who used the service including a PPG member. We observed how people were being cared for and talked with carers and/or family members. We also reviewed comment cards where patients 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 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve patient safety including reported incidents and comments/complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, practice nurses' outline of how they would report a sharps injury was consistent with the practice's infection control and prevention policy. The practice also had a safety alert protocol detailing the procedure for sharing received drugs alerts throughout the practice. Staff knew their roles and accountability in this process. There were effective arrangements in place to report safety incidents in line with national and statutory guidance.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We looked at twelve events recorded during 2014. They included a record of the area of concern and staff learning. We also noted that in addition to identifying where improvements could be made, the significant events records also identified good practice. For example, following a patient medical emergency, the log recorded that staff had performed their duties in accordance with the practice's medical emergency procedure.

The practice demonstrated a team based learning environment. Records showed that significant events were routinely discussed at weekly clinical meetings (which included administrative managers to enable learning across staff teams). A partner GP also had responsibility for sharing learning amongst staff; including helping staff to understand and fulfil their responsibilities to raise concerns and report incidents or near misses. We saw how significant events had been used to improve the service. For example, the practice's significant events log recorded that a homeless person had registered at the practice in 2014 and had had a blood test. The patient had been advised to contact the practice for the results but failed to do so. When the blood test results came back they were abnormal but there had been no way to contact the patient. As a result of this incident, the practice had improved systems for registering homeless patients and for contact of contacting them in the event that blood test results were abnormal.

Reliable safety systems and processes including safeguarding

There were systems in place which ensured patients were safeguarded from the risk of abuse. A senior GP was designated safeguarding lead. GPs were Level 3 trained in child protection and non clinical staff had attended basic children and vulnerable adults safeguarding training. The practice nurse was also safeguarding trained to the appropriate level. Staff were able to recognise types of abuse (including in older patients) and knew how and to whom they would report or escalate a concern. The practice had policies for child protection and at risk adults which included local authority and CCG contact details. Staff were aware of these contacts.

Non clinical staff had undergone Disclosure and Barring Service (DBS) checks. The practice had a chaperone policy and we were told that some administrative staff undertook chaperoning duties.

We were told that in house training had been provided although there was no record to confirm this.

We noted that the personnel record of a locum GP did not contain evidence of safeguarding or criminal record checks. Shortly after our inspection, we were advised that this information was on file.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example patients experiencing poor mental health.

Medicines Management

We looked at all areas where medicines were stored and looked at records including audits, procedures and records of incidents regarding medicines. We heard from the prescription clerk how the practice managed repeat prescriptions and how they ensured the GPs checked and signed the prescriptions before they were collected by the patient or sent to the persons chosen pharmacy. We heard from two patients that there was no delay in obtaining their repeat prescriptions. We saw detailed procedures for staff to follow regarding repeat prescribing and writing Controlled Drug prescriptions.

We looked at the security of medicines. All refrigerated medicines such as vaccines were kept in locked fridges and temperatures were monitored to ensure that the vaccines were stored within the temperature range necessary to

main their effectiveness. However, we noted that the procedures for storage (including that of vaccines) were brief and did not cover what to do if the "cold chain" was disturbed (the cold chain refers to the continuous maintenance of low temperatures required for some medicines such as vaccines).

No Controlled Drugs were kept by the practice. Blank prescriptions rolls were stored securely so that they could not be misused.

The practice carried out many routine vaccinations and some travel vaccines. Nurses gave the childhood vaccines under Patient Group Directives. These are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. For the nurse employed by the practice the directive was signed by the practice governance lead that they were competent to administer the appropriate injection.

However, we noted that a locum nurse working at the practice and giving vaccinations had no such authorisation and was therefore not legally able to give these injections. We fed this back to the practice and were advised that the locum would not be offered further sessions until signed PGDs were on file. Shortly after our inspection we were advised that procedures had been amended so that any nurse working at the practice was given time to read and sign PGDs as part of their induction and before commencing their clinics. We were further advised that all locum nurses had signed PGDs on file.

The practice undertook a range of medicines audits triggered by the practice, Enfield CCG or national guidance. We noted that any errors in prescribing were discussed as serious Incidents at site level. The practice was also supported by a pharmacist from Enfield CCG who visited the practice and reviewed prescribing and supported audits.

Cleanliness & Infection Control

Patients were treated in a clean, hygienic environment. All clinical, communal and non-clinical areas of the practice were maintained and cleaned routinely by a cleaning contractor and we were told that regular monitoring meetings took place. Patients spoke positively about the environment. Consultation rooms had vinyl flooring and we noted that clinical waste was stored securely away from patient areas whilst awaiting collection. Notices about hand hygiene techniques were displayed in staff and patient toilets and communal areas. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Hand gel was available in communal areas such as reception/waiting area.

On the day of our inspection, the practice was unable to confirm the Hepatitis B immunisation status of the practice nurse. However, shortly after our inspection we were advised that immunisation had taken place in 2014.

The practice manager was the Infection Prevention and Control (IPC) lead and responsible for ensuring effective infection control throughout the practice. Personal protective equipment such as gloves and aprons were readily available for staff to use. Patients confirmed that this was regularly used by staff.

The practice had an infection control policy and we noted that in accordance with the policy, infection control audits took place every six months. We looked at the latest audit results (January 2015) and were able to confirm for example, that sharps bins were signed and dated upon assembly.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). A legionella risk assessment had taken place in 2014 and we noted that no issues had been identified.

Records confirmed the practice was carrying out regular checks in line with its legionella policy to reduce the risk of infection to staff and patients.

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 regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence that calibration of relevant equipment such as weighing scales and blood pressure measuring devices had taken place within the last twelve months.

Staffing & Recruitment

The practice had systems in place to ensure that staffing levels and skill mix were planned, implemented and

reviewed to keep people safe at all times. Electronic records showed that actual staffing levels and skill mix were in line with planned staffing requirements. Staff told us there were usually enough staff to maintain the smooth running of the practice and we saw evidence that systems were in place to keep patients safe.

The practice had recruitment procedures in place to ensure that staff were recruited appropriately but we noted areas where improvements were required. For example, the file of a locum GP working at the practice on the day of our inspection did not include a Disclosure and Barring Service (DBS) background check or evidence of child protection training to the required level. In addition, the file of a health care assistant indicated that they had started work at the practice before a reference had been taken up. This was not in accordance with the practice's recruitment policy. Shortly after our inspection we were advised that the practice now had on file pre-employment checks for all locum GPs and practice nurses, including evidence of professional registration, DBS check, Hepatitis B status, basic life support, safeguarding and references.

Monitoring Safety & 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 annual, bi-annual and monthly checks of the building and equipment, infection control, medicines management, staffing and dealing with emergencies. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Records showed that identified risks were routinely discussed at clinical meetings.

Arrangements to deal with emergencies and major incidents

There were sufficient systems in place to deal with a medical emergency. The practice had an emergency trolley containing medicines and equipment including a defibrillator (used in cardiac emergencies) which was sealed and also a separate oxygen cylinder. Expiry dates of medicines were recorded and all were checked daily to ensure that they were available promptly in an emergency. However, we noted that the practice's emergency drugs protocol did not include a list of the contents of the emergency trolley.

A separate doctor's bag also contained emergency medicines and equipment. This was checked daily by the practice nurse. The practice had three fridges to store vaccines. All were locked and the contents kept in an orderly manner and were in date. We saw also that there was an anaphylactic box in each room where vaccines were given so that an emergency could be promptly resolved. Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated. Clinical staff had received cardiopulmonary resuscitation (CPR) training within the last twelve months. Non clinical staff had received CPR training within the last three years.

Plans were in place to respond to emergencies and major situations. The practice had a business continuity plan which described to staff what to do in the event of an emergency. The plan covered areas such as pandemic flu, fire, staff shortage and IT system failure, and contained relevant contact details for staff to refer to (such as support numbers in the event of an electrical power failure). If the practice had to close urgently, there was a reciprocal arrangement in place with a nearby practice which used the same clinical system, therefore minimising disruption. Staff understood their roles and responsibilities.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure that patients' care and treatment was assessed, planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. This included use of Quality and Outcomes Framework (QOF- a national performance measurement tool). For example, QOF data showed that 90% of newly diagnosed diabetic patients had been referred to an education programme within nine months (compared with the respective England and Enfield practice averages of 84% and 82%).

We also noted that the practice performed slightly better than the Enfield practice average for patients with atrial fibrillation (irregular heartbeat) for whom stroke risk had been assessed in the preceding twelve months (96% compared to 95.7%).

GPs had undertaken specialist post graduate training (for example in chronic disease management) and staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice. Clinical meetings included discussions on changes to guidance and best practice including NICE guidance.

GPs led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurse had received training in chronic disease management. This meant that the practice could focus on specific conditions prevalent in the area such as diabetes.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients including data input, scheduling clinical reviews, managing child protection alerts and medicines management. Information was collated by the practice manager and used to support the practice's clinical audits.

Information about patient's care and treatment, and their outcomes, was routinely monitored and information used to improve care. For example, weekly clinical meetings routinely included a review of vulnerable patients.

We saw evidence of two clinical audits that had taken place between June 2012 and June 2014; and of how audit results had been used to improve patient outcomes. For example, in 2012 the practice audited the prescribing of anti-psychotic drugs in patients with dementia. This was triggered by NICE guidance which states that anti-psychotic drugs should only be used as a last resort or where there is a risk to the patient or others. The audit highlighted that six patients living with dementia had been prescribed anti-psychotic drugs in accordance with NICE guidelines. The resulting audit action plan included refinements to patient review procedures and we noted that the June 2014 re-audit highlighted that only one patient from thirty four was being prescribed antipsychotic drugs .

The practice performed better than the England practice average in a number of Quality and Outcomes Framework (QOF) clinical targets for the year ending March 2014. For example, performance on the percentage of diabetic patients who had had a dietary review within the last twelve months was better than the Enfield practice average (82% and 86% respectively). QOF performance was also above the Enfield practice average regarding percentage of diabetic patients who had had a foot examination and risk classification in the previous 15 months.

We noted that one of the GPs had undertaken nationally recognised post graduate training in diabetic care and that the practice nurse had also received specialist training in diabetic care. Overall, unplanned hospital admissions for diabetic patients were much lower than the England and Enfield practice averages.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff training records showed that all staff were up to date regarding mandatory training (for example safeguarding). We noted a good skill mix amongst the GPs and also noted a mixture of female and male GPs. We noted that GPs were up to date with their yearly continuing professional development requirements and had had their five yearly medical licence revalidation within the last twelve months. 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.

Staff were supported to deliver effective care and treatment, including through meaningful and timely supervision and appraisal. Administrative staff we spoke with had completed annual appraisals within the last

Good

Are services effective?

(for example, treatment is effective)

twelve months where performance was reviewed and training needs identified. They told us that although formal supervision meetings did not take place, they felt supported in their roles. We noted that the practice nurse had not had an annual appraisal.

Working with colleagues and other services

The practice had systems in place to help ensure that when care was received from a range of different teams or services it was coordinated. For example, records showed that regular meetings took place with district nurses and health visitors to monitor and review patient care and treatment. Minutes of clinical meetings showed that clinicians were regularly invited to attend practice clinical meetings. Systems were also in place to signpost or refer patients to specialist third sector agencies including mental health and carer support. We also noted that the practice shared the building with community dental services, family planning clinic, community nursing team and health visitors.

Information Sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care including test results and information to and from other services such as hospitals. All staff were fully trained on the system and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. When we reviewed the system we saw that patients were referred in a timely manner and that all the information needed for their ongoing care was shared appropriately. We also noted that incoming correspondence was processed in a timely fashion. However, there was no formal audit system in place to assess the completeness of records and identify action to be taken where necessary.

Consent to care and treatment

Staff demonstrated knowledge of consent to care and treatment in line with legislation and guidance including the Mental Capacity Act 2005. Systems were in place to support patients to make decisions including where appropriate, an assessment of their mental capacity. Systems were also in place for situations where patients lacked the mental capacity; ensuring that 'best interests' decisions were made and recorded in accordance with legislation.

For example, staff were able to give examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Staff demonstrated a clear understanding of Gillick competencies (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Health Promotion & Prevention

GPs spoke of the importance of early intervention to prevent but also diagnose and treat long term conditions before the emergence of complications. We were told that clinicians were encouraged to perform opportunistic health checks and the practice had recently employed a Health Care Assistant specifically to deliver NHS Health Checks and promote advice and support for health and wellbeing.

We noted that a range of health promotion activity took place including ante natal clinics, sexual health clinics and smoking cessation.

In 2013, the practice identified that cervical screening and childhood immunisation rates were lower than the locality average. It was felt that the low immunisation rates were due to cultural reasons and a lack of awareness. We noted that the practice's local population was diverse and also that it had a high percentage of people aged under eighteen. Two coordinator posts were created (which included an element of community outreach) and we noted that both post holders were multi-lingual; recognising the diverse nature of the population. The practice told us that these posts had had a positive impact.

For example, prior to the creation of the posts, the practice did not meet Department of Health 90% immunisation target for either two or five year olds. Following the introduction of the immunisation co-ordinator, we were told that the practice now routinely achieved immunisation targets for two year olds and was close to reaching the target for five year olds. The figures for the last complete quarters were 93.1% for two year olds and 84.1% for five year olds. For the first quarter of 2013, the equivalent figures had been 88.7% and 81.1% respectively. We were also told that in 2013, only 63% of women in the target age group had undertaken cervical screening. Latest available data showed that the practice's performance was 79.8%.

Good

Are services effective?

(for example, treatment is effective)

The practice reception area contained patient information on conditions which were prevalent amongst the local community such as cardiovascular disease and mental health. However, some information was not available in local community languages.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Before our inspection, we noted NHS England 2014 national GP patient survey feedback that 69% of respondents found receptionists helpful. When we spoke with patients they were positive about how they were treated by reception staff and during our inspection, we observed that reception staff treated patients with dignity and respect. When we spoke with a receptionist they stressed the importance of seeing a patient as an individual. Patients were also positive about how they were treated by GPs and nurses; and we noted that this was also consistent with comment card feedback. For example, 76% of respondents to the 2014 national GP patient survey fedback that the last nurse they saw or spoke to was good at treating them with care and concern.

The practice offered a chaperone service which was publicised in reception. Reception staff were DBS checked and undertook chaperone duties. They had received training.

We observed that the reception area was adjacent to the waiting area and that conversations between the receptionist and patients could be overheard. Privacy in reception was not identified as an issue in any of the comment cards we looked at or in PPG feedback. Additionally, none of the respondents to the practice's 2014 patient survey mentioned privacy as an area of concern.

Care planning and involvement in decisions about care and treatment

The 2014 national patient survey reported that 73% of respondents said the last GP they saw or spoke to was good at explaining tests and treatments (82% for nurses). Patients told us they felt involved in decisions about their care and treatment. This was consistent with patient and comment card feedback. However, we noted that only 55% of respondents felt that their GP was good at involving them in decisions about their care.

The practice's QOF performance was better than the national average for the percentage of patients who had a documented comprehensive care plan on file, agreed between individuals, their family and/or carers as appropriate.

The practice website and reception contained a range of information to help patients make informed decisions about their care and treatment; although we noted that reception information was not available in local community languages. Receptionists outlined the steps that they routinely undertook to help patients who needed additional support to understand and be involved in their care.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website advised people how to access local and national support groups and organisations, although we noted that these were not available in local community languages. 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, 70% of respondents fed back that the last GP they saw or spoke to was good at treating them with care and concern (76% for nurses). This was consistent with face to face and comment card feedback which highlighted that staff responded compassionately and provided support when required (such as during times of bereavement or prolonged treatment).

The practice signposted patients to organisations providing specialist support such as cancer and diabetes support. The practice's computer system alerted staff if a patient had a terminal illness, enabling a priority appointment to be booked.

We noted that 18% of patients had a caring responsibility. We were advised that the practice routinely signposted patients to a local carer support network and we noted that carers information was provided in the practice reception and on the practice website.

We also looked at support offered to patients with depression. We noted that QOF performance was below the Enfield average for patients with a new diagnosis of depression who had had a review not later than the target 35 days after diagnosis (58% compared with 52%).

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, 12% of patients were aged 0 to 4 and in response, the practice had employed an immunisation coordinator to increase uptake. We noted that child immunisation rates were at or better than the average for Enfield and England.

We saw minutes of meetings which evidenced that the practice worked with its CCG to identify needs, agree service improvements and monitor delivery. For example, we noted that 44% of patients were living with a long term condition and that the practice was part of a CCG led initiative to educate patients and help them manage long term conditions. Data showed that unplanned hospital admissions for conditions such as diabetes and lung disease were amongst the lowest in the borough.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services following PPG feedback. This included the introduction of a new telephone system, offering ten and fifteen minute appointment slots and increasing availability of pre bookable appointment slots. When we spoke with the PPG chair, they spoke positively about these improvements and particularly about how the PPG had been consulted on telephone phone system features and the overall planning.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. For example, longer appointment times were available for patients with learning disabilities, older people and/or long term conditions.

Systems were in place to access online and telephone interpreting/translation services including British Sign Language. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients (although these were not readily available in local community languages).

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties. All floors were accessible by lift. Consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting area was large and had sufficient space for wheelchairs and pushchairs. This made movement around the practice easier and helped to maintain patients' independence. The reception desk included a lowered section to enable ease of access for wheelchair users and children. We noted that the practice web site was available in local community languages such as Hebrew, Polish and Somali. However, we did not see evidence of translated materials in reception such as the practice complaints policy or its new patient information leaflet.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. The practice was part of a scheme which provided GP services to people who had been barred from other practices because of violent or abusive behaviour. There was also system for flagging vulnerability in individual patient records.

The practice provided text appointment reminders to all patients which we noted was of particular support to patients with a hearing impairment or who were living with dementia. A screen with the name of the next patient to be seen was located in reception which was responsive to the needs of patients with a hearing impairment.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months. When we asked reception staff how they applied equality and diversity to their roles, they spoke of the need to treat patients as individuals.

Access to the service

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8:30am to 6pm daily. Extended hours surgeries are offered weekdays from 6.30pm to 8pm. Outside of these times, patients are referred to a local out-of-hours provider.

Comprehensive information was available to patients about appointments on the practice website including in local community languages. This included how to arrange

Good

Are services responsive to people's needs?

(for example, to feedback?)

urgent appointments and home visits and how to book appointments through the website. There were also arrangements 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 depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patient survey feedback was negative regarding access to appointments. For example although

72% were satisfied with the practice's opening hours only 58% described their experience of making an appointment as good. We also noted that only 39% found it easy to get through to the practice by telephone. The practice explained that a new telephone system was shortly to be introduced; developed in close consultation with its PPG. This was confirmed when we spoke with the PPG chair.

Patients we spoke with were generally satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, patients told us that children requiring urgent treatment were routinely seen the same day.

The practice's appointments system recognised the needs of different population groups. Home visits and longer appointments were available for older people and people with long-term conditions. Appointments were available outside of school hours for children and young people.

Extended opening hours were responsive to the needs of working age people. We noted that online appointment booking was available and that text message reminder for appointments and test results were also available. The practice was part of a scheme which provided GP services to people experiencing poor mental health who had been barred from other practices because of violent or abusive behaviour. These appointments were offered at less busy times for people who may have found this stressful. We noted that the appointments and telephone phone system were discussed as a standing agenda item at weekly clinical meetings.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. 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 noted that there was some information available to help patients understand the complaints system. This included posters in reception and downloadable leaflet on the practice website. However we also noted that this information was only available in English. None of the patients we spoke with were aware of the process to follow if they wished to make a complaint. They told us that they had never needed to make a complaint about the practice.

We noted that complaints were discussed at weekly clinical meetings as and when they arose. Administrative managers also attended so that all staff were able to share learning and contribute to any improvement action that might be required. There was evidence that lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, one complaint related to alleged limited appointment availability for an end of life care patient; shortly prior to their death. The practice investigated and concluded that no diagnostic opportunities had been missed but amended its appointments system so that end of life care patients were offered priority appointments on demand.

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 vision to deliver good quality patient centred general practice. We spoke with a range of staff including reception staff, practice nurse and GPs; all of whom described a patient centred approach to delivering care. We did not see evidence of a business plan but discussions with staff and review of staff and clinical meeting minutes highlighted that the practice's focus was upon delivering a high standard of medical care with a commitment to addressing patient's needs.

Governance Arrangements

We noted that partners undertook lead roles (for example significant events). We looked at a range of policies including infection control, data protection and safeguarding. The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. However, we noted that in some instances the practice was not working in accordance with its own policies. For example, some pre-employment checks (such as criminal records checks and evidence of safeguarding training) were missing from the personnel records of a locum GP. This was not in accordance with the practice's recruitment policy. We also identified concerns with aspects of the recruitment policy. For example, it did not specify the pre-employment checks required for locum nurses working at the practice. Shortly after our inspection we were advised that the recruitment policy had been amended and also that appropriate pre-employment checks were now on file for all staff.

The practice undertook clinical audits. Clinical meetings included discussions of audits and their role in improving patient outcomes. We noted that the practice's weekly clinical meetings included discussion about performance, quality and risk.

The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

There had been little turnover of staff during the last five years which enabled good continuity of care. Staff told us that there was an open culture at the practice and that they felt comfortable raising issues at team meetings.

We saw evidence that senior GPs encouraged supportive relationships among staff so that they felt valued and supported. We also saw that the practice's significant events procedure was used to provide positive feedback to staff.

The service was transparent, collaborative and open about performance. Records showed that QOF performance was regularly reviewed and there was evidence that clinical audits had been used to improve patient outcomes in clinical areas such as dementia.

Practice seeks and acts on feedback from users, public and staff

We saw evidence that the practice had acted on patient feedback from surveys, comment cards and complaints received. For example, after each consultation, patients were sent an SMS text asking them to rate their consultation. This data was collated and discussed at quarterly meetings.

The practice had an active patient participation group (PPG). The PPG included representatives from various population groups including people with long term conditions, older people and Black and minority ethnic communities. We noted that a new telephone system, fifteen minute appointments slots and customer care training for reception staff had all been introduced following discussion with the practice's PPG.

The practice generally sought and received staff feedback at monthly team meetings and there was evidence that staff members' views were sought and acted upon. Staff told us they felt supported by partner GPs and informed and involved in decision making. A staff "away day" had taken place in the last twelve months.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. The practice was a teaching practice and we also noted that GPs undertook part time undergraduate and post graduate teaching. Staff spoke positively about how this helped ensure that care was based upon latest guidance and best practice.

Significant events and complaints were discussed at weekly clinical meetings to share learning and improve patient outcomes.

Are services well-led?

Good

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

There was a strong focus on continuous learning and improvement at all levels of the organisation which was supported by GPs' involvement in part time undergraduate and post graduate teaching roles.