Boundary House Surgery

Quality Report

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Date of inspection visit: 21 March 2017
Date of publication: 20/07/2017

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?	Requires improvement
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 9 December 2015. The overall rating for the practice was requires improvement. Subsequent to this the provider submitted an action plan detailing how it would make improvements and when the practice would be meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an announced follow-up inspection at Boundary House Surgery on 21 September 2016. The practice was rated as inadequate for providing safe, effective and well-led services and was rated inadequate overall and urgent enforcement action was taken to suspend the provider 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. The practice was also placed in special measures for a period of six months. Subsequent to this the provider submitted an action plan detailing how it would make improvements and when the practice would be meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

A caretaker practice was put in place by NHS England to provide primary medical services to patients of the practice during the period of the suspension.

The full comprehensive report on the December 2015 and September 2016 inspections can be found by selecting the 'all reports' link for Boundary House Surgery on our website at www.cqc.org.uk.

This inspection was undertaken prior to the end of the six month suspension period whilst the practice remained in special measures on 21 March 2017. Overall the practice is still rated as inadequate.

Our key findings were as follows:

- It was unclear whether concerns about the lead GP's lack of knowledge of the patient record management system had been addressed as they

had been unable to undertake training during their absence from the practice. Following the inspection, the lead GP told us they could use all systems at the practice but we did not see evidence to support this.

- When we inspected in September 2016, we were told that difficulties recruiting permanent GPs had a significant impact on the lead GP's capacity to manage the practice. Since the inspection, the practice had recruited two new GP partners to the practice and the process of adding these to the practice's CQC registration was ongoing.

- There was some evidence of recent clinical and non-clinical audit being carried out at the practice. However, there was no evidence that these had been used to bring about improvements.
- Data showed patient outcomes for some conditions were low compared to the national average although current but unvalidated data indicated that these had recently begun to improve.
  - The practice had worked closely with a caretaker practice, the local clinical commissioning group and NHS England to improve leadership capacity and governance arrangements. However, as the lead GP had been absent from the practice since the September 2016 inspection, their contribution to improvement was limited. We were told the lead GP had had a role in developing the action plan produced in response to the September 2016 inspection report, but this action plan had been substantially realised and implemented by the caretaker practice and practice management. Following the inspection, the lead GP responded by telling us that they had been significantly involved in bringing about improvements at the practice but we did not see evidence of this during the inspection.

  - With the support of the caretaker practice, the practice had put effective systems in place to manage clinical correspondence in a safe and timely manner.

- There was now an open and transparent approach to safety and a system in place for reporting and recording significant events.
  - The practice was actively engaging with commissioners to change the leadership structure to improve governance and bring about improvements to patient outcomes.

  - Patients were positive about their interactions with staff and said they were treated with compassion and dignity although some patients said they had concerns about continuity of care by some clinicians.

  - The practice had taken action to reduce waiting times for appointments.

- The practice had a number of policies and procedures to govern activity and had recently reviewed and updated these.

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

Importantly, the provider must:

- Ensure that all clinicians have a thorough knowledge and understanding of the patient management and document management systems.
- Ensure that the practice's quality improvement programme includes effective audit arrangements that drive improvement across key clinical outcomes.

In addition the provider should:

- Continue with plans to change the leadership structure at the practice to improve quality of service provision.

- Continue to closely monitor systems used to review and act on clinical correspondence to ensure all correspondence is acted upon without delay and that decisions made about patient care are clearly documented in the clinical patient's notes.
- Continue to closely monitor systems used to refer patients to secondary care to ensure that these are fully embedded into practice procedures.
- Continue to ensure management arrangements for overseeing performance (for example QOF) in the practice are robust and that actions are recorded, planned, implemented and reviewed.
- Make arrangements to carry out regular fire drills.
- Review patient access and availability of appointments to better meet the needs of patients.
  - Continue to take action to reduce the length of patient waiting times for GP consultation.

  - Review the practice business continuity plan to ensure that information is up to date.

This service was placed in special measures in February 2017. Insufficient improvements have been made such

Summary of findings

that there remains a rating of inadequate for providing effective services and well-led services. The service will remain in special measures, be kept under review and if needed could be escalated to urgent enforcement action. Another inspection will be conducted within six months, and if there is not enough improvement we will move to 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.

Professor Steve Field CBE FRCP FFPH FRCG
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.

- There was no evidence that the lead GP had been involved in recent improvements or had yet received training to address their lack of knowledge of the practice's clinical management system.
- The practice had a business continuity plan for major incidents such as power failure or building damage although this included contact details for clinical staff who were no longer employed or associated with the practice and the communication cascade had not been updated to reflect this.
- Risks to patients around health and safety, fire, electrical equipment, clinical equipment and legionella were assessed and well managed although a fire drill was overdue.
- When we inspected in September 2016, we found there were concerns with how the practice recorded serious incidents. At this inspection, we found the practice had reviewed these arrangements and had put an effective system in place to identify, record, investigate and learn from serious incidents.
- During our inspection in September 2016 we found there was insufficient attention to safeguarding children. At this inspection, we found that policies and procedures used to safeguard children had been reviewed and updated, non-clinical staff had received additional safeguarding training and were able to use the patient record system to identify patients at risk of abuse or harm.
- The practice had taken actions to bring about improvements with significant support from a caretaker practice.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services.

- When we inspected in September 2016, we identified approximately 22,000 incomplete correspondence records dating back to 2012 in the lead GP's work flow. These included, items such as clinical letters, discharge letters, radiology reports, histology results, faxes, and results from social care teams. At this inspection we found that although almost 12,000 items had since been reviewed by the caretaker practice, approximately 3,000 had been identified as requiring actions to be taken and a further 10,000 were still to be reviewed.

Summary of findings

- When we inspected in September 2016, we noted that systems for managing patient clinical correspondence were not safe. At this inspection we found the practice had put systems in place to manage patient correspondence in a timely manner and this included processes to monitor progress and reassign tasks when necessary. However it was unclear whether concerns about the lead GP's lack of knowledge of the patient record management system had been addressed as they had been unable to undertake training during their absence from the practice. Following the inspection, the lead GP told us they could use all systems at the practice but we did not see evidence to support this.
- When we inspected in September 2016, we were told that difficulties recruiting permanent GPs had a significant impact on the lead GP's capacity to manage the practice. Since the inspection, the practice had recruited two new GP partners to the practice and the process of adding these to the practice's CQC registration was on-going. However this had not yet impacted on the lead GPs capacity to address concerns.
- At our inspection in September 2016, data showed patient outcomes were low compared to the national average for Diabetes and Hypertension. This data was still the most recent published data available, and although we saw current but unvalidated data which indicated that patient outcomes had improved, these were still lower than the national average for Diabetes and Hypertension.
- The practice employed a significant number of locum GPs and had developed a locum induction pack which provided clear guidelines around practice procedures including those for referring patients to secondary care, managing patient correspondence and repeat prescribing.

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 as comparable to others for most 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.
- The practice had a designated carer's champion and had identified more than 1% of the patient lists as carers.

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Are services responsive to people's needs?

Requires improvement

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

- During our September 2016 inspection, feedback from patients reported that access to a named GP and continuity of care was a concern. At this inspection, we found that patients still reported problems with continuity of care. Since the inspection, the practice had initiated the process to add two new GP partners to the practice's registration. However this process was on-going and had not yet impacted on the lead GPs capacity to address concerns.
- When we inspected in September 2016, we noted the practice had not put in place a plan to improve outcomes for patients with diabetes and hypertension.
- At this inspection, we found that the practice had established a weekly nurse-led hypertension clinic as well as a weekly GP-led clinic to support patients with other long term conditions including diabetes and asthma. However, we were unable to assess the impact of these changes or whether they would be sustainable when the caretaker arrangement came to an end.
- The practice had responded to low patient satisfaction levels around waiting times for appointments. When we inspected in September 2016, the average waiting time for an appointment according to a practice audit was 17 minutes. At this inspection we saw a second audit of waiting times and noted that the average waiting time had reduced to 13 minutes.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- During our inspection in September 2016, there was no system in place for recording patients verbal complaints and we saw no evidence that any verbal complaints had been recorded. At this inspection, we noted that verbal complaints were now being recorded.

Are services well-led?

Inadequate

The practice is rated as inadequate for providing well-led services.

- When we inspected in September 2016 we found that the practice did not have a clear, robust and realistic strategy to support its vision. At this inspection we noted that the practice had worked closely with a caretaker practice and the local clinical commissioning group to develop a realistic strategy and had begun to implement plans to improve services.

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- At our September 2016 inspection, we noted that governance arrangements were unclear. For example, practice management did not have a comprehensive understanding of their performance and governance arrangements within the practice were not effective.

  At this inspection we noted that whilst the lead GP had been absent from the practice since the September inspection, other practice leaders now had a good understanding of performance and had taken steps to improve governance arrangements including reviewing and updating policies and putting in place effective systems to support these policies. Although we were told the lead GP had had some involvement in developing these improved governance systems, it was not clear that they had been involved in their implementation or whether their understanding of practice's performance had improved since the September 2016 inspection.
- When we inspected in September 2016 we found there was a lack of openness and transparency, which resulted in the identification of risk, issues and concerns being discouraged or repressed. At this inspection, we saw that the practice had nurtured a 'no blame' culture at the practice to encourage greater transparency and had reviewed arrangements for identifying, reporting and investigating significant events and serious incidents.
- During our September 2016 inspection, we found leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively. When we inspected on this occasion, we were aware that the lead GP had not been working at the practice since the previous inspection which meant that we were unable to reasonably assess whether this had improved. We noted that other members of the practice team had received additional training and mentoring support and had used this to bring about significant improvements.
- We discussed the long term future of the practice and were told that there were realistic plans in place to change the leadership structure and that interviews for prospective new partners had already taken place.
- The practice had proactively sought feedback from staff and patients since the September 2016 inspection. The virtual patient participation group had been replaced with a live 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 effective and well-led, requires improvement for being safe and responsive and good for being caring. The concerns which led to these ratings apply to everyone using the practice, including this population group. There were examples of both good and poor practice.

- Outcomes for some conditions often associated with older people were lower than local and national averages. For instance, 65% of patients with hypertension had well controlled blood pressure compared to the CCG average of 81% and the national average of 83%.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population. However the majority of GP appointments were provided by locum GPs which meant there were concerns around continuity of care.
- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

People with long term conditions

Inadequate

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

- Performance for diabetes related indicators was significantly below the national average. For instance 45% of patients with diabetes had well controlled blood pressure compared to the national average of 78%. The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 67% compared to 80% nationally.
- Performance for hypertension related indicators was below CCG and national averages. For example, the percentage of patients

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with hypertension in whom the last blood pressure reading was 150/90 mmHg or less compared was 67% compared to the CCG average of 81% and a national average of 84%. At this inspection, unvalidated data for 2016/2017 indicated this had improved to 73%.

- The practice had recently begun to provide a weekly nurse-led dedicated hypertension clinic and a weekly GP-led clinic to support patients with other long term conditions
- With the support of a caretaker practice, an effective system had been put in place to recall patients for a structured annual review to check their health and medicines needs were being met.

Families, children and young people

Inadequate

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

- When we inspected in September 2016, we noted concerns with how the practice managed safeguarding for children. For instance, the lead GP was unable to access practice registers of children with a safeguarding alert.At this inspection we noted that as the lead GP had been absent from the practice since the September 2016 inspection, they had been unable to undertake any training in this regard.
- The practice had reviewed policies and processes used to safeguard children from abuse and had appointed an interim clinical lead as well as an administrative lead for safeguarding.
- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- The practice's uptake for the cervical screening programme was 85%, which was comparable to the CCG average of 81% and the national average of 82%.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

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Working age people (including those recently retired and students)

Inadequate

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

- Results from the national GP patient survey published in July 2016 showed that only 53% of patients said that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment, compared to CCG average of 69% and the national average of 76%.
- The practice offered extended opening hours on a Tuesday evening between 6:30pm and 7:30pm and Wednesday evenings between 6:30pm and 8:30pm.
- 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

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

- The practice held a register of patients living in vulnerable circumstances including refugees, travellers and those with a learning disability.
- The practice website provided meaningful and practical information for patients who had recently experienced bereavement, for instance information about how to navigate statutory processes when someone dies in their own home.
- 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 had information available for vulnerable patients, including carers, about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may

Summary of findings

make them vulnerable. They 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.

People experiencing poor mental health (including people with dementia)

Inadequate

The provider was rated as inadequate for being effective and well-led, requires improvement for being safe and responsive and good for being 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 the national average. The percentage of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 91% compared with a CCG average of 85% and a national average of 84%.
- Performance for mental health related indicators were similar the national average. For example: 97% 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 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations and was working with the patient participation group to promote awareness of these amongst the practice population.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

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What people who use the service say

- The most recent national GP patient survey results were published in July 2016 and these were the same as those referenced during our inspection in September 2016. The results showed the practice was performing in line with 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%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 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 was sometimes very difficult to get an appointment and that continuity of care with the same GP was often not possible.

We spoke with 8 patients during the inspection. All patients 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 do not run to time because there were not enough GP's.

Areas for improvement

Action the service MUST take to improve

- Ensure that all clinicians have a thorough knowledge and understanding of the patient management and document management systems.
- Ensure that the practice's quality improvement programme includes effective audit arrangements that drive improvement across key clinical outcomes.

Action the service SHOULD take to improve

- Continue with plans to change the leadership structure at the practice to improve quality of service provision.
- Continue to closely monitor systems used to review and act on clinical correspondence to ensure all correspondence is acted upon without delay and that decisions made about patient care are clearly documented in the clinical patient's notes.
- Continue to closely monitor systems used to refer patients to secondary care to ensure that these are fully embedded into practice procedures.
- Continue to ensure management arrangements for overseeing performance (for example QOF) in the practice are robust and that actions are recorded, planned, implemented and reviewed.
- Make arrangements to carry out regular fire drills.
- Review patient access and availability of appointments to better meet the needs of patients.
- Continue to take action to reduce the length of patient waiting times for GP consultation.
- Review the practice business continuity plan to ensure that information is up to date.

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 and two other CQC inspectors.

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 is registered with the Care Quality Commission to carry on the regulated activities of Maternity and midwifery services, Treatment of disease, disorder or injury, Family planning, Surgical procedures and Diagnostic and screening procedures.

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

The staff team at the practice consists of one GP partner lead (female), one long term GP locum (male) and one practice manager partner. There are two practice nurses (female) and six administrative staff. All staff work a mix of full time and part time hours.

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 and 7 practice nurse sessions available per week.

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 was higher than the national average for males and in line with the national average for females.

Detailed findings

The practice was previously inspected on 9 December 2015 when it was rated requires improvement overall. A follow-up inspection was carried on 21 September 2016 when it was rated inadequate overall.

After the September 2016 inspection, the lead GP was suspended from the NHSE Performers list and the General Medical Council (GMC) attached conditions to their licence to practice.

Why we carried out this inspection

We undertook a comprehensive inspection of Boundary House Surgery on 9 December 2015 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate for providing safe services and requires improvement for providing effective and well led services. We also issued requirement notices to the provider in respect of safe care and treatment and good governance.

We undertook a follow up inspection on 21 September 2016 to check that action had been taken to comply with legal requirements. Following this inspection, the practice was rated as inadequate for providing safe, effective and well-led services and requires improvement for providing responsive services. On 26 September 2016 we took urgent enforcement action to suspend the provider 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.

The practice was also placed in special measures for a period of six months. A caretaker practice was put in place by NHS England to provide primary medical services to patients of the practice during this period.

We undertook a further announced comprehensive inspection of Boundary House Surgery on 21 March 2017. This inspection was carried out prior to the end of the suspension period to ensure improvements had been made.

The full comprehensive report on the December 2015 and September 2016 inspections can be found by selecting the 'all reports' link for Boundary House Surgery on our website at www.cqc.org.uk.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, including NHS England and Enfield Clinical Commissioning Group to share what they knew. We carried out an announced visit on 21 March 2017. During our visit we:

- Spoke with a range of staff including GPs, practice nurses, practice manager and members of the administration team.
- Spoke with members of the management team from the practice commissioned as caretaker practice during the suspension period and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Looked at information the practice used to deliver care and treatment plans.

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).

Detailed findings

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.

Requires improvement

Are services safe?

Our findings

At our previous inspection on 21 September 2016, we rated the practice as inadequate for providing safe services as the arrangements in respect of identifying, reporting and investigating serious incidents and those for managing the safeguarding of children were not adequate.

These arrangements had improved when we undertook a follow up inspection on 21 March 2017. These improvements had been brought about with significant support from the caretaker practice and during a period when the lead GP was absent from the practice. During our discussions with the lead GP, they were unable to demonstrate a full understanding of the improvements which had been made. The practice is now rated as requires improvement for providing safe services.

Safe track record and learning

When we inspected in September 2016, we noted a limited use of systems to record and report safety concerns, incidents and near misses. Staff did not always recognise concerns, incidents or near misses. 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.

At this inspection we noted that the practice had worked closely with the caretaker practice to implement an effective system for reporting and recording significant events. We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. Nine significant events had been recorded since our September 2016 inspection and we saw evidence that lessons were shared and action taken to improve safety in the practice.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under 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).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.

Staff told us that openness and transparency about safety was encouraged; and that they understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff spoke positively about how learning from significant events was now discussed at team meetings and used to improve patient safety. For instance, we saw a record of an incident when the practice received a discharge letter from a secondary care provider which contained inaccurate information about a medicine prescribed to a patient. The patient had pointed the error out to the practice but the incorrect medicine had been prescribed regardless. The secondary care provider subsequently contacted the practice and explained the error and the practice had contacted the patient and arranged to issue the correct prescription and collect the incorrect medicine. The practice had reviewed the incident and had reminded clinicians to undertake additional checks when issues were raised regarding the accuracy of discharge letters.

Overview of safety systems and process

When we inspected in September 2016, we noted that 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. We also noted that the lead GP had been unable to access practice registers of children with a safeguarding alert and we were told these patients were discussed on an ad hoc, informal basis rather than as part of a recorded regular clinical discussion.

At this inspection, we found the practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety and locum GPs, nurses and non-clinical staff were able to access patient registers. However, the lead GP had been absent from the

practice since the September 2016 inspection which meant they had not been involved in bringing about improvements and we did not see any evidence that they had undertaken training to address their lack of knowledge of the practice's clinical management system. Following this inspection, the practice told us that the lead GP knew how to use all systems and that the concerns around the use of the document management system at the September 2016 inspection had not been due to a lack of knowledge by the lead GP. However evidence gathered during the September 2016 and March 2017 inspections did not support this.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. During the period when the lead GP had been absent from the practice, the role of safeguarding lead had been filled by the long term locum GP who had been a partner at the practice prior to resigning in 2014. The practice had also appointed a named individual to be the administrative lead for safeguarding.
- The practice had reviewed arrangements for identifying vulnerable children on the computer system and we saw evidence of recent entries on the practice's child protection register.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs, nurses, the practice manager and two members of the administration team were trained to child protection or child safeguarding level 3. All other staff were trained to child safeguarding level 1.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC 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 minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment although a fire drill was overdue. There were designated

fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments 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).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Administrative staff were multi-skilled and every member of this team could undertake any administrative or reception task. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements 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.
- When we inspected in September 2016, we noted that although the practice had oxygen on the premises, the child's mask for this was not stored with the oxygen. At this inspection we noted that this had been rectified and the practice now had oxygen with adult and children's masks and we saw evidence that these were checked regularly. The practice had a defibrillator available on the premises. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However, we noted that this also included details for clinical staff who were no longer employed or associated with the practice and the communication cascade had not been updated to reflect this. For instance, the person who had been assigned the task of communicating with the nursing team was not employed at the practice.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 21 September 2016, we rated the practice as inadequate for providing effective services. Systems and processes to support effective needs assessment and coordination of patient care were inadequate. We identified approximately 22,000 incomplete correspondence records dating back to 2012 in the lead GP's work flow. These included items such as clinical letters, discharge letters, radiology reports, histology results, faxes, and results from social care teams. The lead GP 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. We also noted that patient outcomes were low compared to the national average for Diabetes and Hypertension and we had concerns that clinicians' actions noted in clinical audits had not been reviewed and followed up through governance systems.

Arrangements had improved when we undertook a follow up inspection on 21 March 2017 but there were still significant concerns. For instance, although the caretaker practice had undertaken a systematic review of incomplete correspondence records, this process was on-going had not yet been completed. This meant we were unable to see evidence that risks to patients were fully understood or that all reasonable actions to mitigate associated risks to patients had been taken. The provider is rated as inadequate for providing effective services.

Effective needs assessment

At the September 2016 inspection, we found the management of patient related correspondence presented a serious and significant risk to patient care. 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. At that inspection we were told that the practice had experienced difficulties recruiting additional GPs to the practice and this had impacted on the lead GPs capacity to manage clinical correspondence. We identified approximately 22,000 incomplete correspondence records dating back to 2012 in the lead GP's work flow. As a result of the September 2016 inspection, the caretaker practice had been commissioned to undertake a review of incomplete correspondence and to complete any required actions where it was still possible to do so. At this inspection, the caretaker practice provided an interim report which showed that of the 22,000 documents, 12,000 had now been reviewed and this included all correspondence dating back to 2014. We were told that for the majority of documents, required actions had been taken at the time of receipt but these actions had not always been entered on patient management system records. However, we were told that approximately 3,000 items had actions outstanding and these had been carried out by the caretaker practice. The caretaker practice told us that there were a further 10,000 items which were yet to be reviewed. We were also told that the Medical Directorate at NHS England would be undertaking a detailed review of patient records at the practice. Following the inspection, the practice told us the remaining 10,000 documents had since been reviewed by the caretaker practice although we were not provided with evidence to demonstrate that this review had been completed or confirmation of overall findings.

At this inspection we discussed processes the practice had put in place to manage incoming patient related correspondence and measures taken to mitigate the risk of future backlogs. We noted that the practice implemented a protocol whereby a GP was assigned to the role of duty doctor every day and this person had responsibility for reviewing all clinical correspondence. This involved carrying out actions or assigning tasks to other clinicians where appropriate and ensuring that patient records were updated in a timely manner. Administrative staff had been provided with global access to the document management inbox for all clinicians, including locums, which meant that they were able to monitor activity and could reallocate tasks to other clinical staff when the duty doctor was unable to complete actions. We looked at all inboxes and noted that the only documents awaiting actions had been received on the day of the inspection. In addition to these measures, the practice had also developed a range of referral templates and these were available to all clinical staff. We were told that the caretaker practice had provided guidance and support whilst processes were being developed and implemented and although the practice was now managing this independently, the caretaker practice was continuing to provide governance oversight. Since the inspection, the practice had recruited two new GP partners to the practice and the process of adding these to the practice's CQC registration was on-going.

Inadequate

Are services effective?

(for example, treatment is effective)

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). When we inspected in September 2016, we reviewed data from 2015/2016 as this was the most recent published information. This showed that the practice had achieved 84% of the total number of points available compared with the clinical commissioning group (CCG) average of 94% and national average of 95%. At this inspection, data from 2015/2016 was still the most recently published. This meant that we were unable to see validated evidence of improvements to patient outcomes although we were able to review unvalidated data which showed the practice's current performance for 2016/2017.

When we inspected in September 2016, we noted that performance for diabetes and

hypertension related indicators was lower than local and national averages and that these had not made any improvement since 2014/15 when they had also been lower than average. Both long term conditions are highly prevalent amongst the patient population.

The practice told us that since the September 2016 inspection, as the lead GP had not been available at the practice, it had worked with the caretaker practice and long term locum GPs to put measures in place to bring about improvements to patient outcomes. An effective patient recall system had been implemented and administrative staff had been trained to manage this. Staff told us they now produced a weekly list of patients whose reviews were due and we saw evidence that these patients were contacted by telephone, letter and text message to invite them to appointments. Staff told us they reviewed GP daily appointment lists in advance to identify patients whose reviews were due and alert the GP to carry out reviews for these patients opportunistically. A nurse-led weekly clinic for hypertensive patients had been established and this was held whilst a doctor from the caretaker practice was available to provide GP support. A long term locum GP had helped the practice to develop a weekly QOF review clinic and this was used to undertake patient reviews for a range of conditions including diabetes and asthma. Following the inspection, the lead GP responded by telling us that they had been significantly involved in bringing about improvements at the practice but we did not see evidence of this during the inspection.

During our September 2016 inspection, data from 2015/2016 showed:

- Performance for hypertension related indicators was below CCG and national averages. For example, the percentage of patients with hypertension in whom the last blood pressure reading was 150/90 mmHg or less compared was 67% compared to the CCG average of 81% and a national average of 84%. At this inspection, unvalidated data for 2016/2017 indicated this had improved to 73%.
- Performance for diabetes related indicators was also lower than CCG and national averages. For instance, patients on the diabetes register in whom the last blood pressure reading was 140/80 mmHg or less was 46% compared to the national average of 78%. At this inspection, unvalidated data for 2016/2017 indicated this had improved to 50% but this was still significantly below the national average. We also looked at blood sugar management for patients with diabetes. According to 2015/2016 data, 62% of patients had well controlled blood sugar levels (CCG average of 73%, national average 78%). Unvalidated data for 2016/2017 indicated this had increased to 68%. The percentage of patients on the diabetes register, whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was 67% (CCG average 78%, national average 80%) and unvalidated data for 2016/2017 showed this had increased to 73%.
- Performance for mental health related indicators were higher than CCG and national averages. For example, 97% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a

comprehensive, agreed care plan documented in the record compared to the CCG average of 92% and national average of 89%. The exception reporting rate for this indicator was 3% (CCG average 6%, national average 13%). At this inspection, unvalidated data for 2016/2017 indicated performance for this indicator had remained similar at 95%. In 2015/2016, 90% of patients diagnosed with dementia had a comprehensive, agreed care plan documented in the record compared to the CCG average of 85% and national average of 84% and unvalidated data for 2016/2017 showed this had increased to 96%. The exception reporting rate for this indicator had been 15% in 2015/2016 but we were unable to see the indicative exception reporting rate for 2016/2017 as this could not be calculated until the end of the clinical recording period. (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).

When we inspected in September 2016, we noted the lead GP had a very limited knowledge of the patient management system. The lead GP had had been absent from the practice since the September 2016 inspection and had only returned to work the week before this inspection. They had been unable to engage with any training in this period which meant that we were unable to see that their knowledge of the patient management system had improved. Following the inspection, the lead GP told us they could use all systems at the practice but we did not see evidence to support this.

Practice leads acknowledged that although there had been recent improvements in diabetes and hypertension indicators, their QOF figures remained lower than CCG and national averages for patients diagnosed with these conditions. However, the practice told us that support from the caretaker practice had led to more consistent QOF reporting, the introduction of an effective patient recall system and additional clinics for patients with long term conditions. For instance a weekly hypertension clinic as well as a weekly clinic for other long term conditions including diabetes.

At our inspection in September 2016, we found limited evidence of quality improvement including clinical audit. At that inspection, we noted that the practice did not have a programme of clinical audit. The practice had introduced three non-clinical audits covering appointment waiting times, numbers of patients who did not attend booked appointments and an audit of the time taken to send referrals.

At this inspection we found that the practice still had limited evidence of quality improvement including clinical audit . We saw evidence of a single cycle audit of hypertensive patients. However, this was a single data collection exercise and there was no evidence that findings had been used to drive positive change. Although we noted that there were plans to highlight the records of patients with uncontrolled hypertension, we did not see evidence that any action had yet been taken as a result of the audit. We also saw evidence of two audits around the physical care of patients with mental health conditions; however, these did not represent a completed audit cycle as it was unclear whether the two data sets were comparable. For instance, the first audit had consisted of a review of the first twenty patients with mental health conditions, taken in alphabetical order. The second audit reviewed data for patients with conditions described as 'severe mental illness' but did not provide any narrative to define this population group. We saw the practice had undertaken a second audit of two of the three non-clinical audits including the time taken to send referrals. During the first audit cycle which had been undertaken in July 2016, the average time taken to send referrals had been 10 days and this had been identified as a serious concern during the September 2016 inspection. Since that inspection, the practice had reviewed how referrals were completed and with the support of the caretaker practice, had introduced a new referral management process. For instance, a named member of the administration team was given lead responsibility for maintaining a log of all referrals and used this to monitor the progress of every referral. This included ensuring that the referral had been received by a secondary care provider, that an appointment had been made and that the patient had attended this appointment. We were also told that clinical staff were allowed additional non-patient facing time in every session to complete referrals and that every referral was passed to the member of staff responsible for monitoring the referral system. All other members of the administration team had also been trained to manage and monitor this system. A second audit cycle had been undertaken in February 2017 and this showed that the average time taken to complete a referral was now 0.5 days.

Inadequate

Are services effective?

(for example, treatment is effective)

We reviewed the practice referral log and saw evidence that it was being used effectively. For instance, we could see that the practice had followed up every referral and had recorded appointment dates where these had already been made. We also saw notes indicating that the patient had attended the appointment or details of new arrangements where the patient had failed to attend. We noted however that the system used by the practice did not separate 2 week wait urgent cancer referrals from all other referrals which meant that there was a risk that these might not be easily identified when necessary. We discussed this with the practice and were provided with an updated system the day after the inspection, which showed that these referrals were now recorded in a dedicated section of the referral system.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- 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.
- 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 on-going support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- We were told that at the most recent appraisal meeting of one practice nurse, a gap in the practice's provision of sexual health services had been identified. As a result of this, the practice was supporting this practice nurse to undertake a one year, part-time university course in this field.
- Staff received training that included: safeguarding, 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

When we inspected in September 2016, we found that 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. This meant that we could not be certain that care and risk assessments, care plans, medical records and investigations and test results were dealt with safely. At this inspection, we found that the practice had put a system in place so that all clinical correspondence was reviewed by a duty doctor within 24 hours of receipt. We also noted that administration staff had access to all document management inboxes and had been given responsibility to monitor these throughout the day to ensure that all tasks were completed within target times. The document management system also included a protocol for the duty doctor to advise administration staff if there was likely to be a delay completing tasks within the target time so that these be reallocated to another clinicians. Records we looked at showed that this system appeared to be working properly.

As a result of these improvements to the patient document management system, we found that the information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. We reviewed 12 care plans and saw that these were detailed.
- 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 on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from

hospital. Information was shared between services, with patients' consent, using a shared care record. 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.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance and although this was always in the form of verbal consent patient records, this was noted in patient records.

- Staff could demonstrate an understanding of the relevant consent and decision-making requirements of legislation and guidance but there was no evidence that staff, including clinical staff, had received formal training around the Mental Capacity Act 2005. Following the inspection, the lead GP told us they attended an annual safeguarding conference which included a section around the Mental Capacity Act.
- 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.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. 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.

The practice's uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 81% and the national average of 81%. We reviewed unvalidated data for 2015/2016 and noted that the uptake rate was 82% for this period also. There was a policy to offer telephone or written 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. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisation rates for the vaccinations given were comparable to national averages. There are four areas where childhood immunisations are measured; each has a target of 90%. The practice achieved the target in three out of four areas. These measures can be aggregated and scored out of 10, with the practice scoring 9 which was the same as the national average.

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

At our previous inspection 21 September 2016, we rated the practice as good for providing caring services.

During this inspection, we found that the practice had maintained standards at this level and the practice is still rated as good for providing caring services.

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 35 comment cards, all of which included positive comments and the majority of which were exclusively positive. Patients stated that practice staff were helpful, caring and treated them with dignity and respect. However, five cards also included comments about poor continuity of care due to the high number of locum GPs engaged at the practice.

We spoke with six 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.

Good

Are services caring?

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 58 carers which was 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 although this has not been possible during the period that the lead GP was absent from the practice. 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

At our previous inspection on 21 September 2016, we rated the practice as requires improvement for providing responsive services as the practice did not have suitable arrangements in place to improve outcomes for patients diagnosed with diabetes and hypertension and could not demonstrate recording, investigating and learning from verbal complaints. We also noted that patient satisfaction around some aspects of accessing the service were lower than local and national averages and feedback from patients reported that access to a named GP and continuity of care was a concern.

These arrangements had improved when we undertook a follow up inspection on 21 March 2017. For instance, dedicated weekly clinics had been introduced to support patients with hypertension and diabetes but the practice was unable to demonstrate the impact of any new arrangements as the most recent QOF and national GP patient survey we were able to see were the same as those available at the time of the September 2016 inspection. At this inspection, we found that patients still reported problems with continuity of care. Since the inspection, the practice had initiated the process to add two new GP partners to the practice's registration. However this process was on-going and had not yet impacted on the lead GPs capacity to address concerns. The practice is still rated as requires improvement for providing responsive services.

Responding to and meeting people's needs

Since we inspected in September 2016, the practice had reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- The practice had established a nurse-led weekly clinic for patients diagnosed with hypertension. The clinic was supported by a GP from the caretaker practice and administration staff had been trained to identify patients who would benefit from this service and to encourage these patients to engage with the clinic.
- The practice had established a GP led weekly clinic to review patients diagnosed with other long term conditions, including diabetes and asthma. Administration staff could access the appropriate patient registers to identify and contact patients and arrange appointments for this clinic.
- 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.
- 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 six weeks in advance, urgent appointments were also available for people that needed them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or lower than local and national averages.

- 79% of patients were satisfied with the practice's opening hours compared to the national average of 76%.
- 82% of patients said the last appointment they got was convenient compared to the national average of 92%.
- 64% of patients described their experience of making an appointment as good compared to the national average of 73%.
- 65% of patients said they could get through easily to the practice by phone compared to the national average of 73%.
- 37% of patients usually wait 15 minutes or less after their appointment time to be seen compared to the national average of 65%.

At the September 2016 inspection 37% of patients said they usually waited 15 minutes or less after their appointment time compared to a national average of 65%. Following that inspection, we were told that changes had been made to the practice telephone system to improve access and that waiting times and consultation times were discussed with clinicians to improve satisfaction scores although these discussions had been informal.

In 2016, we also noted that the practice had undertaken an audit of patient waiting times, to identify how the appointment system could be further improved. Findings identified the lead GP had significantly longer waiting times than other GPs and suggestions included ensuring that appointments start on time. Patients were asked to limit their appointment to one medical problem where possible and the practice were to identify which patients required longer appointments. At this inspection we found that the practice had undertaken a second audit in February 2017, to identify whether there had been any improvements. This showed that the average waiting time to see a clinician had reduced from an average of 17 minutes to 13 minutes.

We spoke to three patients who told us that although that appointments did not always run to time, delays had shortened noticeably in recent months.

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 21 September 2016 the practice had recorded five formal complaints, one of which was a verbal complaint. These had been 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.

Are services well-led?

Inadequate

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

Our findings

At our previous inspection on 21 September 2016, we rated the practice as inadequate for providing well-led services as there was no vision or strategy for the practice, no overarching governance structure and leaders did not have the necessary experience, knowledge, capacity or capability to lead effectively. We also noted the clinical team did not have a comprehensive understanding of the performance and supporting governance arrangements in the practice.

Following this inspection, we took urgent enforcement action to suspend the providers of Boundary House Surgery from providing primary medical services for a period of six months to protect patients. The practice was placed in special measures for a period of six months and a caretaker practice had been put in place to run services and ensure continuity of care for patients.

When we undertook a follow up inspection on 21 March 2017, we found that in the absence of the lead GP, other members of the practice management team including the practice manager, who was a partner in the practice, had worked closely with the caretaker practice to bring about improvements to the governance structure and had developed their own knowledge and management capabilities to the benefit of the practice. For instance we saw that effective processes had been implemented to manage clinical correspondence, patient referrals, patient recall systems and child safeguarding. However as the lead GP had been absent from the practice for the previous six months, we were unable to assess whether their understanding of performance and governance had improved. Following the inspection, the practice told us the lead GP had been in regular contact with the practice manager and had discussed all improvements being put in place and suggested further improvements. They also told us the lead GP was aware of governance arrangements but we did not see evidence of this during the inspection. The practice is still rated as inadequate for providing well-led services.

Vision and strategy

Since the last inspection on 21 September 2016, practice management had made progress in developing and implementing a strategy to bring about improvements at the practice. With the support of the caretaker practice and in the absence of the lead GP, the practice manager had prioritised the key concerns identified in the September 2016 inspection and had put measures in place to mitigate identified risks to patient safety and improve outcomes for patients. We were told the lead GP had had a role in developing the action plan produced in response to the September 2016 inspection report, but this action plan had been substantially realised and implemented by the caretaker practice and practice management. The practice could describe their vision for the future and staff we spoke with were able to talk about this vision with confidence. Following the inspection, the lead GP responded by telling us that they had been significantly involved in bringing about improvements at the practice but we did not see evidence of this during the inspection.

Governance arrangements

When we inspected in September 2016, 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. For instance, we found that staff did not have comprehensive understanding of the performance of the practice and noted that 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. At that inspection, we found significant concerns in regard to the management of clinical correspondence by the lead GP. We found 22,086 patient letters, tests and reports dating back from 2012 from secondary care in the patient document management system.

At this inspection, we found that the practice had developed a stronger understanding of the performance of the practice and were able to identify areas where improvements were needed and put measures in place to bring these improvements about. We saw evidence that links between clinical and non-clinical functions were now more explicit and non-clinical staff had a greater understanding of how their roles related directly to patient outcomes. For instance, the practice had appointed an administrative lead for the management of referrals and this person supported clinicians to ensure that referrals were completed in a timely manner. Staff we spoke with told us they found this empowering. We also noted that the practice had introduced an effective document

Are services well-led?

Inadequate

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

management system and non-clinical staff were engaged in supporting clinical performance by monitoring progress several times each day in order to mitigate the risk of clinical correspondence backlogs developing in the future.

- We identified that significant 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 reviewed its significant event policy to ensure that staff were able to understand what constituted a significant event. A significant events reporting process had been put in place and we saw records which indicated that the practice was now identifying and analysing incidents that have an impact on patient safety through a significant event meeting. Staff we spoke with told us that practice management had developed a 'no blame' culture and had that this had been an important step in helping them to understand that the recording of significant events was an opportunity to learn and reduce the risk of incident recurring in the future.
- The practice had a clear staffing structure and all staff we spoke with understood their day to day roles and responsibilities.
- The practice had specific policies and these had been implemented and were available to all staff. We could see that policies were up to date and the practice was able to tell us how they could ensure that policies would be regularly updated.
- The practice had an on-going programme of clinical audits, however, there was no evidence that these had been used to bring about improvements. We looked at the programme of planned clinical audits and could see that the practice was linking its planned clinical audits with its performance management processes to improve health outcomes for patients. For instance we were told the practice had planned to undertake clinical audits around hypertension and diabetes as these were areas where the practice had identified that patient outcomes were lower than local and national averages.
- The practice had reviewed how clinical governance meetings were conducted and minuted and we saw that minutes were now produced in a timely manner and included more detailed information about the topics discussed.

Leadership and culture

When we inspected in September 2016, we found that clinical leadership arrangements did not support the delivery of high-quality person-centred care. In particular, we noted that although the lead GP was clear about their role and accountability for quality, there were serious concerns about their ability to make improvements and we could not be assured that they had the necessary capacity to lead effectively.

At this inspection, the lead GP had only returned to the practice in the week before the inspection, following an extended period of absence. We discussed the long term strategy to address identified weaknesses in current management arrangements and the practice told us they were actively working to change the leadership structure at the practice. We were told that a plan to recruit new partners was already under way and that a number of interviews with prospective new partners had already taken place and that further meetings were planned in the weeks following the inspection. In the month after the inspection, we were told that these meetings had gone ahead and that leadership changes at the practice would take place. We were also told that a plan to merge the practice with a specified local practice was being considered as a contingency in the event that recruiting new partners was not successful.

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.

- When we inspected in September 2016, the practice patient participation group (PPG) only existed in a virtual form. At this inspection we saw that the practice was now holding PPG meetings in person at the practice. We met with five members of the group and were told that the practice had been very attentive in their meetings and had expressed a wish to work closely

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with the group to improve services. The PPG had recruited an experienced chairperson and had provided administrative support to the group to begin producing a quarterly newsletter. The group had discussed patient concerns around access to GPs and had identified areas where it felt it could contribute to reducing some stresses in this area. For instance the group was aware that there were many occasions when GP appointments were made for conditions or concerns which could be better managed with a different care provider including local pharmacists or support organisations. The group had decided that it would focus on identifying and promoting at least two such alternative care providers in every newsletter. We looked at the most recent publication and saw that information about three organisations who provided support for people experiencing poor mental health.

- 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 practice manager and long term locum GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice despite the leadership capacity challenges.
- The provider was aware of and had systems 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).This included support training for all staff on communicating with patients about notifiable safety incidents. The practice had systems in place to ensure that when things went wrong with care and treatment.
- The practice gave affected people reasonable support, truthful information and a verbal and written apology.

Continuous improvement

We saw evidence that the practice had engaged with and responded to the support provided by the caretaker practice and had developed strategies to mitigate risks to patient safety and bring about improvements to patient outcomes. For instance, we saw that the practice had put in place an effective document management system to mitigate the risk of future backlogs of unmanaged clinical correspondence; additional clinics to improve care for patients with long term conditions and an active patient participation group to advise and provide reflection on services at the practice.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was failing to: • ensure that all clinicians and those supporting clinical work have a thorough knowledge and understanding of the patient management and document management systems. • ensure that the practice's quality improvement programme includes effective audit arrangements that drive improvement across key clinical outcomes. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.