Grovelands Medical Centre

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Grovelands Road Medical Centre is a small practice situated in a residential road in Palmers Green North London. The practice provides primary medical services to people in the local community.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, family planning and maternity and midwifery services.

We inspected Grovelands Medical Centre. We did not inspect the two other practices two practices associatd with Grovelands Medical Practice which are 1 Grenoble Gardens and 7 Natal Road.

During our inspection we spoke with two GPs, the practice nurse, a health care assistant, the practice manager and two non-clinical staff members. We spoke with three patients and used comment cards to ask people for their views. We received positive feedback from patients who were satisfied with the care they received. A Patient Participation Group (PPG) had recently been set up to involve patients in developing the service and provide feedback on patient care to the practice staff.

Staff we spoke with were aware of their professional role and responsibility and were trained to meet the needs of patients. The practice provided care and treatment in accordance with best practice standards and guidance and worked in collaboration with other services to deliver effective care to patients. The practice was responsive to patients needs and responded to concerns and complaints. A complaints procedure was on display and a record had been made of complaints. Evidence was available to demonstrate that the practice had responded to complaints and had provided training for staff.

The practice had good leadership and was continuously looking for areas of improvement. We found there were some areas that required improvement. The practice had a procedure for reporting and investigating near misses and significant events. The records were not always fully completed and there was no evidence of the practice shared the learning with staff.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

There were procedures in place to ensure patients received safe care but some of them needed further development. Accidents, serious incidents and safety alerts were identified. However learning from incidents was not always disseminated to all staff.

Guidance and procedures were in place for staff to recognise abuse and appropriate pre-employment checks were in place for staff. They reported alleged abuse to the correct safeguarding agencies.

Policies and procedures were in place for infection prevention and control and medicines management but they need to record the minimum and maximum temperature of vaccines to ensure they are safe to use.

Plans were in place to deal with emergencies including fire and medical emergencies.

Are services effective?

Patients received effective care. Staff were suitably qualified and trained and worked to best practice standards and guidelines to deliver an effective service to patients.

The provider had participated in audits and peer review to evaluate and improve patient care.

The provider engaged with other health and social care services and professionals to deliver effective care to patients with complex needs.

Are services caring?

Feedback from patients was positive about the service. Patients said they were given both emotional and medical support by the practice staff. Patients said staff were knowledgeable, helpful and caring and their privacy was maintained.

Patients' privacy was respected.

Are services responsive to people's needs?

The service was responsive to patients needs and took a proactive approach to meeting them.

The practice had an accessible appointments system and patients were encouraged to give their views on access to appointments and their experience of care at the surgery.

Summary of findings

The practice was responsive to patients concerns and complaints. Both verbal and formal complaints were addressed and responded to appropriately.	
Are services well-led? The provider had leadership and governance arrangements in place. Staff were aware of their role and responsibilities and who they were accountable to. Patients were listened to and their opinions valued and incorporated into the running of the service. Staff were engaged and felt supported to deliver quality care to patients.	

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 had procedures in place to ensure older patients received appropriate care and their needs were met.

People with long-term conditions
The practice managed chronic disease through collaborative team work and referral to specialist care when appropriate.

Mothers, babies, children and young people
The practice had a wide range of services to meet the needs of mothers, babies and children.

The working-age population and those recently retired
The practice had arrangements in place to meet the needs of working age people including flexible appointment times and on line booking systems.

People in vulnerable circumstances who may have poor access to primary care
The practice had some arrangements in place to support patients in vulnerable circumstances who may have poor access to primary care.

People experiencing poor mental health
The practice had procedures in place to deliver appropriate care and treatment to people experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with three patients during our inspection and received twenty six comments cards completed by patients. The feedback from patients we spoke with and heard from, corresponded with the results of the survey conducted and analysed by the practice. Patients commented they were satisfied with the service offered by the GP's and the practice nurses and their health care needs were met by the practice.

Patients had differing experiences of making an appointment for a consultation with a GP. Some people told us they were able to get appointment promptly when they needed a consultation. A small number of patients mentioned that getting an appointment when they needed one was not always possible.

We looked at the results of the GP Patient Survey. The GP Patient Survey is an independent survey commissioned by NHS England. Of the 349 patients who were sent the questionnaire 102 patients responded. The majority of patients felt they could get through to the practice to make an appointment and the waiting time at the surgery was less than 15 minutes. Levels of trust in practice nurses were high. Areas for improvement identified included patients being able to see the GP of their choice and how the GP explained test results. Some patients felt that the GP could treat them with more care and concern.

Areas for improvement

Action the service COULD take to improve

Minimum as well as maximum temperatures recorded for fridges which store medicines.

Information on learning from incidents could be more effectively disseminated to staff.

Infection control audits carried out to ensure infection prevention and control procedures are being correctly implemented.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice had introduced the "White Wall" initiative which is internet based support for patients with psychological health issues. The practice provided patients with a password to log into an internet based support programme. Patients then had access to accredited therapists. Patients gave information about their current psychological condition which was assessed by a therapist and as a result of this assessment patients were assigned a suitable therapist. Access to this programme gave patients immediate support.

Grovelands Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP**.** The GP specialist advisor was granted the same authority to enter the Grovelands Medical Centre as the CQC Inspector.

Background to Grovelands Medical Centre

Grovelands Medical Centre provides GP led primary care services to 8758 patients living in the surrounding area of Palmers Green, Enfield. Grovelands Medical Centre is one of three medical centres registered to provide primary medical services within a group of Medical Centres. The services at Grenoble Medical Centre and Natal Road Medical Centre were also available for patients registered at Grovelands Medical Centre. We only inspected Grovelands Medical Centre during this inspection.

Grovelands Medical Centre operates in the area of Enfield Clinical Commissioning Group (CCG.) The Enfield population is proportionally younger than the national average, with a higher percentage of people under the age of forty years old. The number of people diagnosed with diabetes and the new cases of tuberculosis were significantly higher than the national average.

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 organisations to share their information about the service.

We carried out an announced visit on 12 June 2014. During our visit we spoke with a range of staff including GPs,

Detailed findings

reception staff, the practice nurse, and the practice manager. We spoke with three patients who used the service. We observed how people were being cared for and reviewed comment cards where patients and members of the public shared their views and experiences of the service. We also looked at policies and procedures, audits, staff records and minutes of staff meetings.

Are services safe?

Summary of findings

There were procedures in place to ensure patients received safe care but some of them needed further development. Accidents, serious incidents and safety alerts were identified. However learning from incidents was not always disseminated to all staff.

Guidance and procedures were in place for staff to recognise abuse and appropriate pre-employment checks were in place for staff. They reported alleged abuse to the correct safeguarding agencies.

Policies and procedures were in place for infection prevention and control and medicines management but they need to record the minimum and maximum temperature of vaccines to ensure they are safe to use

Plans were in place to deal with emergencies including fire and medical emergencies.

Our findings

Safe patient care

The provider had procedures in place to guide staff on what action to take following accidents and safety incidents. Medicines and Healthcare products Regulatory Agency (MHRA) alerts were sent to relevant staff and stored in an electronic file.

Learning from incidents

The practice had arrangements in place for reporting and recording incidents and significant events. In one instance we saw evidence of changes that had been made to patient documentation as a result of an incident. Although the practice recorded details of significant events the records had not always been signed off as complete. We found that information on learning from significant events could be more effectively disseminated to staff.

Safeguarding

The provider had procedures in place for safeguarding children and adults. Staff had received training in safeguarding adults and children and were aware of their responsibilities in relation to recognising and reporting any concerns. Clinical staff had received child protection training to Level 3 and non-clinical staff to Level 1. The contact details of the local authority safeguarding teams were available to staff to ensure they could report any concerns promptly. There was a designated GP for safeguarding who was responsible for ensuring any concerns were followed up appropriately.

Monitoring safety and responding to risk

The practice had undertaken health and safety checks of the premises and maintained equipment. Fire equipment had been serviced annually as recommended by the manufacturer. A fire risk assessment had been completed for the premises.

A protocol was in place for managing staffing levels at the practice. The procedure included guidance on maintaining minimum staffing levels, how to manage short term and long term staff absence and reviewing staff availability in relation to number of registered patients.

Medicines management

These covered medicines with their expiry dates which were kept in each GP visiting bag, the stock of medicines kept for emergencies, and medicines kept in each clinical room.

Are services safe?

Cleanliness and infection control

Two staff at the practice were the designated lead for infection prevention and control and were responsible for ensuring correct procedures were carried out. The practice had an infection control and prevention policy which included guidance on hand hygiene, personal protective clothing, laundry management and waste management and spillages. We saw no evidence that an audit of infection control had taken place.

We observed that all but one clinical room was carpeted. This meant there could be an infection control risk with regard to spillages and cleaning floor surfaces. A cleaner's protocol and schedule was in place that detailed the areas of the practice to be cleaned daily, which were the consultation rooms, patient areas and staff rooms. The list was signed by the cleaner daily on completion of the tasks.

Staffing and recruitment

The practice reviewed staffing levels to ensure they were in line with the practice protocol on staffing. The protocol set out a procedure for maintaining a minimum staffing level and the action to be taken in case of short term unexpected absence or long term absence of staff.

We spoke with the practice manager about recruitment procedures and the recruitment of staff. We were informed that since the practice registered with the Care Quality Commission in 2013 one new member of staff had been recruited to join the team at the practice. The recruitment documentation for this member of staff included a reference from an employment and skills agency, identity verification and a Disclosure and Barring Check (DBS) which had been procured whilst they were on a student healthcare placement.

A record had been made of clinical staff qualifications and their General Medical Council (GMC) professional registration number. A GMC registration renewal date had been identified and recorded.

Dealing with Emergencies

Staff had completed training in basic life support and cardiopulmonary resuscitation (CPR). In addition clinical staff had been trained in anaphylaxis management. The practice did not have an oxygen cylinder as part of the emergency equipment.

Emergency medicines were stored at the practice and they could be accessed promptly if the need arose.

There was an incident and serious incident policy for reporting, investigating, risk assessing and managing incidents in relation to patients, staff and the premises. This guidance was provided by Enfield Clinical Commissioning Group.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found that staff were qualified, trained and worked to recognised best practice standards and guidelines to deliver an effective service to patients that met their needs.

The provider had participated in audits and peer review to evaluate and improve patient care. We saw electronic records of clinical reviews for GPs and the nurse and records of staff peer review meetings.

The provider engaged with other health and social care services and professionals to deliver effective care to patients with complex needs.

Our findings

Promoting best practice

Best practice and national guidance such as National Institute for Health and Care Excellence (NICE) The Children Act, Mental Capacity Act and Gillick Competency (Gillick Competency is a medical term used to establish if a child under the age of 16 is able to consent to their medical treatment) were used to inform patient care and treatment.. Staff we spoke with were aware of the Mental Capacity Act 2005 and how to apply this in practice. The practice attended quality assurance meetings with neighbouring practices.

Management, monitoring and improving outcomes for people

The practice used the Quality and Outcomes Framework and data collected by the Clinical Commissioning Group to monitor and benchmark and improve the service. For example the practice was able to identify the number of patients over the age of 65 who attended the accident and emergency department frequently. The practice used this information to develop an action plan which enabled people to have their needs met within a primary care setting. We looked at information from Enfield CCG which indicated that the practice had the second lowest presentation of registered patients, at the local accident and emergency (A&E) department.

The practice had looked at patient pathways. Patient pathways included community health care support such as the community matron, social services and the occupational therapy service. Early assessment of symptoms, educating patients on self-care and the correct timing of patients discharge from hospital influenced patient presentation at the A&E department.

We saw documentation which demonstrated that patients care and treatment was routinely reviewed through audits. The practice had carried out repeat prescription audits for the year 2013/2014. The practice had looked at repeat prescriptions by age group and total number of repeat prescriptions. This enabled the practice to review prescribing to patients. An action plan had been developed with the aim of continuing to involve patients in a regular review of their medicines.

Are services effective?

(for example, treatment is effective)

We saw from the records that that both GPs and the practice nurse met to discuss the care, treatment and progress of patients. For example, updates on clinical protocols such as the protocol on smear tests and vaccines.

We spoke with staff who said there was a system in place for managing patient communication and information. Care records and treatment plans were stored on an electronic patient record system. Patient alerts could be set on the system to inform clinical staff of areas of care and treatment which were a priority for the patient. An example given to us by staff was the 45-75 health check for a weight and cholesterol reading.

Staffing

Staff told us their training and professional development needs were met and they had appropriate mentoring and clinical supervision. We saw a record of staff training which indicated that all staff had received training in safeguarding children and adults and basic life support. In addition clinical staff had attended Hepatitis B status training and practice nurses had updated their training in smear testing. All staff had had a yearly appraisal.

We saw records of three practice meetings and clinical staff meetings which evidenced that staff received a briefing on key issues and developments.

Working with other services

Multi-Disciplinary team records indicated that the care of housebound patients received from the district nursing service was reviewed weekly by both the nurse and the GP.

End of life care was organised effectively within a multi-disciplinary team framework involving district nurses, the palliative team and out of hour's service who provided care to individual patients who were registered with the practice.

Health, promotion and prevention

Literature was available for patients on a wide range of topics related to healthy living to ensure they had the necessary information to make informed decisions about their health. A number of screening services were available to detect the early signs of disease. Other services included a health check service, a smoking cessation clinic and child immunisation and vaccination clinics.

Are services caring?

Summary of findings

Feedback from patients was positive about the service. Patients said they were given both emotional and medical support by the practice staff. Patients said staff were knowledgeable, helpful and caring and their privacy was maintained.

Patients' privacy was respected.

Our findings

Respect, dignity, compassion and empathy

All of the staff interviewed and observed demonstrated a compassionate and caring attitude towards patients. Patients were treated with dignity, respect and their confidentiality was respected. Many patients were positive about their experience of receiving care and treatment at the practice. Patients commented that GPs were polite and courteous. Some patients felt that staff on reception were not always approachable.

The principal GP was instrumental in initiating the Enfield Carers Centre. Information on this service was displayed on the notice board in the waiting room. This meant that patients in the role of a carer for another person had support to look after their own health needs and were given additional support if this was needed.

The surgery had recently introduced an additional question for patients who registered with the practice on whether or not they were a carer to another person. Patients could then be referred to a carer support organisation if they wished for additional support.

The practice supported bereaved patients in a sensitive and supportive manner, through contact by mail and telephone.

The practice had a chaperone policy which included guidelines for staff who chaperoned patients. The guidelines covered information on promoting patients privacy and dignity and ensuring a record of chaperoning was made in the patients record.

Involvement in decisions and consent

All of the staff interviewed were familiar with informed consent and conditions affecting patients capacity to consent. Staff we spoke with were aware of the Mental Capacity Act 2005. We saw that the practice website gave patients information on how to access independent advocacy services.

The practice website had a language interpretation facility. Patients could choose their language and information on the website was converted into their chosen language.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to patients needs and took a proactive approach to meeting them.

The practice had an accessible appointments system and patients were encouraged to give their views on access to appointments and their experience of care at the surgery.

The practice was responsive to patients concerns and complaints. Both verbal and formal complaints were addressed and responded to appropriately.

Our findings

Responding to and meeting people's needs

The practice was responsive to the needs of patients. One GP at the practice had developed clinical guidelines for the management of patients with diabetes who practiced fasting during religious festivals. This information was given to diabetic patients for their information during periods of fasting.

We looked at the on-line therapy system which the principal GP had secured for patients who required psychological support. Patients had access to the "White Wall" which is an on line pathway to support patients with their psychological health problems. Patients using this service were assigned a therapist who offered NICE approved therapies in cognitive behavioural therapy, interpersonal psychotherapy and dynamic interpersonal therapy. We were informed that although patients could be referred to a counsellor/therapist there was a waiting list. The on line therapy system gave patients immediate access to therapies and the opportunity to discuss their problems and receive support.

A female GP was employed at the practice and patients who requested a gender preference had this noted on their records.

Access to the service

Information for patients about the appointment system was available in the practice leaflet and the website. There was a morning session for appointments and an afternoon session. A 'nurse led' walk- in clinic was available for an hour on Wednesday mornings and an hour on Friday evenings. People who were unable to visit their GP were asked to phone the practice reception between 8.00 and 10.30 am to request a home visit. Patients had the option to book on-line. There was a system of sending patient appointment reminders by text.

We were informed patients who phoned the practice for an emergency appointment were able to discuss their condition with a GP, who carried out an assessment of their medical needs. If patients were assessed as requiring an emergency appointment this was offered to them at Grenoble Gardens Surgery or Natal Road Surgery. We spoke with one patient who said although they were unable to get an emergency appointment at Groveland Medical Centre, as an alternative they were offered an

Are services responsive to people's needs?

(for example, to feedback?)

appointment at one of the satellite services. Staff informed us that all children were seen on the day the appointment was requested. Patients were directed to the 111 out of hours service and a local NHS medical centre with a walk in service, when the surgery was closed.

The response from patients with regard to their experience of the appointments system was mixed. One patient commented that different doctors gave different advice and another patient commented that staff had been able to book them an appointment when they needed it even if this was at another practice. Information from the independent GP survey told us that patients were able to get through to the surgery and book an appointment promptly.

The practice had carried out a number of audits to evaluate the effectiveness of the current appointment system. Due to the closure of a local GP surgery Grovelands Medical Centre had received an influx of applications for new patient registrations. The patient demand for appointments had been monitored to ensure there was the capacity, and plan to meet patients needs. An audit of telephone consultations had taken place for the period of 2013 -2014. The aim of the audit was to monitor the demand for telephone consultation appointments and monitor patients needs for better access. As a result of the audit the practice had concluded that they had the capacity to meet requests for both telephone appointments and patient/GP consultations.

Due to there being a transient local population and patients leaving the practice, appointment demand had risen by 14%. The practice was meeting the increased demand for appointments.

The practice had also monitored the number of patients who Did Not Attend appointments (DNA's) The practice had concluded that the number of DNA's had decreased due to educational information provided to patients on missed appointments.

Concerns and complaints

Patients were asked for their views by completing the annual patient survey provided by the practice. The survey results showed that overall patients were satisfied with their care at Grovelands Medical Practice. Access to appointments had been raised by patients and the practice demonstrated that the appointments system was being monitored and reviewed.

The practice complaints procedure was displayed on the notice board in the waiting room and on the practice website. Staff we spoke with were aware of the protocol for managing complaints.

Complaints were recorded and investigated. As a result of the complaints received, staff had received training in customer care.

Are services well-led?

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

Summary of findings

The provider had leadership and governance arrangements in place. Staff were aware of their role and responsibilities and who they were accountable to.

Patients were listened to and their opinions valued and incorporated into the running of the service.

Staff were engaged and felt supported to deliver quality care to patients.

Our findings

Leadership and culture

The provider had leadership and governance arrangements in place. Staff were aware of their role and responsibilities and who they were accountable to.

Patients were listened to and their opinions valued and incorporated into the running of the service.

Staff were engaged and felt supported to deliver quality care to patients.

Governance arrangements

Staff we spoke with were aware of clinical governance arrangements. There were clear lines of responsibility and staff had designated lead roles in safeguarding children and adults and as a Caldicott Guardian (The Caldicott Guardian was responsible for patient records and information sharing with NHS and social care providers.) Staff were clear about their primary responsibility to patient safety and were aware of the whistleblowing policy.

Systems to monitor and improve quality and improvement

Clinical Staff had an internal and external peer review process. GPs and the nurse met to discuss and review the care offered to patients. GPs attended Quality and Productivity (QP) meetings with other practices in the local area to review patient care and how the practice could offer effective health care to prevent admissions to the Accident and Emergency Department.

The practice used the Quality and Outcomes Framework and Clinical Commissioning Group referral rates to monitor benchmark and improve the service. For example the practice were able to identify the number of patients over the age of 65 who attended the accident and emergency department frequently.

The practice had reviewed complaints and organised training for staff as a result of the concerns raised by patients. The practice had monitored the appointments booking system and patient access to the health care they needed by asking people for their views and auditing the appointment booking system to ensure the practice had the capacity to meet patients needs.

However, evidence of regular and timely dissemination of learning from near misses, significant events and

Are services well-led?

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

complaints was sporadic and not systematic. Significant event audits were not always fully completed and signed off. Therefore it was not possible to confirm that action plans had been effectively implemented.

Patient experience and involvement

The practice had a patient participation group (PGG). At the time of the inspection the PGG had just formed and were due to have their first meeting on the 13th June. We met with the chair of the PGG who said an introductory meeting had taken place with the principal GP and practice manager where the aims of the group had been discussed.

We looked at analysis of the patient feedback survey which was given to patients by the practice. Twenty patients had responded to the survey which covered the quality of the equipment used at the practice, access to appointments, experience of treatment and overall opinion of the practice. Overall the results of the patient survey were positive with all the respondents rating the practice as good. One patient responded that access to the practice was not sufficient and six patients were unable to comment on the quality of the equipment. Patients were also able to leave their comments on the 'patient electronic tablet' in the reception area.

Staff engagement and involvement

Staff we spoke with confirmed that they participated in a yearly appraisal, undertook training and development which was relevant to their role and attended staff meetings. We looked at the record of staff training for 2013 and 2014. All staff had attended training in cardiopulmonary disease (CPD) safeguarding adults and children, anaphylaxis (choking) and basic life support. In addition clinical staff had attended Hepatitis B status training and practice nurses had updated their training in smear testing.

We saw records of three practice meetings and clinical staff meetings which evidenced that staff received a briefing on key issues and developments.

Learning and improvement

The practice had a system of staff appraisal where staff were able to review and plan for their professional development. A peer review system operated for clinicians where the delivery of care was reviewed. The care and needs of patients was discussed at MDT meetings and staff team meetings took place to enable staff to review the management of the practice.

The provider had learnt from complaints and serious incidents although information had not always been disseminated to all staff. For example staff had received training on customer care and the appointments system had been reviewed and audited to try to identify trends and appointment capacity.

Identification and management of risk

The practice had a contingency/disaster plan for unforeseen circumstances which may affect the running of the practice. The contingency plan was regularly reviewed. The practice did not have a formal strategic plan or succession plan but informed us they intended to develop a plan in the near future.

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 had procedures in place to ensure older patients received appropriate care and their needs were met.

Our findings

The practice provided health checks for patients over the age of 75. An annual health check, flu vaccinations and pneumonia protection was provided for this age group. The practice made referrals to the district nursing service to administer flu vaccinations. We were informed that a 'search' of all groups was carried out by the practice and the district nursing team were informed of patients who were prioritised for the flu vaccine.

The practice aimed to identify patients who had a caring responsibility to ensure they received the support they needed for their health and wellbeing.

The practice worked with district nurses and the palliative care service. An 'alert' was attached to the electronic patient record, this acted as a reminder to staff of patient palliative care treatment needs when their medical record was accessed. The practice completed a 'hand over' form for all patients in this group. This meant that the Out of Hours Service who provided care for patients had key information about people's medical needs.

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

The practice managed chronic disease through collaborative team work and referral to specialist care when appropriate.

Our findings

The GPs and Practice Nurse monitored patients with long term conditions. Patients over 45 years were offered health checks with the aim of screening them for long term conditions such as heart disease, diabetes and kidney disease.Patients were able to attend a diabetic clinic on Tuesday morning for advice and support with their condition.

We spoke with one patient who had a long term condition. The patient said they had been registered for a number of years and had received good care from experienced and knowledgeable GPs. Another two patients we spoke with commented that their conditions were monitored and where further investigation or additional medical treatment was required, they had been promptly referred by the practice to the relevant service.

The provider website had a range of healthcare information on common health conditions and long term conditions. This information was divided into advice sections such as A-Z of common conditions, health topics and questions, and published news items on various health care conditions. This meant that patients had readily available advice and support in managing their common or long term conditions.

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

The practice had a range of services to meet the needs of mothers, babies and children.

Our findings

The practice provided a clinic for mothers, babies and children. The practice nurse was primarily responsible for running the mother and baby clinic. We spoke with the practice nurse who informed us that the practice carried out baby/child health checks and immunisations in accordance with the 'Red book'. The 'Red Book' is a record of the infant's health development and progress. We were informed by the practice nurse that the postnatal check for the mother would be made at the same time as the health check for the baby. This meant that mother and child could be seen together at one appointment instead of two appointments.

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

The practice had some arrangements in place to meet the needs of working age people including flexible appointment times and on line booking systems.

Our findings

Patients who were not able to attend the surgery during working hours had the option of making an appointment to see a GP between 17.50 and 18.30pm. There was an on line booking system for appointments and repeat prescriptions for the convenience of patients who were not able to visit the practice.

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

The practice had some arrangements in place to support patients in vulnerable circumstances who may have poor access to primary care.

Our findings

The practice manager told us that the local population were generally home owners or a transient working population. The information we received from the practice identified adult patients with a learning disability. This information stated that an alert was attached to their patient record with the instruction that liaison with regard to their care was only to be carried out with a named carer or the patients nominated individual.

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

The practice had procedures in place to deliver appropriate care and treatment to people experiencing poor mental health.

Our findings

The practice had arrangements in place to meet the needs of people with mental health problems. The principal GP was the mental health lead for Enfield - Clinical Commissioning Group and practice lead for supporting and treating people with mental health problems. The practice nurse told us that a number of patients attended her clinic for support with their medicines. We were informed that in the case of a patient requiring assessment or additional support, advice would be sought from the principal GP.

We spoke with the principle GP who informed us that an on line support system had been initiated for patients with psychological and emotional problems called the 'White Wall'. Patients who would benefit from therapy could be referred to the service which offered on line support. We were informed by the GP patients were often placed on a long waiting list for therapy. We saw the on – line system and the support options available for people who needed immediate access to psychological therapies.