Green Cedars Medical Services

Quality Report

93-95 Silver Street
Edmonton
London
N18 1RP
Tel: 020 8887 9272

Date of inspection visit: 3 June 2014
Date of publication: 30/09/2014

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.

Summary of findings

Contents

Summary of findings

Overall summary

Green Cedars Medical Services, also known as Green Cedars Medical Centre, is situated in Edmonton in the south-east of the London Borough of Enfield. The area was one of very high social and economic deprivation compared with the west of the borough and with England as a whole. This impacted on the practice's performance in relation to providing healthcare for patients with long term conditions, for example, because high numbers of its patients did not respond to reminders to come in for routine health checks and reviews. It was beyond the capacity of the practice to address the many misconceptions about, and misunderstanding of, disease management and the workings of the NHS that were prevalent in its practice population.

The practice is housed in premises that were originally two shops and had been adapted for primary medical services. The practice provided primary care medical services to around 5,600 patients. The practice did not provide GP services at any other sites.

During our inspection we spoke with GPs, the Practice Manager, the Practice Nurse and Health Care Assistant, and reception and administrative staff. We also spoke with patients and their families.

Patients and their families we spoke with were very satisfied with the practice and had confidence in the treatment and care the practice provided. They found the doctors and staff approachable and that they explained things well to them. They felt the practice cared about them and was responsive to their needs.

While we identified some areas for improvement, the practice was providing services that were safe, effective, caring, responsive and well-led. The day-to-day operation of the service was well managed and systems were in place to keep patients safe and protect them from avoidable harm. Patients' needs were met by suitably qualified staff and the practice was demonstrably working to recognised best practice guidelines in some areas. Patients were treated with compassion and understanding. They found it easy to get in touch with the practice to make an appointment to see a GP and were seen within a clinically appropriate timeframe.

The practice had many fewer patients aged over 65 on its practice list than average and therefore relatively few patients with dementia. The practice had met the national requirement that all its patients aged 75 and over had a named GP responsible for their care.

The practice was developing ways of ensuring patients with long term conditions received ongoing monitoring to keep them as well as possible and to prevent hospital admissions.

The practice provided services to meet the needs of pregnant women attending their GP for the first time late in their pregnancy. It was working hard to meet the nationally expected childhood immunisation rate of 90%.

The practice provided access to GP appointments within a clinically appropriate time frame and within 48 hours at most. It provided services aimed at preventing disease.

The practice worked hard to make its services responsive to the needs of migrants to the UK arriving in the area.

The practice referred patients with depression to specialist services including psychological therapy, and promoted the physical health and wellbeing of patients with a serious mental illness.

The practice was registered with the Care Quality Commission (CQC) to carry on the following regulated activities:

- Treatment of disease, disorder or injury
- Diagnostic and screening procedures
- Maternity and midwifery services
- Family planning
- Surgical procedures

The practice had not been inspected by CQC before.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients received services that were safe, although we found areas for improvement. The practice learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

Patients were protected from the risks associated with medicines, and from unsafe or unsuitable equipment.

GP telephone triage ensured patients were seen within a clinically appropriate period of time and appointments were set aside every day for patients who needed to be seen urgently. The practice was equipped, and staff were trained, to deal with medical emergencies. Contingency plans were in place to avoid disruption in the service for patients, for example in the event of loss of utilities or incapacity of GPs.

Areas for improvement included:

- There was no procedure in place for staff to follow when the personal safety alarm was activated to ensure they provided a safe and effective response.
- There was no alarm cord in the patients' disabled toilet to enable patients to call for help.

Are services effective?

Patients received services that were effective, although we found areas for improvement. Patient's needs were met by suitably qualified staff who worked with other services to ensure they received coordinated care. It was clear the practice was working to recognised best practice guidelines in some areas.

Are services caring?

Patients received services that were caring. Some of the practice's patients had little understanding of the purpose of general practice and of how the NHS worked in general. For many, English was an additional language and this presented the practice with additional challenges in meeting patients' needs. Reception staff in particular found themselves at the brunt of patient's frustrations. Nevertheless GPs and staff treated their patients with compassion and understanding. Reception staff were patient and helpful and took time to understand and resolve concerns.

Summary of findings

Are services responsive to people's needs?

Patients received services that were responsive. The practice made provisions to meet the needs of the diverse population it served. For example, the practice used a telephone interpreting service and could book interpreters for patient appointments including British Sign Language.

Patients could get in touch with the practice easily to make an appointment to see a GP and were seen within a clinically appropriate timeframe. Patients could choose to see a male or female GP, or a named GP.

Good practice included:

- The practice recognised that letters were not an effective way of communicating with many of its patients, and was using texts and phone calls to improve uptake of routine checks and reviews.
- The practice provided a range of support for patients who were speakers of a second language, including use of a telephone interpreting service and interpreters for patient appointments including British Sign Language. The Practice Manager was a qualified medical translator.

Are services well-led?

Patients received services that were well-led. The day-to-day operation of the service was well-managed. Clinical and non-clinical staff worked as a team to meet the needs of patients. They were open and honest with one another and with patients.

There were systems in place to reduce the risk of harm to patients on a routine basis. The practice learned from incidents to improve patient safety and the safety of GPs and staff working in the practice.

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

Older people received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice had many fewer registered patients aged over 65 than the Enfield Clinical Commissioning Group (CCG) average, reflecting the nature of the population of its catchment area.

The practice had met the national requirement that from April 2014 all its patients aged 75 and over had a named GP responsible for coordinating their care.

People with long-term conditions

People with long term conditions received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice was developing ways of ensuring these patients received ongoing monitoring to keep them as well as possible and to prevent avoidable hospital admissions. This was a challenge for the practice because of the nature of the population it served.

Mothers, babies, children and young people

Mothers, babies, children and young people received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice faced challenges in providing treatment and care to this population group. For example a relatively high proportion of pregnant women visited the GP for the first time late in their pregnancy which had an impact on the practice's ability to provide a full programme of antenatal care. A significant number of parents would not allow their children to have the measles, mumps and rubella (MMR) vaccine.

The practice worked with other services to provide effective ante- and postnatal care and child health services.

The working-age population and those recently retired

Working age people (and those recently retired) received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice provided services aimed at preventing disease. For example, the practice was completing NHS Health Checks for its

Summary of findings

target population and for new patients joining the practice. It was meeting its target for cervical screening. The practice managed its appointments well and patients were seen within a clinically appropriate time frame and within 48 hours at most.

People in vulnerable circumstances who may have poor access to primary care

People in vulnerable circumstances who may have poor access to primary care received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice. The practice was often the first port of call for new migrants to the UK arriving in the area and the practice worked hard to meet the needs of patients who had little understanding of how to access healthcare in England.

People experiencing poor mental health

People experiencing poor mental health received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

Patients diagnosed as having depression received appropriate assessment of the severity of their depression and appropriate referral to specialist services including psychological therapy.

The practice promoted the physical health and wellbeing of its patients with a serious mental illness.

Summary of findings

What people who use the service say

We spoke with eight patients or a member of their family. Patients had not left any comment cards for us to review.

Patients and their families were very satisfied with the practice, and a few told us it was the best practice in the area. They told us that while the phones were busy in the morning, they could get through to the practice to make appointments, that appointments were easy to get including same day appointments, and that they could see the doctor of their choice. They said the doctor would ring them back if they asked for this instead of making an appointment.

Patients and their families found the doctors and nurses easy to talk to and felt listened to. One patient told us they had noticed that if patients felt they needed to speak about something privately, a receptionist would come and take them off to one side, out of other people's hearing.

Patients and their families felt the practice cared about them and tried really hard to help. For example, one patient was impressed that the practice had phoned and asked them to come in for a check-up because they had not been to the practice for a while. Another patient was very pleased that their GP had been persistent so that they had managed to stop smoking.

Patients and their families found the practice to be accommodating, for example when they needed a prescription urgently or were feeling anxious about their, or their child's health.

Areas for improvement

Action the service COULD take to improve

- There was no procedure in place for staff to follow when the personal safety alarm was activated to ensure they provided a safe and effective response.
- There was no alarm cord in the patients' disabled toilet to enable patients to call for help.

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice recognised that letters were not an effective way of communicating with many of its patients, and was using texts and phone calls to improve uptake of routine checks and reviews.
- The practice provided a range of support for patients who were speakers of a second language, including use of a telephone interpreting service and interpreters for patient appointments including British Sign Language. The Practice Manager was a qualified medical translator.

Green Cedars Medical Services

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector and a GP and the team included a Practice Manager Specialist Advisor.

Background to Green Cedars Medical Services

Green Cedars Medical Services, also known as Green Cedars Medical Centre, was situated in Edmonton in the south-east of the London Borough of Enfield. The practice was in Haselbury ward, the 6th most socio-economically deprived of the 21 wards in the borough, and within the most deprived 20% of wards in England. The practice was close to the boundary with Edmonton Green and Upper Edmonton wards, which were within the most deprived 4% of wards in England.

The practice had around 5,600 registered patients and had a relatively high patient turnover of around 20% a year. Many of the new patients it registered were new arrived migrants to the UK and did not stay long in the area before moving elsewhere. Their lives were unsettled and they joined the practice without detailed medical histories. Sometimes they spent long periods out of the country. All of this impacted on the nature of health problems the practice was presented with, and on the ways in which it met its patients' needs. For example there were women visiting the GP for the first time for antenatal care late in their pregnancy.

A relatively high proportion of the patients on the practice's list had a poor understanding of the purpose of general practice and of how the NHS worked in general. Sometimes their expectations were unrealistic, for example to be seen by a GP immediately when the urgency of their condition did not warrant such a response.

The practice had outgrown its premises and had for some years been looking to move to bigger premises in order to broaden the range of services it provided to meet the needs of its patients. For example there was a one year waiting list for chiropody in the area and the practice wanted to provide its own chiropody service. The practice had received little consistent support from NHS England or the Primary Care Trust before it. Like many practices in a similar position, it feared that the withdrawal of the Minimum Practice Income Guarantee (MPIG) scheme would make the practice unviable.

There were two male and two female GPs (one partner, one salaried GP and two long-term locum GPS), a part-time Practice Nurse and a part-time Healthcare Assistant, a Practice Manager, an Office Manager and a team of reception and administrative staff.

Green Cedars Medical Services referred patients for specialist treatment to Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital NHS Trust. Community health services and community and hospital psychiatric services in the area were provided by Barnet, Enfield and Haringey Mental Health NHS Trust.

Green Cedars Medical Services was a member of NHS Enfield Clinical Commissioning Group (CCG). The CCG is responsible for commissioning health services for the people registered with its 50 member GP practices.

Detailed findings

Enfield is a suburban north London borough. Census data shows an increasing population and a higher than average proportion of Black and Minority Ethnic residents. The main minority languages of residents in Haselbury ward where Green Cedars Medical Services was situated were Turkish, Polish, Somali and Greek. However the January 2010 Schools Census recorded 148 languages or dialects spoken by pupils in Enfield. The practice told us there were many preferred languages amongst its patients and that around 10% of its patients spoke very little or no English.

While male and female life expectancy in Enfield is higher than the England average, it is around eight years lower for men and around 6 years lower for women in the most deprived areas of Enfield than in the least deprived. Enfield has a relatively high rate of long-term unemployment and high proportion of obese children.

Strategic goals for Enfield CCG included enabling people to live longer fuller lives by tackling the significant health inequalities that exist between communities; providing children with the best start in life; ensuring the right care in the right place, first time; and commissioning care in a way which delivers integration between health, primary, community and secondary care and social care services.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we hold about the service, including NHS Quality and Outcomes Framework (QOF) data. We asked other organisations, including NHS England, Enfield Clinical Commissioning Group and Healthwatch Enfield to share what they knew about the service.

We carried out an announced visit on 03 June 2014. During our visit we spoke with a range of staff including GPs, the Practice Nurse and Health Care Assistant, the Practice Manager, and reception and administrative staff. We spoke with patients who used the service and family members. We observed how patients were being cared for and spoken to by GPs and staff working at the practice.

Are services safe?

Summary of findings

Patients received services that were safe, although we found areas for improvement. The practice learned from incidents to improve the safety of the service. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse. There were effective systems in place to reduce the risk and spread of healthcare acquired infection.

Patients were protected from the risks associated with medicines, and from unsafe or unsuitable equipment.

GP telephone triage ensured patients were seen within a clinically appropriate period of time and appointments were set aside every day for patients who needed to be seen urgently. The practice was equipped, and staff were trained, to deal with medical emergencies. Contingency plans were in place to avoid disruption in the service for patients, for example in the event of loss of utilities or incapacity of GPs.

Areas for improvement included:

- There was no procedure in place for staff to follow when the personal safety alarm was activated to ensure they provided a safe and effective response.
- There was no alarm cord in the patients' disabled toilet to enable patients to call for help.

Our findings

Safe patient care

There were clear lines of authority within the practice for incident reporting and staff could describe their role in the reporting process. However, some staff told us about near misses that they had not formally reported, for example an incident when a patient had got past the keypad controlled door to the consulting rooms area of the practice and intruded on another patient's consultation. Staff had dealt with the situation effectively, but had not completed an incident report. We have highlighted this to the practice an area for improvement.

There had been incidents when patients and staff had felt threatened by other patients' behaviour. Staff shared awareness of the key risks to themselves and to patients using the service. They acted with confidence and poise in their interactions with patients. Staff were sure that help would arrive if they needed it, and the practice's computer system enabled GPs and staff to summon help if they found themselves in a threatening situation. However, there was no procedure in place for staff to follow when the alarm was activated to ensure they provided a safe and effective response. We have highlighted this to the practice as an area for improvement.

Learning from incidents

The practice had an incident management policy which set out the process for reporting, recording, investigating and disseminating learning from incidents. Staff we spoke with were recording incidents and the practice was taking action to reduce the risk of harm to patients, GPs and staff working in the practice. For example, the practice had hired a security guard. The GP partner was funding the security guard out of his own pocket.

The security guard had received induction from the practice and was sensitive to the needs of patients coming to the surgery worried about their health or frustrated by the practice being unable to meet their demands, for example to be seen by a doctor immediately. The security guard viewed their role to be one of supporting staff to calm patients down and explain what can be done for them. The practice reported there had been few incidents of aggressive behaviour in the waiting area since the security guard starting working there.

Are services safe?

Safeguarding

GPs and staff employed by the practice were up to date with child protection and safeguarding adults training. The GPs had completed more advanced Level 3 child protection training in line with their closer involvement with patients. The practice had a lead GP for child protection and safeguarding adults to oversee implementation of the practice's safeguarding policies and procedures. Staff were aware of the signs of possible abuse or neglect and knew how to act on any concerns they had to protect patients from harm. The GPs were regularly involved in child protection issues, providing reports for social services.

Monitoring safety and responding to risk

The practice set aside a number of emergency appointments for each GP each day in order to respond to patients who needed to be seen urgently. The practice also operated GP telephone triage to ensure patients were seen within a clinically appropriate period of time. Arrangements were in place for patients who needed to be seen by a GP when the practice was closed.

Medicines management

The practice was making use of the expert support offered by the Clinical Commissioning Group (CCG), including meeting with the CCG's pharmacist every six months, to ensure medicines were used to achieve the best outcomes for patients.

A system was in place to ensure the practice maintained adequate stocks of the medicines it used regularly to treat patients and of medicines required to treat medical emergencies. The practice reported having good relationships with its local pharmacies to ensure patients received the medicines they needed. Medicines we looked were within their expiry date. The practice had a system in place for ensuring medicines for treating medical emergencies were always within their expiry date.

Medicines were stored correctly to ensure they remained fit for use. Medicines requiring cold storage, for example vaccines, were stored in a refrigerator fitted with a max/min thermometer so that the temperature at which these medicines were kept could be monitored at all times. However, the refrigerator was not fitted with a second thermometer independent of mains power in case there was power cut, in line with Public Health England guidance, Protocol for ordering, storing and handling vaccines. We highlighted this to the practice as an area for improvement. The refrigerator was not wired into switchless a socket to avoid it being turned off accidentally, as recommended in the guidance, however the plug was not easily accessible and it was unlikely the refrigerator could be unplugged accidentally.

Systems were in place to ensure patients received the medicines they needed in a timely way. Incoming mail from hospitals was dealt with as a priority to ensure patients received the medicines they needed after their visit to hospital. Repeat prescriptions were issued within 48 hours and patients could order their repeat prescription in a variety of ways for convenience. The practice was introducing a facility for patients to order their prescriptions online, for added convenience.

There were safeguards in place to ensure repeat prescribing was safe. For example the practice's computer system flagged up to staff when a medication review was due and there was guidance to staff about what to do in this event, so that a clinically appropriate decision could be made about whether or not to issue the prescription. The practice told us that not all patients regularly attended medication reviews despite repeated reminders.

Prescription forms were kept securely to prevent them being stolen or misused.

Information we reviewed prior to the inspection indicated Green Cedars Medical Services may not be meeting best practice in prescribing non-steroidal anti-inflammatory drugs (NSAIDs). We found prescribing in the practice to be safe and effective. NSAIDs are used to relieve pain, reduce inflammation and bring down a high temperature, and can be can be used to treat arthritis and back pain, for example.

Cleanliness and infection Control

The practice was visibly clean and a few patients commented that the practice was always clean and hygienic. The practice completed regular checks to ensure standards of cleanliness and infection control were maintained. Domestic cleaning equipment, for example mops and buckets were colour-coded to prevent cross-contamination. There were appropriate facilities for hand-washing and for dealing with clinical waste. Personal protective equipment for example disposable gloves, and adequate supplies of single use items were available to prevent cross infection.

Are services safe?

Staffing and recruitment

The practice used locum GPs and nurses to cover planned absence of clinical personnel where necessary. The practice dealt with one agency and requested locum staff by name, whom they trusted to be effective and reliable. In addition to the assurances provided by the agency, the practice carried out its own checks to ensure locum staff were suitably qualified and suitable for the role, including for example that their registration with their professional body and membership of a professional defence organisation were up-to-date.

Recruitment processes and pre-employment checks were in place to ensure the practice employed suitably qualified, skilled and experienced staff. The practice had received conflicting advice about the need to apply for a Disclosure and Barring (DBS) check before appointing non-clinical staff, however it had taken a policy decision to apply for this check for all its staff to minimise the risk of harm to patients, and was looking into how best to do this.

Dealing with emergencies

Clinical and non-clinical staff completed basic life support refresher training. This year's update was due shortly. Emergency equipment including an automated external defibrillator was checked regularly to ensure it was fit for use at all times.

The practice's business continuity plan set out the alternative arrangements to be put in place so that there would be no disruption to the service for patients, for example in the event of loss of utilities or the premises becoming unusable.

Equipment

The practice had contracts in place for the maintenance, repair, safety testing and annual recalibration of its medical and electrical equipment to ensure it was fit for use.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients received services that were effective, although we found areas for improvement. Patient's needs were met by suitably qualified staff who worked with other services to ensure they received coordinated care. It was clear the practice was working to recognised best practice guidelines in some areas.

Our findings

Promoting best practice

The GP principal used online resources to keep up to date with best practice clinical guidelines.

Clinical staff were aware of the provisions of the Mental Capacity Act 2005 to safeguard the interests of patients who lacked capacity to make some decisions in relation to their treatment and care.

Management, monitoring and improving outcomes for people

We found the practice had direct access, and referred patients to a wide range of diagnostic services, including MRI, Ultrasound, DEXA scan (to measure bone density), X-ray and cardiac diagnosis (blood pressure monitoring and ECG scanning). The practice also referred patients for 24-hour ambulatory blood pressure monitoring to confirm a diagnosis of primary hypertension, in line with National Institute for Health and Care Excellence (NICE) guidelines. High blood pressure is one of the most important preventable causes of premature ill health and death in the UK. The practice performed some diagnostic tests itself, or example spirometry which measures lung function. The practice diagnosed and treated diseases effectively.

The practice had systems in place to ensure it completed the New Patient Health Check for each patient joining the practice. This ensured the practice had a record of the person's medical and family history, and that their health checks, for example cervical screening, were brought up to date.

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. We saw that GPs at the practice were completing clinical audit cycles as required for revalidation.

Staffing

Arrangements were in place to support the GPs' continuing professional development, appraisal and revalidation, including protected learning time and funding to attend courses.

There was a system of yearly appraisals in place for staff employed by the practice and the practice used the system to support and engage its staff in developing the service, for example the implementation of the NHS electronic

Are services effective?

(for example, treatment is effective)

medical information system for patient records in 2013. The practice was also using the appraisal system to help a member of reception staff to realise their ambition to become a nurse, and had trained and supported them to become the practice's Healthcare Assistant as a first step.

The Practice Nurse had their appraisal with the GP principal and was given protected learning time to attend courses and nurse forum meetings to extend and update their clinical skills.

In addition to refresher training in core areas such as safeguarding and basic life support, staff received training to meet specific needs of the practice's patents, for example on domestic abuse.

Clinical and non-clinical staff felt well supported by the practice, and that the GPs and Practice Manager were approachable and listened to them. There were staff, clinical and whole practice meetings when the need arose, for example to discuss the practice's performance or to rectify problems in the operation of the practice. For example, a new system had been implemented so that a person had to sign a book when they collected their prescription, in response to an incident when a person had thought the practice had lost their prescription when it had been collected for them by a member of their family.

The practice recognised that more of the tasks GPs performed could be carried out by a practice nurse however the practice had not been able to recruit any more practice nurses.

There was a locum induction protocol in place to ensure locum GPs and nurses were able to take up the responsibilities quickly and effectively.

Working with other services

The practice worked with other services to ensure patients received coordinated and effective care. It had direct access to diagnostic services and links with community health services, for example the community nurse consultant for diabetes, the anticoagulant monitoring service, the health trainer to help patients make lifestyle changes in relation to their diet and physical activity and nearby health visitor and drug and alcohol services.

The practice used the NHS electronic medical information system for patient records which enabled different services to share information securely and appropriately about patients. This made sure, for example, that information the GP held about the patient was available to hospital clinics and community based services. The programme also flagged information to GPs about vulnerable patients, for example children on the at risk register, to ensure they received the appropriate care they needed.

The practice shared information with the out-of-hours service in the form of Special Patient Notes, for example about the few patients on its list with palliative care needs. The practice received information in a timely way about patients who had used the out-of-hours service to ensure continuity of care.

Health, promotion and prevention

The practice was recording the smoking status of its patients. Knowing whether a patient smokes makes it easier for the practice to help patients give up smoking. A smoking cessation counsellor visited the practice once a week to help patients stop smoking.

Information on a range of topics was available to patients in the waiting area. There was information about specific conditions, for example diabetes, high cholesterol and cancer, and about local support groups, for example a local women's aid advice service. Health promotion literature included information about alcohol and smoking cessation services, for example. There was also information about the NHS 111 service and minor ailments scheme to help patients access services designed to meet some of their needs more appropriately than the GP practice or A&E. The practice used online resources where these were available to provide written health promotion and disease prevention advice to patients in other languages.

Are services caring?

Summary of findings

Patients received services that were caring. Some of the practice's patients had little understanding of the purpose of general practice and of how the NHS worked in general. For many, English was an additional language and this presented the practice with additional challenges in meeting patients' needs. Reception staff in particular found themselves at the brunt of patient's frustrations. Nevertheless GPs and staff treated their patients with compassion and understanding. Reception staff were patient and helpful and took time to understand and resolve concerns.

Our findings

Respect, dignity, compassion and empathy

A high proportion of the patients on the practice's list had little understanding of the purpose of general practice and of how the NHS worked in general. For example, some patients wanted treatments that were not primary medical services or wanted to be seen by a doctor sooner than the urgency of their clinical need warranted. English was an additional language for many patients which sometimes added to the sense of frustration which was on occasion turned on practice staff. While the GPs and staff shared awareness of the key risks to themselves and to other people using the service, they treated patients with compassion and understanding. We observed staff communicating clearly and being helpful and courteous when talking to patients. They were patient, and took time to listen to patients and to explain things to them.

Patients and their families we spoke with said they felt listened to and that the doctors explained things well. One patient said they liked how reception staff spoke to them on the phone. Another patient told us they had noticed that if patients felt they needed to speak about something privately, a receptionist would come and take them off to one side, out of other's hearing. The practice's performance in the national GP Patient Survey did not compare unfavourably with other practices in Enfield.

There was a chaperone policy in place and staff were on hand to be present during a face-to-face consultation if the patient or GP required a chaperone.

Involvement in decisions and consent

When it was agreed that a patient needed an appointment at a hospital or clinic the practice made available the national electronic referral service, Choose and Book, so that patients could choose the date and time of their appointment. The practice reported there was little uptake of this service amongst its patients.

The practice's patient satisfaction survey in 2013 showed patients were happy with the level of their involvement in their care.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Patients received services that were responsive. The practice made provisions to meet the needs of the diverse population it served. For example, the practice used a telephone interpreting service and could book interpreters for patient appointments including British Sign Language.

Patients could get in touch with the practice easily to make an appointment to see a GP and were seen within a clinically appropriate timeframe. Patients could choose to see a male or female GP, or a named GP.

Our findings

Responding to and meeting people's needs

The practice sought to meet the diverse needs of the population it served. The main minority languages of residents in Haselbury ward where Green Cedars Medical Services was situated were Turkish, Polish, Somali and Greek. The practice told us there were many preferred languages amongst its patients and that around 10% of its patients spoke very little or no English.

The Practice Manager was a qualified medical translator. The practice had use of a telephone interpreting service and could book interpreters for patient appointments including British Sign Language. However, the practice told us it relied on patients bringing an interpreter with them in many cases and that it was impractical to involve an interpreter in every consultation that would ideally benefit from one when 50% to 80% of the practice's patients required some level of language support. Clinical staff were sensitive to the risks attached to this. Reception staff took care to respect patients' confidentiality and wishes, and noted on the system when a person asked that the practice channel all communications with them via their daughter, for example.

Patients could choose to see a male or female GP, as well as a named GP.

We saw that paper medical records were stored securely and archived appropriately to protect patients' confidential personal information.

The practice was accessible to wheelchair users and there was a disabled toilet for patients' use. There was a policy in place that enabled the practice to support patients with assistance dogs.

Access to the service

We found patients were usually seen within 1 to 2 days of requesting an appointment if the matter was not urgent. The practice set aside a number of emergency appointments for each GP each day in order to respond to patients who needed to be seen urgently.

Patients were able to book appointments up to one week in advance to give them flexibility around fitting in seeing their GP with other commitments. The practice had in the

Are services responsive to people's needs?

(for example, to feedback?)

past offered appointments up to month in advance but found that there was a high did-not-attend rate for these appointments. The practice provided an online appointment booking facility for patients for convenience.

Reception staff in particular played a proactive role in encouraging and supporting patients to have routine health checks, for example cervical smears, by taking the opportunity to remind them and book them in when they visited the practice for another reason.

Concerns and complaints

Information for patients about how to make a complaint was available on request from reception. Information for patients about making complaints and about the role of the Parliamentary and Health Service Ombudsman was on display in the waiting area. We saw that the practice took complaints seriously and maintained a log of complaints to help identify any areas for improvement. The practice responded to complainants in an open and timely manner.

The practice received around two complaints per month on average. Most complaints were about the appointment system. We found the practice managed its appointments effectively and appropriately.

Are services well-led?

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

Summary of findings

Patients received services that were well-led. The day-to-day operation of the service was well-managed. Clinical and non-clinical staff worked as a team to meet the needs of patients. They were open and honest with one another and with patients.

There were systems in place to reduce the risk of harm to patients on a routine basis. The practice learned from incidents to improve patient safety and the safety of GPs and staff working in the practice.

Our findings

Leadership and culture

Staff felt well supported and that the practice cared about their safety and wellbeing. They described their interactions with one another and with patients as open and honest. Staff enjoyed working for the practice and working as a team. They described the GPs as dedicated and devoted to caring for patients.

GPs and staff demonstrated commitment to understanding and responding to patients' needs in the most effective and appropriate way possible.

The practice had outgrown its premises and had for some years been looking to move to bigger premises in order to broaden the range of services it provided to meet the needs of its patients. For example there was a one year waiting list for chiropody in the area and the practice wanted to provide its own chiropody service. The practice also wanted to be able to hold smoking cessation and diabetes clinics and to accommodate more translators.

The practice had been approved to teach medical students. This benefited the practice by extending GPs' skills, keeping GPs in touch with new developments, and providing a stimulus to maintain clinical standards and standards of record keeping.

Governance arrangements

There were staff, clinical and whole practice meetings where the operation and performance of the practice was discussed, including incidents. The GP principal was the lead for clinical governance to provide oversight of the practice's processes for maintaining and improving the quality of patient care.

Systems to monitor and improve quality and improvement

The practice used the NHS Quality and Outcomes Framework (QOF) to monitor its performance. QOF includes clinical and public health indicators that have been designed to encompass best practice guidelines. It also enables practices, and their patients, to compare their performance with other practices.

There were clear lines of accountability within the practice. GPs and staff were clear about what decisions they were required to make and about the limits of their authority.

Are services well-led?

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

Risks to the delivery of high quality care were identified and action taken to reduce risk, for example the practice had reliable arrangements in place for GP and Practice Nurse cover.

The practice fed back to the Clinical Commissioning Group (CCG) information about the wider NHS in Enfield to improve services for patients. For example, one of the local A&E departments was not providing a complete course of antibiotics to its patients in line with current protocols. This put considerable pressure on the patient and the practice to ensure the patient completed a course of antibiotic treatment effectively, and had led on one occasion to practice staff and another patient at the practice being verbally and physically abused by a person worried about their child getting the antibiotics they needed.

Patient experience and involvement

The practice had found it difficult to establish a patient participation group given the nature of its practice population. People lacked the resources, for example time, to get involved with their practice in this way. The practice however completed patient satisfaction surveys and used this feedback to monitor its patients' experience of the services they provided.

Staff received feedback from patients, both concerns and compliments, as part of their supervision.

Staff engagement and involvement

There were staff, clinical and whole practice meetings where the performance and operation of the practice was discussed, including incidents. Staff had also been involved in plans for developing new services once the practice moved to bigger premises. While there were few regular formal meetings, clinical and non-clinical staff were satisfied that there were enough opportunities for discussion and involvement. They described the GP principal and Practice Manager as open and approachable.

Learning and improvement

The practice used supervision and appraisal to enable staff to meet the practice's performance objectives and to support staff development.

The practice targeted its efforts at meeting the needs of its patients in the most effective and responsive way possible. For example, it had made completing the NHS new patient health check a precondition for taking a new patient onto its list to ensure that it had an up to date medical history on record. The practice had also trialled booking appointments for patients up to one month in advance but found that this led to a rise in missed appointments. The practice had then withdrawn this service in order to make best use of the appointments available for patients.

Identification and management of risk

Systems were in place to reduce the risk and spread of healthcare acquired infection and to protect patients from the risks associated with medicines and from unsafe or unsuitable equipment. Policies and procedures were in place to protect children and vulnerable adults from the risk of abuse.

The practice learned from incidents and put improvements in place to reduce the risk of harm to patients and clinical and non-clinical staff.

The practice managed its appointments to ensure patients had access to the service within a clinically appropriate time frame.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Older people received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice had many fewer registered patients aged over 65 than the Enfield Clinical Commissioning Group (CCG) average, reflecting the nature of the population of its catchment area.

The practice had met the national requirement that from April 2014 all its patients aged 75 and over had a named GP responsible for coordinating their care.

Our findings

The practice had far fewer patients aged over 65 on its practice list than the Enfield Clinical Commissioning Group (CCG) average, reflecting the nature of the population of its catchment area. This explained the relatively few patients on its list that had been diagnosed as having dementia. Dementia in people under the age of 65 is comparatively rare.

The practice had met the national requirement that from April 2014 all its patients aged 75 and over had a named GP responsible for coordinating their care.

The practice was providing flu vaccinations for people aged over 65.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

People with long term conditions received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice was developing ways of ensuring these patients received ongoing monitoring to keep them as well as possible and to prevent avoidable hospital admissions. This was a challenge for the practice because of the nature of the population it served.

Our findings

Information we reviewed prior to the inspection showed the practice had higher coronary heart disease hospital admissions and rates of exception reporting than might be expected. Exception reporting enables GP practices to declare patients that they unable to provide care to and to not be penalised for this.

We found the high rate of exception reporting related to patients who did not respond to three or more reminders from the practice to come in for routine checks and reviews. The practice recognised that letters were not an effective way of communicating with many of its patients, and was using texts and phone calls to improve uptake of routine checks and reviews. Patients we spoke with appreciated the practice contacting them by phone. The practice was using an electronic recall system to support the timely completion of routine health checks for patients with long term conditions.

We found the practice was providing effective care for patients with coronary heart disease.

The practice told us that disease management clinics were not an effective way of meeting its patients' needs, whose often unsettled lifestyles required a more responsive and ad hoc approach. We found the Practice Nurse was providing disease management treatment and care for patients with diabetes, asthma, and coronary heart disease. The practice was developing nurse-led services for patients with chronic obstructive pulmonary disease (COPD).

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Mothers, babies, children and young people received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice faced challenges in providing treatment and care to this population group. For example a relatively high proportion of pregnant women visited the GP for the first time late in their pregnancy which had an impact on the practice's ability to provide a full programme of antenatal care. A significant number of parents would not allow their children to have the measles, mumps and rubella (MMR) vaccine.

The practice worked with other services to provide effective ante- and postnatal care and child health services.

Our findings

A relatively high proportion of pregnant women visited the GP for the first time late in their pregnancy which had an impact on the practice's ability to provide a full programme of antenatal care.

There was a weekly clinic held at the practice to improve access to ante- and post natal care and the six-week baby check. Health visitor services were provided at a local clinic. The practice was working hard to meet the nationally expected childhood immunisation rate of 90%. The practice told us that a significant number of parents did not think the measles, mumps and rubella (MMR) vaccine was safe and would not allow their children to have the vaccine.

Parents we spoke with told us they were reassured that a GP would always see their children quickly if a child was unwell.

The practice had nappy changing facilities to support families with babies.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Working age people (and those recently retired) received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

The practice provided services aimed at preventing disease. For example, the practice was completing NHS Health Checks for its target population and for new patients joining the practice. It was meeting its target for cervical screening. The practice managed its appointments well and patients were seen within a clinically appropriate time frame and within 48 hours at most.

Our findings

The practice was completing the NHS Health Check for its practice population. The practice had identified those patients eligible for the Check and the Healthcare Assistant had set themselves weekly targets for completing the Check with the patients on their list. The NHS Health Check is aimed at adults in England aged 40 to 74. It checks a person's vascular health and works out the person's risk of developing diabetes, heart disease, kidney disease, stroke and dementia so that the practice can help the person make lifestyle changes to prevent disease. The Check also aids early diagnosis and treatment where necessary.

The practice was exceeding the target for cervical screening. It offered the contraceptive injection as part of the range of contraceptive methods it provided.

Patients were able to book appointments up to one week in advance for convenience. The practice had stopped offering the facility to book appointments up to one month in advance when this lead to an increase in the number of missed appointments.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

People in vulnerable circumstances who may have poor access to primary care received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice. The practice was often the first port of call for new migrants to the UK arriving in the area and the practice worked hard to meet the needs of patients who had little understanding of how to access healthcare in England.

Our findings

The practice was often the first port of call for new migrants to the UK arriving in the area. It worked hard to overcome language and other barriers to accessing its services. The practice encouraged these patients to participate in health promotion activities, for example smoking cessation and cervical screening.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

People experiencing poor mental health received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

Patients diagnosed as having depression received appropriate assessment of the severity of their depression and appropriate referral to specialist services including psychological therapy.

The practice promoted the physical health and wellbeing of its patients with a serious mental illness.

Our findings

People experiencing poor mental health received services that were safe, effective, caring, responsive and well-led, although we found some areas for improvement in the practice.

Patients diagnosed as having depression received appropriate assessment of the severity of their depression and appropriate referral to specialist services including psychological therapy.

The practice promoted the physical health and wellbeing of its patients with a serious mental illness.