Care Quality Commission

Enfield Island Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Enfield Island Surgery is a small surgery consisting of two General Practitioners (GP's), a part time practice nurse, practice manager and reception staff. The surgery is located at Enfield Island Way and has a list size of 4200 patients of which 1800 are under the age of sixteen. The majority of patients are either young families or working age people.

We carried out an inspection on 28 May and on 30 May 2014. As part of the inspection we spoke to GP's, the practice nurse, practice manager, reception staff and patients awaiting their appointment. We also received feedback through Care Quality Commission (CQC) feedback cards which were available for the public to complete prior to the visit.

We inspected the following CQC regulated activities, diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

The practice had systems to monitor safety and staff reported and learnt from incidents. Data from the Quality and Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) was used to review and improve the practice performance.

The practice was well led with a clear leadership structure and open and transparent culture. Governance procedures were in place and feedback from patients and external data was used to monitor and improve the quality of service provided.

The practice had a Patient Participation Group (PPG) but attendace at meetings was low and the practice was reviewing the timing of meetings in order to improve attendance. Patients had mixed views about accessing appointments with some saying it was difficult to get an appointment. Another key issue was the length of time it took to make an appointment using the telephone and how long they were kept on hold. The practice was aware of this issue but said it was unable to install additional phone lines.

The practice was able to meet the needs of the different population groups who accessed the service. Many of whom are either working age or young families. It had a range of services with some GPs undertaking further training in specialist areas, for example care of older people and women during pregnancy and early identification of childhood illness.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice had systems in place to ensure patients received safe care. This included systems for reporting and learning from incidents and protecting patients from the risk of abuse. There were effective arrangements and equipment in place to respond to emergencies. Medicines were managed and stored correctly and procedures for the prevention and control of infection were in place. The premises were clean and well maintained.

The practice had up to date child protection and safeguarding vulnerable adults' policies and all staff were trained to the required level.

Are services effective?

Patients received services that were effective. The practice used National Institute for Health and Care Excellence (NICE) guidelines to promote best practice. Information from the Quality and Outcomes Framework (QOF) was used to monitor and improve performance and the practice had carried out a range of clinical audits.

Staff received an induction programme which included mandatory training and they had yearly appraisals.

The practice worked closely with other health care professionals. Multi-disciplinary meetings were held to discuss patient cases to form a strategy for the care to be delivered.

Healthy living was promoted through literature and referral to clinics such as weight management and smoking cessation.

Are services caring?

Patients received services that were caring. Patients told us reception staff were helpful and polite and that their privacy was maintained. Support was given to patients and their families at a time of bereavement by the GP which patients found helpful.

Patients felt supported and included in the decisions about their treatment. Provision was made for patients who lacked full capacity to give consent which included policies for obtaining consent and maintaining confidentiality for patients who were under the age of eighteen.

Summary of findings

Are services responsive to people's needs?

The practice had arrangements in place to meet the needs of patients. Access to the premises was on one level with wide spaces to allow ease of wheelchair use. The needs of the differing cultural groups were met and a telephone translation service was available for people for whom English was not their first language.

Patients could book appointments for the same day and a telephone consultation was offered if all appointments had been taken. Emergency appointments were also available on a daily basis and pre-booked and evening appointments were also available. However some patients were unhappy about the length of time they had to wait to speak to someone once they were connected.

The practice used complaints and other feedback from patients to improve the service.

Are services well-led?

Patients received services that were well led. We found that the practice had a clear leadership structure and that staff worked in an open and transparent way-need to say if there was an open and transparent culture. Governance arrangements were in place with a named lead for areas such as safeguarding and health and safety.

Systems were in place to monitor and improve quality by comparing practice performance data with that provided by the local Clinical Commissioning Group (CCG) and the Quality and Outcomes Framework (QOF).

The practice had a Patient Participation Group however this was not well attended. Patient feedback was provided through comments a comments book which was assessed by the practice manager and fed back to staff in monthly team meetings.

The practice had a business continuity plan and health and safety risk assessments had been carried out.

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
The practice provided an effective service to older people and had a GP that had undertaken further training in the care of older people. Flexible appointment times were available and a home visit or telephone consultation service was also available with their named GP.

Full health checks which included blood pressure monitoring, vaccinations and the monitoring of long term conditions were offered by the practice and patients were requested to attend on a yearly basis.

The practice led multi-disciplinary meetings with other health care professionals in order to address the care of specific patients and plan an integrated response to care provided. The practice also referred patients to other organisations for help such as Enfield Help the Aged.

People with long-term conditions
People with long term conditions received a service that was responsive and had arrangements in place to meet patient needs. This included regular clinics run by the surgery to monitor specific health conditions such as asthma, diabetes and coronary heart disease.

Care review meetings were held between the practice and the patient with their carer or representative in attendance. These monitored health and put together an integrated care plan to ensure the condition was managed. Prompt referrals to other health professionals were made.

Flexible appointments were offered including same day telephone consultations.

Mothers, babies, children and young people
Mothers, babies, children and young people received a service that was responsive and had arrangements in place to meet patient needs.

The practice has an appointed health visitor who provided a full service to both mother and child and included health checks for mother and regular childhood development checks. A full immunisation programme was offered. A drop in sexual health clinic was available for young people from within the community.

Summary of findings

Regular multi-disciplinary meetings took place between the surgery, community midwives, health visitor and social services to discuss families of concern and provide a care plan to support these families.

The working-age population and those recently retired
Working age people (and those recently retired) received a service that was responsive and had arrangements in place to meet patient needs.

The practice provided a full service to this group which included flexible appointments and extended opening times, making it easier for working age people to get an appointment with their GP. Telephone appointments were offered with the patient only needing to come to the practice for a follow up examination. A choice of referral to other services was offered.

People in vulnerable circumstances who may have poor access to primary care
Patients in vulnerable circumstances who may have poor access to primary care received a service that was responsive and had arrangements in place to meet patient needs. All people were able to register but for those who did not wish to, the practice provided an emergency treatment service and advice as to how to access community health services.

Audits of services to vulnerable people were carried out on an annual basis to ensure that the service was appropriate to the need of the local area.

The practice worked with the community matron service to offer care within patients' homes and the practice worked with other services such as the drug misuse service to offer further support to patients.

Double appointments were offered to those with a learning disability and information was available to patients on health promotion activities that were accessible to all patients.

People experiencing poor mental health
People experiencing a mental health problem received a service that was responsive and had arrangements in place to meet patient needs. A full mental health assessment was provided by the practice and care plans with built in reviews put in place. Routine health checks with medication reviews were offered for those patients who could not access the mental health team and extra support provided to facilitate access to appointments.

Summary of findings

A counselling service was available within the practice through the practice providing a consultation room for a private service to be offered.	

Summary of findings

What people who use the service say

During our inspection we spoke with ten patients at the surgery and collected 27 comment cards that had been completed by patients.

People were happy with the service provided. They told us they were treated with respect and felt staff listened to them. People felt that they were cared for. A small number of people commented that they had to wait "too long" once they arrived at the surgery and some people raised concerns about the length of time it took to make a telephone appointment. Once they were connected to the practice they were kept waiting on hold.

Areas for improvement

Action the service COULD take to improve
Extension of the existing Patient Participation Group (PPG) and the development of further patient surveys in order to improve the feedback on service by patients.

Patients commented that they were often kept waiting on the telephone for a long period of time when making an appointment.

Develop and implement an on-line appointment booking system.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice ran a full sexual health clinic which included sexual health advice, contraception advice and chlamydia checks.

Care Quality Commission

Enfield Island Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by a GP specialist advisor. The GP was granted the same authority to enter Enfield Island Surgery as the CQC inspector.

Background to Enfield Island Surgery

Enfield Island Surgery is a small surgery located on a housing estate of temporary and rented accommodation. The majority of the patients are either young families or working age people. The current patient list of 4200 includes 1800 patients under the age of 16 and the majority of patients are either young families or working age people. The area does not have a large older population or people in vulnerable circumstances. There is a high turnover of patients and the area has higher deprivation than the national average.

The practice is situated in a converted warehouse and exists on one level with ease of access to those with physical disabilities. The practice staff consists of two General Practitioners (GP's), a part time practice nurse, practice manager and reception staff.

Why we carried out this inspection

We inspected this 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 had received from the out-of-hours service and asked other

Detailed findings

organisations including the Enfield Clinical Commissioning Group (CCG) and NHS England to share their information about the practice. We carried out an announced visit on 28 May 2014 and on 30 May 2014.

During our visit we spoke with a range of staff, including two GP's, a practice nurse, practice manager and reception staff.

We also spoke with patients who used the practice. We observed how people were being cared for and reviewed personal care or treatment records of patients. We also viewed practice policies and the audits that the practice have in place.

Are services safe?

Summary of findings

The practice had systems in place to ensure patients received safe care. This included systems for reporting and learning from incidents and protecting patients from the risk of abuse. There were effective arrangements and equipment in place to respond to emergencies.

Medicines were managed and stored correctly and procedures for the prevention and control of infection were in place. The premises were clean and well maintained.

The practice had up to date child protection and safeguarding vulnerable adults' policies and all staff were trained to the required level.

Our findings

Safe Patient Care

The practice had a range of policies in place to protect patients from the risk of harm. Policies included infection control, repeat prescriptions, medicines management, safeguarding of children and vulnerable adults and a whistleblowing. Staff were aware of these of these policies.

Procedures were in place to report incidents, including significant events, health and safety incidents and prescribing incidents. All staff were aware of how to report an incident and who carried out the investigation. This included an understanding of the process of identifying and reporting incidents that affected people's safety and instances of potential abuse. Incidents were discussed in monthly staff meetings.

Learning from incidents

Significant events, including prescribing errors and health and safety incidents were recorded by the practice and significant event analysis took place. Following a significant event, the matter was discussed between the GPs and practice manager and an action plan was developed in order to prevent recurrence. The results of these were shared with remaining staff to ensure any learning was disseminated. Incidents had been reported to other organisations such as NHS England as required.

We viewed an event that had been identified by a staff member and discussed by the GP's before being shared within the staff meeting. The incident had been investigated and used as a training exercise to ensure that the incident was not repeated.

Safeguarding

The practice had a safeguarding vulnerable adults and a child protection policy. Staff had received both external training and internal training through staff meetings. GP's had received Level 3 child protection training, the practice nurse was trained to Level 2 in child protection and the remainder of staff had received Level 1 child protection training. All staff had received adult safeguarding training.

The safeguarding adults and child protection policies included how to recognise abuse and what to do if a member of staff had concerns. The practice had a named individual responsible for safeguarding and staff were

aware to contact the named person if they suspect abuse. The staff were also aware of external contact details and these details were on display in the main reception and within the consulting rooms.

Medicines management

Appropriate systems were in place for the management of medicines within the surgery. Each medicine was logged on arrival by the unique bar code and expiry date. The nurse and practice manager checked the medicines weekly to ensure they were still in date. If they had expired they were taken to the local pharmacy for disposal. A record of fridge temperatures was kept and the temperature was checked on a daily basis and double checked by the practice manager on a weekly basis. The fridges were manually plugged into the wall and a sign was present stating that the fridges were not to be unplugged.

Controlled drugs were not held on the premises. Emergency medicines and vaccinations were stored within a locked safe within a locked cabinet and a register was kept of the drugs on the premises. Vaccines were checked and all were in date. The keys to the cupboard were kept within the administration office and were easily accessible to staff.

The practice repeat prescription policy stated that patients were to submit the request to the reception. These requests were processed in date order with the information inputted onto the computer system before a prescription was issued. Patients could collect prescription from the practice or it could be sent to the local pharmacy and the patient could collect it from there.. A renewal date was placed on the prescription and this was automatically renewed unless the patient requested a change to the prescription. In that case the GP would review and contact the person for a consultation before issuing the prescription. The practice did not have an online service for repeat prescriptions.

Monitoring safety and responding to risk

The practice had a comprehensive business continuity plan which identified what the practice would do if there was loss of access to the premises, medical records or computer system. The practice had an agreement with a nearby surgery to “buddy” and share facilities in order to continue to provide a service until the practice building and facilities can be used. This agreement included the use of cold storage for medications if the fridge had broken down.

The practice had received feedback from patients regarding the length of time sick children had to wait to see a doctor and addressed this by introducing non-urgent telephone consultations. For more urgent cases where no appointments were available on the day, parents would bring their children to the surgery and a receptionist would triage the child and if necessary talk with the GP between appointments. The GP would then prioritise existing appointments so the child could be seen in an emergency slot. Receptionists had a set list of questions to ask during the triage process to direct the patient to the correct appointment. If they were unsure they would consult the GP. There was no evidence of any formal training for the triage system.

Cleanliness and infection control

The practice had an infection prevention and control policy that covered all aspects of the surgery and included waste management and cleaning. The practice manager was the appointed lead for infection prevention and control and staff were aware of the policy following training at the monthly staff meeting. All staff had received training in infection prevention and control in line with the practice policy.

We viewed the latest infection control audit carried out by the practice in February 2014. No areas of concern were raised by the practice in this audit. The audit is due to be updated in September 2014. Cleaning audits were not being carried out but the practice manager walked around the premises to check on the cleaning and contact the cleaner if an area was found to be dirty. We saw evidence of a cleaning schedule for the cleaner to follow and it was used as the basis for the practice manager’s check. The practice was found to be clean on the day of the visit. Clinical waste and sharps were collected by a contracted company on a monthly basis and were housed in a lockable bin within a secure unit.

The practice had facilities for hand washing and hand gel was available throughout the building. Hand washing signs were also present to instruct staff and patients in correct procedure.

Staffing and recruitment

The practice had a recruitment process which included the submission of an application form and two interviews. The first interview was with the practice manager and another member of the administration staff and the second follow up interview was with the practice manager and a GP.

Are services safe?

Pre-employment checks were carried out on all staff which included the verification of qualifications, obtaining two references and Disclosure Barring Service (DBS) checks. Once all checks were in place, an offer of employment was sent out.

Dealing with Emergencies

Emergency equipment such as oxygen and emergency drugs were available within one of the consulting rooms which was accessible at any time. All staff were up to date with their basic life support training.

Equipment

The practice was fully equipped to provide all the services required. This included medical equipment such as blood glucose monitoring and blood pressure monitoring and administrative office equipment. We saw maintenance contracts for equipment and viewed calibration records for the fridge and thermometers which showed they had been checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

Patients received services that were effective. The practice used National Institute for Health and Care Excellence (NICE) guidelines to promote best practice. Information from the Quality and Outcomes Framework (QOF) was used to monitor and improve performance and the practice had carried out a range of clinical audits.

Staff received an induction programme which included mandatory training and they had yearly appraisals.

The practice worked closely with other health care professionals. Multi-disciplinary meetings were held to discuss patient cases to form a strategy for the care to be delivered.

Healthy living was promoted through literature and referral to clinics such as weight management and smoking cessation.

Our findings

Promoting best practice

The practice used guidance from the National Institute of Health and Care Excellence (NICE) to inform care and treatment. We were informed that these guidelines were reviewed by the GP's on a regular basis to ensure that the treatment given to patients was appropriate and that examinations were carried out in a way that provided a full diagnosis. The practice used of NICE mapping guidelines for areas such as immunisation and infection prevention and control on display in consulting rooms and a folder of up to date guidelines was available for staff in the administration office. Staff demonstrated an awareness of both where the guidelines folder was kept and use of the folder.

Best practice in relation to gaining consent, infection control repeat prescribing and confidentiality was discussed in monthly staff meetings. Recent staff meeting minutes (April 2014), demonstrated that new policies were discuss and shared with staff. Staff were informed that the safeguarding policy and emergency procedures had been updated.

We found evidence of involvement with the local Clinical Commissioning Group (CCG) of which one of the GP's was a member. This included multi-disciplinary team meetings with the CCG to discuss complex cases to ensure the patient was receiving the appropriate care.

Management, monitoring and improving outcomes for people

The practice submitted information to the Quality and Outcomes Framework (QOF) which compared data from the practice and the local CCG as a whole against the national average. The QOF provides an indicator of the performance of individual practices and gives a point's score.

The practice was found to be performing just below the national average for the treatment of asthma and cancer with an overall clinical QOF score of 91.88% whereas the national average was 92.30% and the Clinical Commissioning Group (CCG) average was 91.97%. The GP's were aware that the practice was an outlier within CCG data for areas such as patients attendance at accident and emergency and they had reviewed this and found one of

the main areas for this was around wheezing children. As a result they had promoted the issue within the practice and encouraged patients to seek treatment from the practice first rather than attending accident and emergency.

Attendance at accident and emergency for long term conditions such as asthma were audited against local available data. The GP's identified this as an issue for the practice which may have related to patients being unable to manager the condition effectively by themselves. The practice responded to this issue by raising awareness during consultations with patients about how they could manage their condition and explaining the correct procedure for their management within consultations.

We found evidence of regular clinical audits undertaken by the practice to ensure standards were being achieved and to highlight any issues identified. Clinical audits initiated by the practice included prescribing and medicines. These audits were discussed in senior staff meetings which included both GP's and the practice manager and any changes to policy were made in this meeting before being cascaded down to other staff members.

The practice undertook an internal audit of children who attended the practice for ear nose and throat (ENT) related concerns. Results showed that there was a high number of children presenting who required a referral to hospital for tonsillitis. In order to address this matter the GP's met to discuss any referrals to hospital before they were sent out to ensure they were appropriate.

The practice undertook audits of services provided to vulnerable people. This included an audit into the service provided at the surgery to those with learning disabilities and those who were alcohol and drug dependent. This was to analyse whether the service being provided was appropriate for the population group that it served. It was found that access to services could be improved however there was a weekly drug and alcohol clinic held at the practice run by an external organisation. The audits helped to develop strategies to work with community matrons to provide care and treatment to patients directly in their home.

Staffing

Each member of staff received a full induction period which included both training for their role and also in the practice policies. All staff were up to date with mandatory training which included cross infection control, governance management, safeguarding and basic life support.

We were informed by staff that they had informal supervisory meetings with the practice manager which were not recorded. Any issues that may arose were discussed with the practice manager when they occurred order to provide a quick resolution. All staff received annual appraisals and we viewed appraisal documents for staff which outlined overall progress for the past year and areas for development including further training needed.

The GP's were currently taking part in the revalidation process. Revalidation is where doctors are required to demonstrate that their skills and knowledge are up to date and they are fit for practice. It included regular peer appraisals, which the GP's were currently undertaking and the provision of a portfolio of current professional development and feedback from patients.

Working with other services

The practice had close links with community services which included local mental health teams, the McMillan Nurses for palliative care, midwives and health visitors. The practice undertook multi-disciplinary meetings to discuss the needs of individual patients. This was to discuss families and patients that were placed on the practice in need register. We were provided with minutes of these meetings where families and individual patients were discussed and an action plan was proposed between the practice and the health visitor team to provide support. It was noted that those patients concerned were also invited to the meetings which ensured that they were able to participate in the decision making.

GPs were involved with local mental health teams to coordinate the assessment of patients with mental health concerns in a formal way. This involved the sharing of information with mental health teams and providing annual health checks.

Health, promotion and prevention

The practice promoted good health for all patients within the practice. Advice and support was given to patients to

Are services effective?

(for example, treatment is effective)

aid a healthy lifestyle. This included weight loss clinics, smoking cessation clinics and a healthy heart clinic. Leaflets were given to patients including guides to healthy living and dieting.

The practice promoted safe sexual health and offered a drop in clinic, run by one of the GPs, for patients and the wider community which provided advice including contraceptive advice. The practice offered chlamydia screening to patients but had not audited this to date.

The Enfield Clinical Commissioning Group (CCG) area had declining numbers of teenage pregnancies and this was reflected at the practice where only 4% of those pregnant were of teenage years. The practice had a policy for teenage pregnancies which included a referral to the Family Nurse Partnership (FNP) if it was a first pregnancy. The FPN could offer further support and provide further help and advice.

The practice provided annual health checks to patients which included diabetes and blood pressure checks and mental health checks.

The practice offered a full immunisation and screening programme including flu vaccinations and pre-school MMR vaccinations. An audit of patients under the age of sixteen requiring routine vaccinations showed that there was a larger number of patients receiving the vaccination as opposed to patients who did not attend.

A poster was on display within the surgery that promoted services provided by both the surgery and the wider community.

Are services caring?

Summary of findings

Patients received services that were caring. Patients told us reception staff were helpful and polite and that their privacy was maintained. Support was given to patients and their families at a time of bereavement by the GP which patients found helpful.

Patients felt supported and included in the decisions about their treatment. However, the National GP Patient survey found that the number of patients who said they were involved in decisions about their treatment , 66%, was below the average for the CCG which was 72 %. Provision was made for patients who lacked full capacity to give consent which included policies for obtaining consent and maintaining confidentiality for patients who were under the age of eighteen.

Our findings

Respect, dignity, compassion and empathy

We found staff at the practice were caring and responsive towards the needs of patients. We observed staff to be empathetic, friendly and accommodating with good interactions toward patients. Patients commented that they found the staff accommodating, friendly and helpful and they were happy with the care they received.

The practice tried to ensure patient's privacy was maintained. The waiting room is open plan but patients could request to talk at a side desk which was more private. The consulting rooms had curtains to give privacy during an examination.

The practice has a chaperone policy and reception staff primarily act as chaperones. Although this is not widely advertised within the practice, patients are asked by reception staff and again by the GP if they wish to have a chaperone present during their consultation.

We were informed that patients received support from the surgery at the time of bereavement. The GP contacted the patient or family member to provide support as well as informing them about the counsellor who provided a clinic at the practice two mornings a week. Positive comments were received from patients regarding the support and assistance provided by the GP at that difficult time.

Involvement in decisions and consent

Patients were supported to make informed decisions and were provided with information during their consultation with the GP. Patients that we spoke with said that they were given information about their treatment and were fully involved in the decisions about their care. They were kept informed if a further consultation with the GP was required or whether a referral was needed. The latest national GP patient survey showed that 65% of patients felt the GP's were good at involving them in their care. This was below the Clinical Commissioning Group (CCG) average of 72%.

The practice had a very high percentage of registered patients who were under the age of eighteen (43%)and the practice had developed specific policies to address the needs of this group. This included a policy for maintaining the confidentiality of young people. All staff had received training and were fully aware of the issues involved. Staff had received training in the Mental Capacity Act 2005. They

Are services caring?

were aware of how to appropriately support patients who for example were unable to fully understand the system of making an appointment by providing written aids to help explain the process.

The practice had adopted Fraser guidelines which allowed them to consider whether it was appropriate to obtain consent from patients under the age of sixteen. We saw evidence of an assessment tool that the practice used to assess whether this was appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had arrangements in place to meet the needs of patients. Access to the premises was on one level with wide spaces to allow ease of wheelchair use. The needs of the differing cultural groups were met and a telephone translation service was available for people for whom English was not their first language.

Patients could book appointments for the same day and a telephone consultation was offered if all appointments had been taken. Emergency appointments were also available on a daily basis and pre-booked and evening appointments were also available. However some patients were unhappy about the length of time they had to wait to speak to someone once they were connected.

The practice used complaints and other feedback from patients to improve the service.

Our findings

Responding to and meeting people's needs

The practice had arrangements in place to respond to the varying needs to patients. There was ease of access to the premises for wheelchair users or patients who had walking difficulties as the surgery was on one level with wide doors for wheelchair access.

The practice had a culturally diverse patient list and had taken steps to ensure that all cultures and languages were accommodated. This included a touch screen sign in screen which was available in Turkish and Somali (the main community languages spoken). Patients had access to a translation service and some literature was available in languages other than English. We were informed that patients could come prepared to either use the translation service which was telephone based or with a member of their family who could translate on their behalf. Patients were encouraged to use the translation service instead of family members.

The practice published a patients charter which outlined patients' rights, repeat prescription procedures, referral procedure, how to make an appointment and explains potential reasons for waiting times. This helped set expectations and for patients to understand practice procedures.

Patients commented that the practice was responsive to their cultural needs especially where it was important for the patient to see a GP of the same sex. Provision was made for this through the appointments policy. However this led to an increased waiting time for an appointment.

For those patients who required a referral to another health professional, the practice offered an urgent referral the same day. Patients felt involved in the process leading to the referral and were fully aware of the reason the referral had been made. The practice shared information relevant to the referral with other professionals to ensure continuity of care.

Out of hours provision was clearly advertised within the practice which directed patients to the 111 number or put them through directly to the BARNDOC service at Chase Farm Hospital. The information was also given on the telephone answering machine system.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients had mixed views regarding access to the service. Most patients found the new appointment system helpful but some found it difficult to get an appointment when it was required. If patients phoned first thing in the morning they were able to book an appointment for that same day. If all appointments had been taken they were offered a telephone consultation. Patients found it especially helpful to be able to book an appointment up to two weeks in advance as it helped with planning routine appointments, especially if working.

Staff stated that if a cancellation was received, the receptionist would routinely call the next person on the list for a telephone consultation and offer it to them. If a patient needed to see a GP urgently, especially a child, reception staff would consult a GP and the patient would be seen as a priority.

Some people raised concerns about the time it took to make an appointment through the telephone system and how long they were kept on hold. While on hold patients were informed how many people ahead of them in the queue. This was an issue that the practice was aware of and was unable to change as there was only one phone line at present used for the appointments system. The practice were unable to have another line installed because of restrictions placed on them by the management of the building. Patients also commented that there was often a long wait to be seen once in the practice as the GP's took their time with patients. The practice had not carried out an audit of the number of patients who had rung off before being connected therefore an exact figure could not be given. The practice did not have an online booking system.

Each older person had been assigned a named GP and if they were unable to make an appointment at the practice, GP's carried out a home visit or a telephone consultation. Patients were happy with this as they were able to call the surgery and speak to the specific GP given to them who knew their history which meant that the practice was more responsive.

The telephone system directed patients to the 111 number when the practice was closed.

The practice provided accommodation for a counselling service for two days a week to provide a service to the local population including patients of the practice.

Concerns and complaints

The practice had a complaints process and this was displayed in the waiting area. Complaints could be made in person or in writing. Written complaints were assessed by the practice manager and if appropriate by the GP. The practice manager acknowledged the complaint within three days. If a complaint was made in person, contact details were placed in a book for the GP to contact them at the end of surgery time. This is in line with the practice complaints procedure.

We found evidence that complaints were discussed at staff meetings and learning points were taken from this. Common complaints included some minor customer service issues such as staff being unhelpful when patients were trying to make an appointment that were discussed and resolved.

The practice had a small Patient Participation Group (PPG) which it found difficult to coordinate.. This was because of the constant change in population within the area of the surgery. The PPG brought concerns such as the premises not being clean and that there were not enough appointments. The practice addressed the issue of appointments by explaining the current situation and then introducing telephone consultations to ease the demand for appointments. Patients were happy with the telephone service as they found it fitted in well with their lifestyle. The practice found that there was a low attendance at PPG meetings and were arranging them at different times of the week, including evenings to try and engage with more of their patient population.

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. We found that the practice had a clear leadership structure and that staff worked in an open and transparent way. Governance arrangements were in place with a named lead for areas such as safeguarding and health and safety.

Systems were in place to monitor and improve quality by comparing practice performance data with that provided by the local Clinical Commissioning Group (CCG) and the Quality and Outcomes Framework (QOF).

The practice had a Patient Participation Group, however this was not well attended. Patient feedback was provided through a comments book which was assessed by the practice manager and fed back to staff in monthly team meetings.

The practice had a business continuity plan and health and safety risk assessments had been carried out.

Our findings

Leadership and culture

The practice was well led and there was an open and transparent culture. There was good team working and roles and responsibilities were clear. The management team met weekly to discuss practice issues and delivery of care. Staff said that they were happy to work there and that they felt valued as employees.

Governance arrangements

The practice had a clear leadership structure with assigned named staff to take responsibility for the different aspects of clinical governance. There was a lead for safeguarding, prescriptions management and health and safety. The practice had clinical meetings to discuss concerns that arose and the results of these discussions were shared in practice meetings involving all staff. Staff we spoke with felt their views were taken on board by the management team and they were able to make a difference within the practice.

Systems to monitor and improve quality and improvement

The practice used data provided by the Quality Outcome Framework (QOF) to benchmark their own service against others in the area. This included comparing data on the attendance at accident and emergency for chronic conditions such as asthma that could be managed in the practice. This enabled them to assess their own service in order to continue to provide what people needed on a local level and free up resources within the hospital setting. It also helped to identify trends in risk to enable the practice to successfully manage current and future risk.

The practice learned from significant events, complaints and QOF data to improve practice and implement new services. It also undertook a schedule of regular clinical audits which included prescribing and medicines.

Patient experience and involvement

Patients were invited to provide feedback through a comments book that was left in the reception area. Any comments left were reviewed by the practice manager and discussed at staff meetings. Changes made through this method included the accessibility of more telephone

Are services well-led?

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

appointments, longer opening times and the re-employment of a health visitor at the practice. We found no evidence of any formal feedback systems including patient surveys.

A touch screen display board was available to patients to rate their experience of the surgery and asked whether they received a good service. In May 2014, 18 out of 22 patients who completed the survey rated the service as very good. We found that a full patient survey had not been completed in three years and the data held was not reflective of the current state of the practice.

The practice had a Patient Participation Group (PPG) but this was not well attended, with only one person attending the last meeting. The practice had reviewed the timing of the meetings and had organised it for different times to ensure better attendance.

Staff engagement and involvement

Staff provided feedback directly to the practice manager through informal meetings. Staff said that they felt valued and cared for by the practice management.

Staff were aware of the practice whistleblowing policy and how this could be used. However no member of staff had used the policy.

Learning and improvement

Each member of staff had objectives for improvement in their personal development plan. These were agreed at their annual appraisal. The objectives were linked to improvements in the delivery of care and were regularly reviewed.

Identification and management of risk

Risk within the practice was identified through the monitoring of delivery of care. Team meetings were held on a regular basis and discussed areas of risk and actions were agreed and implemented.

The practice had a comprehensive business continuity plan which identified what the practice would do if there was loss of access to the premises, medical records or computer system. The practice had an agreement with a nearby surgery to “buddy” and share facilities in order to continue to provide a service until the practice building and facilities can be used. This agreement included the use of cold storage for medications if the fridge had broken down.

Up to date health and safety risk assessments for both the building and equipment are in place in order to minimise the risk to the health of both staff and patients while in the practice.

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

The practice provided an effective service to older people and had a GP that had undertaken further training in the care of older people. Flexible appointment times were available and a home visit or telephone consultation service was also available with their named GP.

Full health checks which included blood pressure monitoring, vaccinations and the monitoring of long term conditions were offered by the practice and patients were requested to attend on a yearly basis.

The practice led multi-disciplinary meetings with other health care professionals in order to address the care of specific patients and plan an integrated response to care provided. The practice also referred patients to other organisations for help such as Enfield Help the Aged.

Our findings

The practice had a very low number (approximately 100) of older people on the list, but those who visited the surgery had their care needs met. One of the GP's had a special interest in the care of older people which meant that further training had been undertaken to ensure they received effective care.

Where appropriate referrals were made to other health professionals such as the community matron and district nurse. Referrals could also be made to other agencies including Enfield Help the Aged.

We were provided with minutes of "virtual" multi-disciplinary meetings which occurred by telephone conference to discuss individual patients care needs. At present the practice do not have any patients within residential care homes but we were provided with evidence through the minutes of meetings that extra support had been given to patients in the past including GP visits to the home and staff of the home being invited to the multi-disciplinary meetings.

Each older person over the age of 75 had been assigned a named GP and if they were unable to make an appointment at the practice, GP's carried out a home visit or a telephone consultation. Patients were happy with this as they were able to call the surgery and speak to the specific GP given to them who knew their history which meant that the practice was more responsive.

Older people had a full health check and were invited to attend on a yearly basis. The health check included the monitoring of blood pressure and any long term conditions and for giving out annual flu vaccinations.

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 a service that was responsive to their needs. This included regular clinics run by the surgery to monitor specific health conditions such as asthma, diabetes and coronary heart disease.

Care review meetings were held between the practice and the patient with their carer or representative in attendance. These monitored health and put together an integrated care plan to ensure the condition was managed. Referrals to other health professionals were made.

Flexible appointments were offered including same day telephone consultations.

Our findings

The practice provided clinics run by the nurse to monitor patients with long term conditions. They were usually "open clinics" (people didn't have to register with the practice) but priority was given to those people who were registered at the practice.

Other clinics held at the practice included smoking cessation, weight management, chronic obstructive pulmonary disease (COPD), asthma, diabetes and coronary heart conditions. The clinic also offered support for alcohol misuse. Following the clinic, if the nurse felt that more treatment was needed, a referral was made for the patient to see the GP. The practice held regular review meetings with patients and their carers or representatives to discuss progress, plan future care and to address whether medication was appropriate and if a change was needed. The meeting enabled patients to manage care themselves and informed the carer of their active role by providing the tools to be able to self-manage their condition. The patient and their carer were able to openly discuss their concerns with the GP and the information was incorporated into their care plan.

If a patient's condition deteriorated, they could telephone the surgery for a telephone consultation and would be advised by the GP regarding further steps to take. Referrals to other services were made either on a two week wait system or if the condition was deteriorating, straight away. This was in line with the practice's referral policy.

Posters were on display in the waiting area regarding access to the clinics held and actively inviting patients to an annual health check.

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 a service that was responsive and had arrangements in place to meet patient needs.

The practice has an appointed health visitor who provided a full service to both mother and child and included health checks for mother and regular childhood development checks. A full immunisation programme was offered. A drop in sexual health clinic was available for young people from within the community.

Regular multi-disciplinary meetings took place between the surgery, community midwives, health visitor and social services to discuss families of concern and provide a care plan to support these families.

Our findings

This was the highest population group that the practice serves and most services that were provided had been developed around this population group. One of the GP's had a special interest in this area and had undergone specific training in the care of women during pregnancy and in early identification of childhood illness. The practice currently had 50 patients who were pregnant of which 4% were under the age of sixteen. This correlates with the current rate of decline of teenage pregnancies in the Enfield Clinical Commissioning Group (CCG) area.

The practice has an appointed health visitor who attended the practice every other Friday and provided a service for mothers and children. This included baby weighing, health advice, regular childhood development checks and a full immunisation programme. The health visitor gave advice and information to patients on living a healthy lifestyle and we were provided with evidence of leaflets including healthy eating and exercise that were given to mothers and their children.

If there were families that the practice was concerned about the health visitor would first of all meet with the family involved and if appropriate raise the concerns with the GP at the monthly concerns meeting. Where appropriate referral to social services were made.

The practice had multi-disciplinary meetings with community midwives, health visitors and social services to discuss and offer support to specific cases especially families that were on a low income or where children were under the care of social services. We were provided with minutes of a meeting and saw where extra support through the offer of more regular check-ups and health monitoring for an expectant mother was provided to ensure both mother and baby remained safe.

The practice offered a sexual health clinic which offered family planning and contraception advice to young people.

Mothers, babies, children and young people

Chlamydia screening was also provided for patients but this had not been audited. This clinic was open to the community and no referral was needed. Posters were on display for this clinic throughout the practice.

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 a service that was responsive and had arrangements in place to meet patient needs.

The practice provided a full service to this group which included flexible appointments and extended opening times, making it easier for working age people to get an appointment with their GP. Telephone appointments were offered with the patient only needing to come to the practice for a follow up examination. A choice of referral to other services was offered.

Our findings

The practice offered a flexible appointments system which included extended opening hours in the evening. Patients could contact the surgery and request a telephone consultation the same day. The GP would call at the end of the morning or afternoon session and if the GP thought that the patient needed to be seen for an examination, the GP would book an appointment direct with the patient at a time that was convenient to the patient. If a referral was needed, patients were given a choice of where the referral was to be made for example whether the referral was made to the local chase farm or north Middlesex hospitals or to a hospital closer to where they worked.

This service had received positive feedback from patients regarding this service and patients stated that the service was helpful because patients were able to coordinate appointments without having to leave work.

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

Patients in vulnerable circumstances who may have poor access to primary care received a service that was responsive to their needs.. All people were able to register but for those who did not wish to, the practice provided an emergency treatment service and advice as to how to access community health services.

Audits of services to vulnerable people were carried out on an annual basis to ensure that the service was appropriate to the need of the local area.

The practice worked with the community matron service to offer care within patients' homes and the practice worked with other services such as the drug misuse service to offer further support to patients.

Double appointments were offered to patients with a learning disability and information was available to patients on health promotion activities that were accessible to all patients.

Our findings

People in vulnerable circumstances were able to register with the practice but we were informed that an emergency service was mainly provided to those with no fixed abode as they were unwilling to register. While at the practice they were provided with information about how to contact community health services and information was no display advertising external support groups such as Alcoholics Anonymous (AA) and the mental health charity MIND.

The practice audited services to vulnerable people on an annual basis. This included audits into the service provided at the surgery to those with learning disabilities and those who were alcohol and drug dependent. This was to analyse whether the service being provided was appropriate. The audits found that access to services could be improved. The audits helped to develop strategies to work with community matrons to provide care and treatment to patients directly in their home. The GP would visit patients in their home if the community matron felt that it was necessary to do so. This service was headed by the GP. The practice worked with the drug misuse service to refer patients and coordinate further care.

Double appointments were offered to patients with a learning difficulty and those patients who found it difficult to communicate in order for the patient and GP to discuss health concerns without being rushed. Carers were invited to meetings to discuss on going treatment needs if it was felt appropriate by the patient.

Patients commented that they felt safe at the surgery and that staff listened. They had confidence in the surgery.

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 a mental health problem received a service that was responsive and had arrangements in place to meet patient needs. A full mental health assessment was provided by the practice and care plans with built in reviews put in place. Routine health checks with medication reviews were offered for those patients who could not access the mental health team and extra support provided to facilitate access to appointments.

A counselling service was available within the practice through the practice providing a consultation room for a private service to be offered.

Our findings

People within this population group were seen by the same GP at each appointment due to their complex needs. The GP's provided a full mental health assessment at the onset of any concerns and worked with patients to produce a care plan with regular reviews built in. If appropriate, the practice could make a referral to social services for further assistance. The practice attended social service reviews to ensure the best care and support was available for patients.

Patients stated that it was helpful for them to be monitored at the practice by the GP rather than going to see another mental health professional for routine health checks. This was a service provided by the surgery where the GP would invite a patient to the practice for their routine health mental check review if they were unable to get to the see the local mental health services.. The GP reviewed medications and discussed any further help needed, which included the arrangement of transport to appointments with other health professionals at the local hospital or at the mental health team office if required.

We viewed policies and procedures in place specific to meeting the needs of people experiencing poor mental health, for example around patient confidentiality and the referral to other agencies. Staff were aware of the Mental Capacity Act 2005 and their obligations under it.

The practice had a counsellor that came in for two days a week. The counselling service was provided by an external organisation. There was a long waiting list for this service which meant that there was poor access to this service for patients of the practice.