Boundary House Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Boundary House Surgery on 21 September 2016. The inspection was a comprehensive follow up of an inspection on 9 December 2015 where the practice was rated inadequate for safe, requires improvement for effective and well led and good for caring and responsive. Overall the practice was rated requires improvement. At this inspection we found breaches of legal requirements and we issued an urgent suspension of the provider's registration for a period of six months to enable the provider to take action to improve while removing patients from the risk of harm. A caretaker practice has been identified to provide care and treatment to patients at the practice during this period. Overall, at this inspection the practice is rated as inadequate.

The report from our last comprehensive inspection can be found by selecting the 'all reports' link for Boundary House Surgery on our website at www.cqc.org.uk.

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

- Patients were at significant risk of harm because systems and processes were not in place to keep them safe. Approximately 22000, items of clinical correspondence had not all been acted on dating back to 2012. These included abnormal test results and requests for changes in medicine; and information in relation to safeguarding cases.
- Systems for reporting and recording significant events had been implemented. However, the process was not inclusive of all staff and we had concerns that the practice was under reporting incidents. For example, with regard to the practice's known significant issues in managing clinical correspondence.
- Data showed patient outcomes were low compared to the national average in key clinical areas such as Diabetes.
- Data showed that although patients were satisfied with GP waiting times the length of time to see a GP was comparatively longer than the local and national average. Patients often waited more than 15 minutes to see a GP. An audit conducted by the practice showed that consultations with the lead GP routinely ran late.

Summary of findings

- The practice had a number of policies and procedures to govern activity, but some required further review to ensure they reflected practice arrangements and best practice. However, it was not clear which required review or what the arrangements were for reviewing policies in the light of changes made in the practice's working processes.
- The practice leadership had insufficient capacity and knowledge of governance systems. For example, the lead GP did not have a clear understanding of the practice's performance (QOF) and had not developed plans to improve outcomes.
- Although some audits had been carried out and were showing some improvement over time in outcomes for patients, there remained a need to further improve clinical recording practices and quality improvement systems to ensure that clinical audit continued to drive positive consistent change.
- Patients were positive about their interactions with staff and said they were treated with compassion and dignity.

The areas where the provider must make improvements are:

- Ensure formal governance arrangements including systems for assessing and monitoring risks and systems and processes for assessing the quality of service provision are effective. For example, ensure all significant events are identified and ensure all staff participate, contribute and learn from events.
- Record, review and share how changes have impacted on patient care and treatment. Demonstrate that effective audit arrangements lead to improvement across key clinical outcomes.
- Ensure all policies and procedures reflect published best practice and locally agreed ways of working. For example, processes that support timely referrals.
- Ensure that all clinicians and those supporting clinical work have a thorough knowledge and understanding of the patient management and document management systems. For example, how to code actions as a result of clinical decisions in order to clearly identify patients, how to access registers for children on a child protection plan and how to ensure clinical correspondence is reviewed and acted upon without unnecessary delay; that decisions made about patient care are clearly documented in the clinical patient's notes.
- Ensure management arrangements for overseeing performance (for example QOF) in the practice are effective and that actions are recorded, planned, implemented and reviewed by practice leads.
- Develop a clear strategy for the practice that is supported by a set of business plans that drive forward improvements in the practice' governance.

The areas where the provider should make improvement are:

- Review storage arrangements for emergency equipment to ensure they are easily accessible should there be an emergency situation.
- Review patient access and availability of appointments to better meet the needs of patients and to reduce the length of patient wait to see their GP.
- Continue with plans to recruit more GP's permanently to improve the quality of service provision.
- Ensure that both verbal and written complaints are recorded as part of the practice's complaints system.
- Review arrangements for compliance with the Duty of Candour (the duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

On 26 September 2016 we took urgent enforcement action to suspend the providers of Boundary House Surgery from providing primary medical services under Section 31 of the Health and Social Care Act 2008 ("the Act") for a period of six months to protect patients. We will inspect the practice again prior to the end of the six month suspension. A caretaker practice has been put in place by NHS England to provide primary medical services to patients of the practice during this period.

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

Summary of findings

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

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

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

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

- Staff did not always recognise concerns, incidents or near misses. Not all staff were aware of and be able to prioritise a significant event. Although the practice had established a system for reporting and recording significant events we had concerns that the practice was under reporting incidents and not agreeing, implementing or monitoring change. For example in regard to the practice's known significant issues in managing clinical correspondence.
- There was insufficient attention to safeguarding children. We had concerns about how vulnerable children were being flagged on the patient record management system and the systems in place to oversee the care and treatment for this group were not effective.
- The practice had systems and processes around infection control and staff recruitment and business continuity.
- Risks to patients around health and safety, fire, electrical equipment, clinical equipment and legionella were assessed and well managed.

Are services effective?

Inadequate

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

- Systems and processes to support effective needs assessment and coordination of patient care, monitoring and managing performance were inadequate. For example, systems for managing patient clinical correspondence were not safe. These included letters from hospital about a patient's care or treatment or from social care team's regarding vulnerable children and young people. There were undue delays to people being referred to other services. Processes for managing referrals had been identified as a significant concern by GPs and patients at the practice.
- Data showed patient outcomes were low compared to the national average for Diabetes and Hypertension. These outcomes had not improved since 2014/15 and remained significantly below national averages in key indicators.
- The provider had taken steps to establish a quality improvement system. Two audit cycles had been completed on

Summary of findings

existing audits and three new audits had been focused on patient survey outcomes. However, the system required further development to ensure that all actions resulting from audits were clear and sustainable and detailed how the learning affected changes in systems and processes to improve outcomes. For instance, although audits showed some improvement in outcomes. There remained concerns in relation to clinical recording amongst clinicians' actions noted in existing audits had not been reviewed and followed up through governance systems.

- Multidisciplinary working was taking place but was generally informal and record keeping was limited.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- The majority of patients said 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 staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Requires improvement

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

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. For example, improving outcomes for patients with diabetes and hypertension.
- Feedback from patients reported that access to a named GP and continuity of care was a concern. Appointments with the lead GP often ran late which meant that patients had to wait a long time to be seen on average.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Patients could get information about how to complain in a format they could understand. However, there was no evidence that verbal complaints as well as written complaints had been recorded and included as part of a system.

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Are services well-led?

Inadequate

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

- Although the practice had a clear vision there was not a clear, robust and realistic strategy which was monitored and regularly reviewed to support delivery.
- Governance arrangements and their purpose were unclear. For example, the clinical team did not have a comprehensive understanding of the performance and supporting governance arrangements in the practice.
  There was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged or repressed. Significant issues that threaten the delivery of safe and effective care are not identified or adequately managed
- Leaders do not have the necessary experience, knowledge, capacity or capability to lead effectively. There is a lack of clarity about authority to make decisions. Quality and safety are not the top priority for leadership.
- The practice had proactively sought feedback from staff and patients and had a virtual patient participation group who provided feedback on patient survey and friends and family test results.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

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

- The practice proactively offered personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice participated in multidisciplinary meetings for older patients with complex needs when capacity allowed.

People with long term conditions

Inadequate

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

- Performance for diabetes related indicators was below the national average. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 46% compared to the national average of 78.03%.
- For the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 70.98% compared to 80.53% nationally.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

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

Summary of findings

- Information about children at risk was not always updated in the electronic records in a timely way. Systems to identify and follow up patients at risk in this group were not always effective.
- Immunisation rates were relatively high for all standard childhood immunisations.
- 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.
- The practice's uptake for cervical screening programme was 85% which was above the CCG average of 81% and the national average of 82%
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate

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

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- 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.

People whose circumstances may make them vulnerable

Inadequate

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

- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

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

- Performance for dementia related indicators were above to the national average. The percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 89% compared with a CCG average of 83% and a national average of 84%.
- Performance for mental health related indicators were similar the national average. For example: 80% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the last 12 months compared with a national average of 88.3%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published July 2016. The results showed the practice was performing below local and national averages.Three hundred and sixteen survey forms were distributed and 101 were returned.This represented 2% of the practice's patient list.

- 65% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 53% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 81% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 65% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%).

Since our last inspection it had continued to be difficult to get through to the practice by telephone. Although there had been a slight improvement in patients being able to get an appointment to see or speak to someone the last time they tried performance remained lower than the national average. The practice had developed an action plan to monitor telephone wait times and to conduct an audit of missed appointments but this had not been completed at the time of this inspection. Practice leads stated that a lack of clinical and managerial capacity meant that the practice had not been able to respond to concerns identified.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards which were generally positive about the standard of care received. Patients stated that practice staff were helpful, kind and considerate to them. However, six patients commented that it is often very difficult to get an appointment and sometimes hard to access the same GP.

We spoke with three patients during the inspection. They said they thought staff were very approachable, committed and caring. However, two patients told us that it was not always easy to get through to the practice by telephone and that appointments did not run to time because there were not enough GPs. One patient also told us that they had experienced delays in some of their recent referrals. They told us that they had raised their concerns informally with the practice. On the day of the inspection the patient told us that they had raised a verbal complaint to the practice. We noted that informal/ verbal complaints are not recorded by the practice team as part of the practice's complaint's system which is the expectation, so the inspection team could not be assured that all complaints are appropriately recorded or responded too.

In the latest friends and family test all of the 280 respondents stated that they were 'likely to recommend' the GP practice to friends and family.

Boundary House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Boundary House Surgery

Boundary House Surgery is situated in Edmonton, North London within the NHS Enfield Clinical Commissioning Group (CCG). The practice holds a Primary Medical Services contract (an agreement between NHS England and general practices for delivering personal medical services). The practice provides a full range of enhanced services including adult and child immunisations, facilitating timely diagnosis and support for people with Dementia, and minor surgery.

The practice had a patient list of just over 5200 at the time of our inspection.

The staff team at the practice included one female GP partner lead, one female salaried GP, one GP male locum all working 40.5 hours a week (equivalent to 10 sessions a week), two female practice nurses both working full time (37.5 hours a week) and one practice manager who was registered with the Care Quality Commission as a partner at the practice.

The practice's reception is open between 8.00am and 6.30pm Monday to Friday. Extended hours surgeries are offered on a Tuesday evening from 6.30pm to 7.30pm and a Wednesday evening from 6.30pm to 8.30pm. The surgery is closed on Saturday and Sundays.

The practice's consultation times are:

Monday	9.30am – 12.30pm	3.30pm – 6.30pm
Tuesday	9.30am – 11.30am	4.00pm – 7.30pm
Wednesday	9.30am – 12.00pm	3.30pm – 8.30pm
Thursday	9.00am – 12.00pm	3.30pm – 6.30pm
Friday	9.30am – 12.00pm	3.30pm – 6.30pm

To assist patients in accessing the service there is an online booking system, and a text message reminder service for appointments and test results. Urgent appointments are available each day and GPs also complete telephone consultations for patients. An out of hour's service provided by a local deputising service covers the practice when it is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on their circumstances. Information on the out-of-hours service is provided to patients on the practice website as well as through posters and leaflets available at the practice. There are approximately 22 GP appointment sessions available per week and 7 sessions available per week for the practice nursing staff (excluding telephone consultations).

The practice had a lower percentage than the national average of people with a long standing health conditions (51% compared to a national average of 54%); and a lower percentage than the national average of people with health related problems in daily life (43% compared to a national average 49%). The average male and female life expectancy for the Clinical Commissioning Group area is higher than the national average for males and in line with the national average for females.

The practice was previously inspected on 9 December 2015 when it was rated as requires improvement overall.

Detailed findings

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. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The practice had been inspected on the 9 December 2015. This inspection was to follow up on areas identified for improvement.

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 21 September 2016. During our visit we:

- Spoke with a range of staff (Two GP's, two practice nurses, and the practice manager) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed a personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

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

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

Inadequate

Are services safe?

Our findings

Safe track record and learning

At 9 December 2015 inspection, we found that significant events were not being systematically identified. We asked the provider to take action.

At this inspection, we noted that there was a system in place for reporting and recording significant events. The practice had introduced regular significant events review meetings with GPs as a process for analysing, discussing and agreeing actions. There had been a review of its policy. Non-clinical staff had been informed of the new process via a practice team meeting.

However, we could not be assured that reporting and learning was embedded in the culture of the practice. For example, although staff told us they would inform the practice manager of any incidents and there was a recording form; we noted that staff were not clear about the differences between an incident and a near miss. It was also unclear how the wider staff team (including practice nurses) participated in discussions about sharing learning from significant events and using this information to maintain patient safety. We also had concerns that some significant events were not being reported or recorded. During this inspection we found significant concerns in relation to how the practice was dealing with patient correspondence. We asked to see minutes of meetings or a significant event or any documentation pertaining to the known issues. We were informed that there were no records of the significant concerns or any actions to resolve the ongoing performance issues. Staff who were aware of the concerns had not acted to report this significant safety concern.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We noted that following the identification of four significant events related to lengthy delays in making both urgent and non-urgent referrals a referral audit had been put in place in July 2016. In one occurrence for example a patient's referral took over six weeks to be sent. The practice lead who had made the referrals agreed this was an unacceptable delay and all routine referrals should be sent within seven working days although this is longer than usually anticipated. The practice lead stated that urgent referrals should be sent within 24 hours. An audit was put in place by the practice manager to check that referrals were being completed and sent off within the practice's timescales. For non-urgent referrals 7 working days and the same day for urgent referrals. Referral delays remained an ongoing issue for the practice and it was not clear what actions were bring taken to stop further undue delays as work load pressures remained a challenge for the lead GP. In one specific urgent referral there had been a significant delay of over four weeks. This referral which had been investigated as a significant event; had resulted in a cancer diagnosis. Referral delays remained an ongoing issue for the practice and it was not clear what actions were bring taken to stop further undue delays as work load pressures remained a challenge for the lead GP.

Overview of safety systems and processes

At our last inspection we found that the practice had not developed systems and processes for monitoring risks to patients. We asked the provider to take action.

We looked again at systems, processes and practices in place to keep patients safe:

- At the last inspection we found that arrangements were not always in place to safeguard children and vulnerable adults from abuse. We found that two locum GPs had not yet undertaken safeguarding vulnerable adults training at the appropriate level. We also identified that children and young people on a child protection plan (CPP) had not been correctly identified or flagged through the coding function on the patient management system. This process enables staff to actively identify report and monitor continually these children and their families.
- At this inspection we found that policies were accessible and outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all clinicians including locum GP's had now received training on safeguarding vulnerable adults relevant to their role. During our discussions with the lead GP we looked at examples of patients who had a child protection plan (CPP) in place. We saw two examples of where patient notes had been flagged with major alerts. However, the lead GP was still unable to

access practice registers of children with a safeguarding alert and they told us that these patients were discussed on an ad hoc, informal basis rather than as part of a recorded regular clinical discussion. The lead GP told us that this remained an issue due to a lack of knowledge of the practice's clinical management system. The lead GP told us that they had not received any recent clinical management system training to support clinical oversight.

- At our last inspection in December 2015 we found that not all chaperones had received a Disclosure and Barring Service check (DBS). During this inspection we found that all five staff who acted as chaperones were trained for the role and had now received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice had a dedicated member of the administration team who monitored the prescription process. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). At the last inspection we found that there was not always a record of whether a medicine review had occurred as patient notes were not correctly coded. During this inspection we looked at six medicine reviews and found that they had been undertaken in line with national guidelines and we saw evidence that administrative staff were recording patient reminders for medicine review attendance in the clinical notes. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- At the last inspection we looked at the personnel file of a locum GP who had joined the practice within the past 2 years it did not contain the appropriate recruitment checks. At this inspection we reviewed three GP locum personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

We looked at how risks to patients were assessed and managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. At the last inspection the lead GP told us that the practice was actively seeking to recruit permanent GPs to provide stability for the practice in the long term; they had been reliant on a part time salaried GP and a number of locums in recent years. Since our last inspection, the practice had successfully recruited one of their longstanding locum GPs to a full time post. However, within the last few months a long standing part time GP had left the

practice. The GP lead told us that clinical capacity continued to be a challenge and this impacted on the time available for clinical and managerial oversight and governance.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- At the last inspection of 9 December 2015 we found that the practice's oxygen was located in the reception area and checked regularly by the practice manager however, we noted that the adult and child masks were not kept with it and were located separately in a consultation room and staff were not clear why this was the case. At this inspection we looked again at oxygen and we found that although there was an adult's mask available there was no child mask. A child mask was located in the practice's storage room and placed with the oxygen cylinder immediately by the practice manager following the discussion with the inspector.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

At the 9 December 2015 inspection, we found that there were no processes for monitoring that clinical guidelines were followed through risk assessments, audits and random sample checks of patient records. During this inspection we noted that the practice had introduced clinical governance management meetings and had begun to record decisions in relation to how guidelines would be reviewed, and monitored over time. For example, we saw that a diabetes, hypertension and mental health audit had been agreed following a published guideline from NICE. However, these audits were yet to report findings and it was unclear as to what stage they were at in their development. The last set of meeting minutes did not set out actions clearly and there were no agreed dates for actions noted or who was to lead.

During this inspection we found the management of patient related correspondence presented a serious and significant risk to patient care. We found the practice did not have systems in place to ensure that clinical staff were following clinical guidance and standards. Clinical results and letters received electronically into the patient document management systems were not always reviewed or acted upon in a timely way and decisions made about patient care were not clearly documented in the patient's clinical notes.

We identified approximately 22,000 incomplete correspondence records dating back to 2012 in the lead GP's work flow. We noted the correspondence included items such as clinical letters, discharge letters, radiology reports, histology results, faxes, and results from social care teams. We asked the lead GP about what we had found, and they told us they did not understand how to use the patient document management system leading to a back backlog of correspondence which they were unable to keep up due to a lack of time . The lead GP told us that approximately 20% of the documents may not have been reviewed and they could not tell us which had or had not been seen or acted upon.

We selected a sample of 22 items of documentation and reviewed the corresponding patient records to check if appropriate action had been taken, for example to follow-up abnormal test results and fulfil requests from social services in relation to safeguarding information. In 12 cases we found that actions had not been completed in the patient's records. The incoming correspondence concerned child safeguarding, discharge from hospital after care, and requests for medication changes.

We discussed these cases with the lead GP and practice manager. The GP lead told us they had acted on some of the letters but could not provide evidence of this. They acknowledged that they had a large backlog of clinical letters and as a consequence they had not followed up every case. We asked if other practice staff were aware of this backlog and were informed that they were and had at times tried to assist the lead GP in reviewing some of the correspondence but this matter had not been followed up in a systematic way. We reviewed the inbox of a long term locum GP and found all patient correspondence had been actioned. The lead GP told us that most of the patient letters and results had come directly to them as the lead GP and due to capacity issues there had been no one to delegate to even during periods of annual leave.

For example:

- A patient discharged from hospital three months ago following admission for respiratory related illness had not had their community DNAR (Do Not Attempt Resuscitation) status arranged as requested. We noted that the discharge summary had not been actioned. There were no clinical notes about the decision to put a DNAR in place and further concerns in relation to medicine were not clearly actioned. We found that the patient record system had not been updated with the change in dosage as instructed by the hospital team and another medicine had not been added to the prescription listing and no comments in the patient record to state that this was to be reviewed by the GP had been made. The lead GP stated that they did not think the patient needed the change in dose and this was why it had not been added. However, this was not reflected in the patient notes.
- A letter (one month prior to the inspection) requesting calcium monitoring for a patient for two to four weeks following the last set of results had not been acted upon in the clinical records. Although a reminder had been noted on the clinical system it had not been actioned and the lead GP was not clear who had added this reminder and why this had not been acted on.

Inadequate

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

At the 9 December 2015 inspection we found the practice was not consistent in its approach to collecting information for the Quality Outcomes Framework (QOF) and in assessing its performance against national screening programmes which monitored outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice was not meeting its targets in a number of areas such as diabetes and hypertension.

At this inspection we reviewed the practice's approach to collecting this information. Data from 2014/15 showed that QOF performance was significantly lower for the management of patients with diabetes and hypertensive patients compared to the CCG and national average. The most recent published results (2014/15) were 78% of the total number of points available, with 5% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from 2014/15 showed;

- Performance for hypertension related indicators was below CCG and national average. For example, 67% of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less compared with aCCG average of 81% and a national average of 84%.
- Performance for diabetes related indicators related to the management of the condition was significantly below the national average. The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 46% compared to the national average of 78%. For the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 71% com-pared to 81% nationally. However, the percentage of those patients with diabetes on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 95% compared with 88% nationally and 98% had had a flu immunisation compared to 95% nationally.
- Performance for mental health related indicators was both a below and above national averages. For example: 80% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the last 12 months compared with a national average of 88% and the percentage of those patients who had a record of their alcohol consumption in the preceding 12 months was 100% compared with a CCG average of 90% and a national average of 90%."
- Performance for dementia related indicators were above to the national average. The percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 89% compared with a CCG average of 83% and a national average of 84%.

We looked at the practice's 2015/16 results which had recently been published. Data showed that overall the practice achieved 84% of the total number of points available. This had been an improvement of 6% on the previous 2014/15 year. . This compared to a CCG average and England average of 94% achievement on target. Exception reporting rates were better than the local and national average. 6% compared to a CCG average 7% and a national average 10%. However, we looked at the performance for diabetes and hypertension related indicators and found that these had not made any improvement since 2014/15. (Both long term conditions are highly prevalent amongst the patient population).

Practice leads acknowledged that their QOF figures remained low for patients with diabetes and hypertension indicators. They told us that consistency of reporting had remained a continual challenge since our last inspection and a lack of clinical capacity to drive forward improved performance and change had remained the issue. In addition, the lead GP had a very limited knowledge of the patient management systems. For example, they were not able to run reports on QOF performance and was unable to comment on how well the practice was meeting patient outcomes. As a result there was a significant lack of clinical leadership in regard to QOF and the practice was reliant on the practice manager to maintain and report QOF performance.

At the time of the inspection, there was one lead GP and one recently appointed salaried GP (who had been a

long term locum and appointed on 1 September 2016), and one locum covering clinical sessions (also a long term locum). The practice also used additional locums when required.

In response to our last inspection; the practice had recently introduced clinical governance meetings. Although QOF performance was not discussed as part of the agenda specifically, we found that plans in regard to clinical audits to look at how the practice intended to improve outcomes in line with national guidelines or best practice had been. For example, the practice was looking to introduce a diabetic and hypertension audit in line with NICE guidance, but it was not clear when these would commence.

- The provider had taken steps to establish a quality improvement system. Two Cycle audits had been completed on existing audits and three new audits had been focused on patient survey outcomes, such as consultation waiting times, patients who do not attend appointments, and the timeliness of referrals. However, the system required further development to ensure that all actions resulting from audits were clear and sustainable and detailed how the learning affected changes in systems and processes to improve outcomes. For instance, although audits showed some improvement in outcomes. There remained concerns in relation to clinical recording amongst clinicians' actions noted in existing audits had not been reviewed and followed up through governance systems. In one example, the referral audit found the average waiting time to send a referral was on average ten working days in July 2016 which was over the practice's seven day target. We noted in the waiting time audit the average waiting time to be seen by the lead GP was significantly more than other clinicians on average 20 minutes.All audits had actions recorded and follow up cycles scheduled.
- In addition, an audit had commenced to check how well the practice was progressing its health checks for patients with poor mental health. The practice had repeated cycles for its Glaucoma, consent and chaperoning, and inadequate smear results. We noted that although action had been recorded, it was not clear how or when these would be followed up at clinical governance meetings. Of 27 patients identified in 2015 who had an intimate examination, 74% of patients had consent documented on their examination compared to 50% in 2014. Of 27 patients identified in 2015, 67% had a chaperone recorded compared to 45% in 2014. Although the practice had demonstrated improvement over two cycles in regard to recording consent and chaperoning, the practice's recording processes were still an issue and clinicians were still not recording accurately. The practice had identified improvement action for staff to continue to better select consent and chaperone codes following examinations. However, there was no date for review of these findings and no record of this to be followed up at a clinical governance meeting.

Effective staffing

We looked at the practice's systems for ensuring that staff had the skills, knowledge and experience to deliver effective care and treatment. We noted the following:

- The practice had an induction programme for all newly appointed staff. At the last inspection we found the induction checklist did not specifically include reference to safeguarding, infection control, fire safety or confidentiality. However, since the last inspection the practice had now included all identified topics.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence.Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.

Inadequate

Are services effective?

(for example, treatment is effective)

- At the last inspection two locums GP's had not completed safeguarding adults training. Since the last inspection all clinical staff had now undertaken safeguarding adults training to the appropriate level for their role. Staff received training also included: safeguarding children, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. However, clinical results and letters received electronically into the patient document management system were not always reviewed or acted upon in a timely way and decisions made about patient care were not clearly documented in the clinical patient's notes. We could not be certain that care and risk assessments, care plans, medical records and investigations and test results were dealt with safely.

The practice did not always share relevant information with other services in a timely way, for example when referring patients to other services. Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. However, we found concerns in relation to the timeliness of referrals. For example, following a number of significant events relating to delayed referrals the practice conducted a snapshot audit in July 2016, the practice's referral audit showed that the practice's lead GP had 23 referrals to action. However, 16 referrals were not actioned within the 7 day target date and all 16 took longer than 10 days to be sent. In one it took 17 days. However, we noted this was not the case for locum GPs who had taken on average 4 days to refer.

Informal meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. We saw examples of care plan reviews and appropriate actions which included a variety of professionals.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. {cke_protected_1}
  When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- At the last inspection we found that the process for seeking consent had been monitored through a record audit and actions to improve recording had been identified. At this inspection, we noted that clinicians had undertaken training in how to record consent on the patient management system which had resulted in some improvement outlined earlier in the report. However, recording practices required attention and we noted this action had no follow up date.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for cervical screening programme was 85% which was above the CCG average of 81% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. (71% of women aged between 50-70 were screened for breast cancer in last 36 months compared to 72% nationally).There were failsafe systems in place to ensure results were received for all

Inadequate

Are services effective?

(for example, treatment is effective)

samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. We noted that the practice's inadequate smear rate improved by 1% in 2015/16.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 26% to 96% (26% refers to children Infant Meningitis C) and five year olds from 95% to 99%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

We received forty one comment cards which were generally positive about the standard of care received. Patients stated that practice staff were helpful, caring and treated them with dignity and respect.

We spoke with three patients. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 85% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

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

Staff told us that interpreting and translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. The practice was actively identifying carers through their carer's champion. The practice had identified

Good

Are services caring?

58 carers just over 1% of their patient list. Written information was available to direct carers to the various avenues of support available to them and clinicians were able to signpost carers to local Enfield services.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered a 'Commuter's Clinic' on a Monday and Wednesday evening until 8.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccines available privately.
- There were accessible facilities, a hearing loop and translation services available.
- The practice was located within a primary care health centre with access to phlebotomy, and podiatry services, as well as a consultant diabetic nurse amongst others available.
- There was an independent pharmacy located in the health centre which was useful to both the practice and patients.

Access to the service

The practice's reception was open between 8.00am and 6.30pm Monday to Friday. Extended hours surgeries were offered on a Tuesday evening from 6.30pm to 7.30pm and a Wednesday evening from 6.30pm to 8.30pm. The surgery was closed on Saturday and Sundays.

The practice's consultation times were:

Monday	9.30am – 12.30pm	3.30pm – 6.30pm
Tuesday	9.30am – 11.30am	4.00pm – 7.30pm
Wednesday	9.30am – 12.00pm	3.30pm – 8.30pm
Thursday	9.00am – 12.00pm	3.30pm – 6.30pm
Friday	9.30am – 12.00pm	3.30pm – 6.30pm

In addition, to pre-bookable appointments that could be booked up to 7 days in advance, urgent appointments were also available for people that needed them. The practice offers emergency appointments bookable twice a day on weekdays at 8.00am for the morning session and 12 noon for the afternoon session. Patients are triaged for urgent problems. The practice also offers pre bookable online appointments. The practice also offers telephone advice every weekday. Results from the national GP survey showed that patients' satisfaction with how they could access care and treatment was mixed in comparison to local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 65% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 53% of patients usually wait more than 15 minutes after their appointment time to be seen compared to the national average of 27%. 35% waited between 5 and 15 minutes compared to the national average of 55%.

At our last inspection 54% of patients said they usually waited more than 15 minutes or after their appointment time compared to a national average of 27%. Results for the 2015/16 survey had showed that the length of waiting times were still too long for the majority of respondents. Following the inspection, we were told that consultation times were discussed with clinicians to improve satisfaction scores although these discussions had been informal. The GP lead told us that her popularity amongst her patients meant that waiting times were longer; as she had dedicated her time to listen and assess often more than one specific concern. The lead GP also told us that recruitment of new GP's had been challenging which had impacted on capacity. However, there was always appointments with locum GP's available.

In 2016, we noted that the practice undertook an audit of patient waiting times over a period of 6 weeks (waiting times to be seen by a clinicians), to identify how the appointment system could be further improved. Findings identified the lead GP had significantly longer waiting times than other GPs. The lead GP told us that they were actively

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

trying to reduce waiting times in the waiting room. Patients were asked to limit their appointment to one medical problem where possible and the practice were to identify which patients required longer appointments. It was not clear however which actions had been implemented and how the practice was yet to review the impact of any change. Following the inspection the lead GP told us that the clinical commissioning group (CCG) had installed a Jayex message board in the waiting rooms in most Enfield GP practices advising patients to discuss one problem per appointment if possible.

Two patients told us that it was not always easy to get through to the practice by telephone and that appointments did not run to time because there were not enough GPs.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- The practice had a complaints policy and procedure 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. For example a poster, and complaints form and summary on the practice's website.

Since the last inspection on 9 December 2015 there had been one formal complaint recorded which had been acknowledged and satisfactorily handled, and dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. However, we noted that the practice had not been recording informal/verbal complaints as they were not aware these needed to be included as part of the practice's complaints analysis.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

Since the last inspection on 9 December 2015, the practice had not made any further progress in developing a strategy. Clinical leadership capacity remained a significant challenge and the practice had not been able to introduce any effective business plans to drive delivery in high quality care and promote good outcomes for patients.

Governance arrangements

At our 9 December 2015 inspection we found no overarching governance framework in place to support delivery of a strategy such as a comprehensive understanding of QOF performance for the clinical team. For example, no formalised meetings where decisions were agreed and actions followed up in regard to lessons learned from mistakes. The governance lead was a locum and it was not clear what their specific responsibilities were in regard to the role. The practice's approach to service delivery and improvement was reactive and focused on short term issues. Improvements were not always identified and action not always taken.

At this inspection, all staff we spoke with understood their day to day roles and responsibilities and there was a clear staffing structure. However, governance arrangements and their purpose remained unclear and underdeveloped.

- We found that clinical staff still did not have comprehensive understanding of the performance of the practice. Although the practice participated in QOF and there had been some improvement in recording processes, it was not recording outcomes consistently. The lead GP did not have a clear and accurate understanding of the practice's clinical performance and did not have an effective understanding of how to use the patient record system to ensure patients were kept safe. We found significant concerns in relation to the management of clinical correspondence. . We found 22,086 patient letters, tests and reports dating back from 2012 from secondary care in the patient document management system. Staff were aware of the backlog but had failed to act to reduce the impact on patient care.
- We could not be assured that the appropriate steps had been taken to deal with all such correspondence to protect patients from harm.
- We identified that some progress had been made in the practice's arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice had introduced a significant events process in line with guidance and were identifying and analysing incidents that have an impact on patient safety through a significant event meeting. However, we could not be assured that reporting and learning was embedded in the culture of the practice. For example, staff were unclear about the differences between an incident and a near miss and it was unclear how practice nurses participated in discussions about sharing learning from significant events. Staff had not identified the backlog of incoming correspondence as a significant event posing a risk to patient safety.
- The practice had specific policies and these had been implemented and were available to all staff. However, it was not clear which required review or what the arrangements where for reviewing policies in the light of changes made in the practice's working processes.
- The practice had a limited programme of clinical audits and it was difficult to assess the extent to which these had led to improvements as some changes had only just been implemented. The governance arrangements for these had yet to be included clearly and succinctly in meeting minutes. We saw that the practice had made some progress in linking its clinical audits with its performance management processes to improve health outcomes for patients. However, we noted that not all audits were two cycle and some planned audits had not commenced for a number of months.
- The practice had introduced clinical governance meetings but these were still in their infancy and did not always include practice nursing staff.Although actions were recorded they were not always followed up and it was not clear how much progress was being made as there were no supporting business plans. It was not clear how learning around quality and risk was shared to improve patient care across the whole practice.
- The practice approach to service delivery and improvement remained reactive. Although

Are services well-led?

Inadequate

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

improvements were now being identified; action was not always being taken appropriately or in a timely way. For example, an assessment of clinical guidelines had not resulted in random sample records checks or audits to ensure the relevance and likely impacts on the patient population.

Leadership and culture

At our 9 December 2015 inspection we found that clinical leadership arrangements did not support the delivery of high-quality person-centred care. Although, the lead GP was clear about their role and accountability for quality, we could not be assured that they had the necessary capacity to lead effectively due to the individual burden being placed on them.

At this inspection we found that practice leads still did not have the necessary experience, knowledge, capacity or capability to lead effectively. Although the lead GP was clear about their role and accountability for quality, we were still not assured they had the capacity to drive systematic improvement. This was demonstrated throughout the inspection and the significant concerns identified. For example, in relation to the management of patient correspondence and a lack of understanding in how to manage the clinical system along with a number of incidents related to patient referral delays including one for breast cancer. There was a lack of cohesive organisation within the clinical team and decisions and actions were not being followed up or delegated appropriately.

Since the last inspection the provider had not been able to successfully recruit permanent salaried GPs through external adverts. Staff told us this was an ongoing concern about capacity to improve and they recognised that the practice could not move forward without an increase in its clinical resources or without stopping its patient consultative work to focus on improving patient care. Recent clinical staff changes had further impacted on clinical capacity and put staff under pressure.

Non clinical staff had team meetings and these were minuted consistently with actions. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported; and involved in the day to day operation of the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- It had gathered feedback from patients through its virtual patient participation group (PPG) and through surveys and complaints received. The practice manager told us that regular consultation took place with the virtual group on patient surveys and proposals for practice improvements. For example, the PPG raised concerns about the practice telephone system which resulted in changes in how calls were prioritised making it easier for patients to access the practice.
- The practice had also gathered feedback from staff through staff events, informal meetings and appraisal. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. All staff were involved in informal discussions about how to run and develop the practice, and the lead GP and locum GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, the practice nurses had developed an effective approach to care planning and we saw good examples of care plans for patients with long term conditions such as COPD.

The provider had a system in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). However, practice staff had not acted on the significant concerns identified in relation to the buildup of patient correspondence. We noted that when an event had been identified records showed evidence of verbal and interactions with patients.

There was a leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so.

Are services well-led?

Inadequate

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

- Staff said they felt respected, valued and supported in the practice. All staff were involved in discussions about how to run and develop the practice, and the staff were encouraged to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The virtual PPG had been involved in discussions about patient surveys and submitted proposals for improvements to the practice management team. The practice had responded to the friends and family test and had begun to act on feedback.
- All staff were involved in informal discussions about how to run and develop the practice, and the lead GP and locum GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice despite the leadership capacity challenges.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was failing to: • mitigate risks by following good practice guidance and adopting control measures to make sure the risk is as low as reasonably possible. Ensure all review methods and measures address changing practice. For examples, significant referral delays. • appropriately risk assess, review and act on patient correspondence such as clinical letters from secondary care in a timely way to ensure that patient care and treatment was safe. Regulation 12 (1)

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was failing to: • assess, monitor and improve the quality and safety of the service. Ensure systems and processes such as audit, QOF identify where quality or safety are being compromised and respond appropriately and without delay. • ensure all significant events are identified and reviewed and acted upon to reduce the likelihood of risk to harm. • ensure that all clinicians and those supporting clinical work have a thorough knowledge and understanding of the patient management and document management systems. • ensure all clinical policies and procedures reflect published best practice and local arrangements.

This section is primarily information for the provider

Enforcement actions

Regulation 17 (1)