Bush Hill Park Trinity Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

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

- Although staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses, reviews and investigations were not thorough enough to learn lessons from incidents and prevent them from happening again.
- Data showed that some patient outcomes were below the local and national averages. Although some audits had been carried out, we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- The majority of patients said they were treated with compassion, dignity and respect.
- Urgent appointments were usually available on the day they were requested.
- The practice had a number of policies and procedures to govern activity, but some important policies were not in place. For example, there was no evidence of a Business Continutity Plan in place.
- The practice had proactively sought feedback from patients and had an active patient participation group.
- The practice had little evidence of effective processes for managing risks to patients. For example, the practice did not have oxygen on site and a risk assessment of not having oxygen had been conducted by the practice.

The areas where the provider must make improvements are:

- Put in place a Business Continuity Plan with supporting arrangements.
- Carry out regular clinical audits and re-audits to improve patient outcomes. In addition, a timetable for regular in-house infection control audits to be established
- Ensure that the practice has access to a supply of oxygen in the event of a medical emergency at the practice.

Summary of findings

- Conduct regular fire drills and to appoint a designated lead with responsibility for fire evacuations, and that Portable Appliance Testing (PAT) of all electrical appliances used at the practice is conducted periodically.
- Ensure that all reviews undertaken are documented and that outcomes identified as a result of review are shared with all practice staff in a timely manner.
- Ensure that all staff have regular performance reviews.

In addition the provider should:

- Review arrangements to enable patient access to a female GP
- Review and update procedures and guidance in accordance with best practice and current regulation.
- Inform all staff of the vision and strategy for the practice devised by the GP partners.
- Review practice strategy for identifying and supporting patients who are carers.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The surgery is rated as requires improvement for providing safe services, as there are areas where improvements should be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.
- There were no written records to indicate that in-house infection control audits were conducted on a regular basis. A lead for infection control had been appointed the week of the inspection.
- Patients were at risk of harm because systems and process were not in place in a way to keep them safe. For example, the surgery did not have access to oxygen should a medical emergency at the the surgery occur.

Are services effective?

Requires improvement

The surgery is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data showed some patient outcomes were low compared to the locality and nationally. Quality Outcomes Framework (QOF) data recorded the surgery as scoring lower than the national average on three out of the five diabetes indicators.
- There was no evidence that audit was driving improvement in performance to improve patient outcomes.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.
- The Surgery could only provide evidence of one two-cycle clinical audit being achieved over the past 18 months.

Are services caring?

Good

The surgery is rated as good for providing caring services.

- Data from the National GP Patient Survey showed patients rated the surgery higher than others for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, not all felt cared for, supported and listened to.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The surgery is rated as good for providing responsive services.

- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The surgery had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the surgery responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice ran extended hours surgery three times a week.

Are services well-led?

Requires improvement

The surgery is rated as requires improvement for being well-led, as there are areas where improvements should be made.

- The surgery had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it.
- The surgery had a number of policies and procedures to govern activity, but some of these were overdue a review.
- The surgery proactively sought feedback from patients and had an active patient participation group (PPG).
- All staff had received inductions but not all staff had received regular performance reviews or attended staff meetings.
- There was a lack of an overarching governance framework which supported the delivery of the strategy and good quality care. Arrangements for monitoring and improving quality and for identifying and managing risk were poor.

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

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Care and treatment of older people did not always reflect current evidence-based practice, and some older people did not have care plans where necessary. The surgery did not hold a register of the older patients in their surgery who needed extra support.
- Longer and urgent appointments were available for older people,as well as home visits when needed. The leadership of the surgery had started to engage with this patient group to look at further options to improve services for them, for example, the surgery campaign to increase the uptake of the seasonal flu vaccination.
- Flu vaccines at home were offered to this population group

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The Quality Outcomes Framework (QOF) recorded the surgery as scoring lower than the national average on three out of the five diabetes indicators.
- Longer appointments and home visits were available when needed. However, not all these patients had a named GP, a personalised care plan or structured annual review to check that their health and care needs were being met.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- Immunisation rates were relatively high for all standard childhood immunisations.

Summary of findings

- 80% of patients diagnosed with asthma on the patient list, have had an asthma review in the last 12 months, compared to the national average of 75%.
- Cervical Screening undertaken for patients within the target period was relatively high
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- There was little evidence of recent joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The needs of the working age population, those recently retired and students had been identified and the surgery had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The surgery ran extended hours surgery on Mondays, Tuesdays and Wednesday for patients who are unable to attend surgery during working hours.
- Telephone consultations were offered to patients at specific time Monday - Friday.
- The surgery was proactive in offering online services (including Skype consultations) as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- The surgery held a register of patients living in vulnerable circumstances including those with a learning disability.
- There were no written policies or arrangements to allow people with no fixed address to register or be seen at the surgery. However, we were told that it is not surgery policy to refuse registering new patients regardless of their circumstances.
- The surgery carried out annual health checks for people with a learning disability, but there was no evidence that any noted outcomes had been followed up.
- The surgery had limited interaction with multi-disciplinary teams in the case management of vulnerable people.

Summary of findings

- Staff knew how to recognise signs of abuse in vulnerable adults and children.
- Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective and well-led. The issues identified as requiring improvement overall affected all patients including this population group.

- 84% of patients diagnosed with dementia who had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average.
- 78% of patients with schizophrenia, bipolar affective disorder and other psychoses have had a comprehensive, agreed care plan documented in their record during the last 12 months. The national average for patients within this population group having an agreed care plan is 88%.
- The surgery regularly had limited interaction with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.
- The surgery carried out care planning for patients with dementia.
- Clinical staff had a good understanding of how to support patients with mental health needs and dementia.
- Longer appointments were available for this population group.

Summary of findings

What people who use the service say

The most recent National GP Patient Survey published it results in July 2015. Results showed the surgery was performing in line with local and national averages. 285 survey forms were distributed and 106 were returned. This represented 3% response rate.

- 81% found it easy to get through to this surgery by phone compared to a CCG average of 67% and a national average of 73%.
- 94% were able to get an appointment to see or speak to someone the last time they tried compared to a CCG average of 81% and the national average of 85%.
- 79% described the overall experience of their GP surgery as fairly good or very good compared to a CCG average of 81% and the national average of 85%.
- 75% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area compared to a CCG average of 72%, and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received nine comment cards, of which the majority were positive about the standard of care received.

We spoke with eight patients during the inspection. The majority of the eight patients said they were happy with the care they received and thought staff were approachable, committed and caring. The Practice Friends and Families Test (FFT) conducted between August 2015 and January 2016 revealed that fifty out of fifty six patients would recommend this practice to others.

Bush Hill Park Trinity Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Bush Hill Park Trinity Surgery

Bush Hill Park Trinity Surgery is a small general practice (GP) service located in the London Borough of Enfield. NHS Enfield Clinical Commissioning Group is a membership organisation of local GP practices, of which Bush Hill Park Trinity Surgery is a member.

Census data shows a mixed population of residents and life expectancy for both men and women are comparable with the national averages. The Enfield population has higher percentages of working age residents than all other population groups.

The practice is located in the South East region of Enfield and is situated in two semi-detached houses on a residential street. The practice is registered with the Care Quality Commission (CQC) as a partnership of two GPs. The practice has a list of approximately 2800 patients. The practice has a Personal Medical Services (PMS) contract and its registered activities are as follows:-

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

Clinical services are provided by two full time male GPs and two part time female practice nurses. The practice is responsible for providing primary medical care. The practice had operated from the same premises for a number of years with the current GPs joining in 2014 and 2015. One of the two practice nurses has been at the practice for a substantial number of years. A second practice nurse has recently joined and between the two nurses they are responsible for running a number of clinics such as Well Woman, Asthma and Diabetes clinics. A phlebotomist also operates from a room on the premises one morning a week.

The practice is open from 08.30 am to 7pm on all weekdays except Thursdays when it closes at midday for training, cleaning and meetings. Clinical sessions run as follows:-

- 08:30am – 12:30pm (Appointments, Emergency Appointments and Telephone Consultations) – Monday to Friday
- 17:00pm – 18:30 (Appointments)Monday, Tuesday, Wednesday and Friday
- 18:30pm – 19:00 (Extended Hours)Monday, Tuesday and Wednesday

On arrival at the practice patients are able to check in either at reception or using a self check-in machine in the waiting area. This machine has two language options; English and Turkish. The practice had arrangements in place for patients to receive care and treatment outside of its normal opening hours. This was through a local out of hours GP service (Barndoc) accessed via the NHS 111 service.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Bush Hill Park Trinity Surgery was inspected under the previous inspection system. At that time, the surgery was not provide with a rating.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17th of February 2016. During our visit we:

- Spoke with a range of staff (which included the two GP partners, Practice Nurse, Practice Manager and Reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events. However the inspection team were unclear who was the designated lead for reporting incidents to.

- Staff told us they would inform the practice manager or the senior GP partner of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out analysis of any significant events.

We reviewed safety records, incident reports, national patient safety alerts and but there was no evidence of discussion of the reports/alerts or safety records and any learning gained during practice meetings.

When there were unintended or unexpected safety incidents, there was no evidence that patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, the practice told us that a significant event had been recorded as a result of a patient not receiving contact from the local hospital a month after an urgent referral was sent by fax from the practice. The patient came into the surgery to find out why they had not heard from the hospital and was given the contact telephone number of the hospital and no further assistance. In addition, the patient was told that the practice had no record of the referral. Subsequent contact with hospital made by the patient, established that the referral had been received. The learning taken from this event by the practice was to ensure that an electronic record of two week referrals is kept, that receipt of all referrals are acknowledged by the receiving authority and that patients are to be advised that the practice will follow up on referrals made on their behalf. There was no evidence that the patient received an apology or was told about a change in process to minimise this event happening again in the future.

Overview of safety systems and processes

The practice did not always have systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The partners attended safeguarding meetings when possible. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The partners were trained to Safeguarding level 3.
- A notice by the reception desk advised patients that chaperones were available if required. All staff who acted as chaperones had received in-house training for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A cleaning schedule was in place and cleaning was conducted in-house. The practice nurse was the infection control clinical lead. However, she had only been appointed to this role during the week of the inspection. There had been some liaison by the practice with the local CCG infection prevention teams, which resulted in infection control issues being identified following a CCG audit conducted in 2015. The practice has recently addressed the issues highlighted which concerned the flooring used in the consultation rooms. Since the audit, new flooring has been laid in the clinical rooms. There was no evidence of an infection control protocol being in place, but staff had received up to date training. No in-house infection control audits had recently been undertaken and the inspection team were not provided with any evidence that in-house audits had occurred.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice

carried out limited medicines audits to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. On the day of the inspection, the Patient Group Directions (PGD) adopted by the practice to allow nurses to administer medicines in line with legislation could not be located. Subsequent contact by the Practice after the inspection provided the inspection team with evidence of the PGD's in use.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Some risks to patients were assessed and managed.

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and but there was no evidence of regular fire drills. There was no official designated lead identified amongst the staff in event of a fire, but all staff knew that it was their responsibility to ensure all patients were evacuated from the building should a fire occur. There was no evidence of recent testing of all electrical equipment to ensure that equipment was safe to use. Clinical equipment (such as scales and thermometers) had been checked and calibrated to ensure they were working properly. The practice had some risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The provider told us that they wished to recruit a female GP, but were having difficult in doing so.

Arrangements to deal with emergencies and major incidents

The practice did not always have arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergencies.
- All staff received annual basic life support training and there were emergency medicines available.
- The practice had a defibrillator available on the premises. A first aid kit and accident book were available.
- There was no oxygen available at the practice. There had been no risk assessment conducted by the practice to document the practice reasons for not having access to oxygen on site.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE. Staff informed us that alerts are received via the Practice Manager, reception staff or EMIS. If the alert relates to a medicine, staff ran a search to identify any patients affected. If any patients are identified, the patient would be alerted and asked to attend the surgery for a review of their mediciation.
- There was no evidence that the practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. QOF is a system intended to improve the quality of general practice and reward good practice. The most recent published results showed that the practice achieved 81% of the total number of QOF points available this is in comparison to the national average of 94%. The practice reported 3% Exception reporting in comparison to the national average of 9%. Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. This practice was not an outlier for any QOF (or other national) clinical targets.

QOF data from 2014/2015 showed;

- Performance for diabetes related indicators was below the national average. For example, the percentage of patients in whom the last blood pressure reading within the preceding 12 months or is 140/80mmHG or less was 58% compared to the national average of 78%, and the percentage of patients with diabetes whose last measured total cholesterol reading within the preceding 12 months is 5mmol/l or less was 66% compared to the national average of 80%. On the day of inspection, the senior partner GP could not inform the inspection team of why the practice QOF figure in this area was below the national average.
- The percentage of patients with hypertension having regular blood pressure tests was below the national average. The practice achieved 72% compared to the national average of 84%. On the day of inspection, the senior partner GP could not inform the inspection team of why the practice QOF figure in this area was below the national average.
- Performance for mental health related indicators was comparable to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the preceding 12 months was 78% with the national average being 88%. The review of care for patients with dementia during a face-to-face meeting in the preceding 12 months was 84% which was the same as the national average.

Clinical audits demonstrated limited quality improvement.

- There had been one full-cycle clinical audit completed in the last two years. Although this was a completed audit where improvement had been made, there was no evidence that there was a system in place for ensuring that audits continued on an on-going basis to monitor sustained improvement to clinical outcomes specifically those in line with published guidelines such as NICE.
- The practice had told us on the day of the inspection that it participated in local audits, national benchmarking, accreditation, peer review and research, but no written documentation was present to show that these activities were taking place.

Information about patient outcomes was used to make improvements such as the practice using QOF data to run a seasonal flu vaccine campaign. This resulted in a larger number of patients registering to have the vaccine administered in 2015 than in the previous year.

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Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccines had received specific training. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attendance at training courses and discussions at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meeting and ad-hoc discussions. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included one-to-one meetings, appraisals, coaching, clinical supervision and facilitation and support for revalidating doctors. Not all non-clinical staff had had an appraisal within the last 12 months due to there not being a Practice Manager in post until mid 2015.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and limited in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred to another service, or after they were discharged from hospital. We were told that multi-disciplinary team meetings took place irregularly, with the last meeting held in June 2015.

Consent to care and treatment

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

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or surgery nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

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

- These included those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service within the community
- Smoking cessation advice was available within the practice and from local support groups.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice's uptake for the cervical screening programme was 90%, which was higher than the national average of 82%.

Childhood immunisation rates for the vaccines given were above average in comparison comparable to the CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 70% to 90% and five year olds from 65% to 93%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

Of the nine patient Care Quality Commission Comment Cards we received, the majority were positive about the service experienced. Patients said they felt the surgery offered a good service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the Patient Participation Group. They also told us they were satisfied with the care provided by the surgery and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2015 showed patients felt they were treated with compassion, dignity and respect. Of the 265 forms distributed, 106 were returned. The surgery was above similar average for its satisfaction scores on consultations with the nurses. For example:

- 80% said the GP was good at listening to them compared to the CCG average of 85% and the national average of 88%.
- 89% said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 95%.
- 80% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average 80% and the national average of 85%.
- 94% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and the national average of 90%.
- 95% said they found the receptionists at the surgery helpful compared to the CCG average of 84% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. All but two patients we spoke to told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also generally positive and aligned with these views.

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

- 78% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and national average of 86%.
- 81% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 76% and the national average of 81%.
- 90% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 79% and the national average of 85%.

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

Patient and carer support to cope emotionally with care and treatment

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

On the day of the inspection the practice's computer system was unable to identify if a patient was also a carer. A subsequent list received from the practice after the

Good

Are services caring?

inspection, identified twenty eight patients as carers. This figure equates to one percent of the patient list. Written information was available to direct carers to the various avenues of support available to them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had some engagement with the NHS England Area Team and Clinical Commissioning Group with a view to improving services provided to its patients (CCG). The practice however had not reviewed the needs of its local population. The inspection team asked for evidence that a review had been conducted in the past, but was not provided with any.The practice offered an electronic check-in system for patients arriving for their appointment in two languages – English and Turkish. The lead Partner of the practice had recently commenced learning Turkish and a number of the non-clinical staff spoke a second language.

- The practice offered extended hours surgery on a Monday and Wednesday evenings until 7.00pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who were not able to attend the practice.
- Same day emergency appointments are available for children and those with serious medical conditions.
- There are disabled facilities, a hearing loop and translation services available.
- There was no regular access to a female GP, but the inspection team were told that efforts had been made to recruit

Online consultations via Skype are available to patients who have registered with the practice for this service.

Access to the service

The surgery was open between 8:00am and 7:00pm Monday to Friday. Appointments were from 8:30 to 11:00 am every morning and 5:00pm to 6:30pm daily. Emergency appointments were available between 11:00am and 12:00pm Mondays to Fridays, followed by telephone consultations between 12:00pm and 12:30pm Mondays to Fridays. Extended surgery hours were offered between 6:30pm and 7:00pm Mondays to Wednesdays. In addition to pre-bookable appointments that could be booked in advance, the surgery also offered online consultations via Skype to patients who had registered with the surgery for this service.

Results from the National GP Patient Survey published in July 2015 showed that patient's satisfaction with how they could access care and treatment was above the local and national averages.

- 84% of patients were satisfied with the surgery's opening hours compared to the CCG average of 74% and national average of 75%.
- 81% patients said they could get through easily to the surgery by phone compared to the CCG average of 67% and the national average 73%.
- 73% patients said they always or almost always see or speak to the GP they prefer compared to the CCG average of 53% and the national average of 60%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them, but that once in the surgery for their appointment, appointment times would not always run to schedule.

Listening and learning from concerns and complaints

The surgery had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the surgery.
- Whilst there was no written information was available within the surgery to help patients understand the complaints system, a poster at the Reception Desk informed patients that they should ask for the Practice Manager if they wish to make a complaint.

We looked at one complaint received in the last 12 months and observed that the complaint was dealt with in an open, transparent and satisfactory way. All details regarding the complaint had been logged in the Complaints folder, along with times and dates when the Practice Manager spoke verbally to the complainant. All written correspondence between the practice and the complainant had been dated and logged in the folder. Lessons were learnt from concerns, complaints and action was taken as a result to improve the quality of care.

Patient concerns were noted and acted upon. For example, there had been a number of concerns raised by patients regarding the lack of available telephone lines when

Good

Are services responsive to people's needs?

(for example, to feedback?)

attempting to make a morning appointment on the telephone. As a result of these concerns being raised, the practice installed another telephone line to help patients to make appointments by telephone in a timely manner.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

Bush Hill Park Trinity Surgery has experienced changes in personnel, primarily a change in partnership, resulting in the current partners joining in late 2014 and 2015. The new Practice Manager joined the practice in June 2015. The Partners told us they were keen to keep all existing members of staff as the practice had gone through changes. It was important to them to have patients come to the practice and recognise members of staff, as this was essential to the continuity of care for patients.

The practice had a vision to deliver high quality care and promote good outcomes for patients. The practice had a Mission Statement which had been composed by one of the partners. However, there was little evidence that the practice had a robust strategy and there were no supporting business plans to monitor whether the practice's Mission Statement was being adhered to.

Governance arrangements

he practice had a minimal governance framework to support the delivery of good quality care. Although this framework was minimal, it ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff

The practice had a business continuity plan in place but it did not address for major incidents such as power failure or building damage. On the day of the inspection, the inspection team saw no evidence that emergency contact numbers for staff was held centrally outside the practice premises. The inspection team was told that the practice telephone number can be diverted to the practice mobile phone. In the event of the practice being unable to open, patients arriving at the practice would be advised to attend their local Accident and Emergency (A&E) department. If there was an electrical failure at the practice, appointments could still continue as the appointment list for the following day is printed out the previous evening. The practice has manual patient records on site and these would be annotated accordingly to reflect that a patient had been seen. Subsequent to the inspection, the inspection team received some evidence that a provisional reciprocal arrangement had been made by a previous partner with another local practice to work from their premises in the event of the practice not being able to open. The provisional arrangement had been drafted in 2014 and no further discussion on this arrangement had been documented or updated by the current partners.

However there was no evidence of:

- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- Arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, the practice did not have policy on what to do in the event of a emergency, whether it be a clinical or non-clincal emergency.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The partners told us they were keen to keep existing staff as the practice had experienced personnel changes during the last two years. To have patients come to the practice and recognise members of staff was important for the continuity of care for patients. One of the partners within the practice is the current chair of the Enfield GP Healthcare Network.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept records of all written correspondence received and sent relating to unintended incidents.

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

- Staff told us the practice held regular team meetings.

Are services well-led?

Requires improvement

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

- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients and staff

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

- The practice had started to gather feedback from patients through the Patient Participation Group (PPG) and complaints received. The current Practice Manager (who commenced her role in June 2015) has been active in trying to recruit new members of all ages to the Group. Although in its infancy, the PPG has made suggestions to the practice which the practice has reviewed and implemented. One such suggestion has been to change the Practice voicemail message to advise patients where they can go to for out of hours care.
- The practice gathers feedback from staff through staff meetings and ad hoc discussions. Staff meetings took place monthly and staff told us they felt comfortable with colleagues to give feedback and discuss any concerns or issues. Staff told us they felt involved and engaged to improve how the practice was run.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered person did not do all that was reasonably practicable to assess, monitor, manage and improve the quality and safety of the services provided in the carrying on of the regulated activity.** **They had failed to identify the risks associated with the lack of a business continuity plan, not conducting regular clinical audits and re-audits and not conducting in-house infection control audits.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of users.** **They failed to identify risks associated with by not having a supply of oxygen on the premises, by not having regular fire drills and identifying a designated lead as a point of contact within the practice should a fire occur, by not having all electrical appliances at the practice tested to ensure they were fit for use. In addition, the registered person did not share with all practice staff, reviews and outcomes of reviews.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Requirement notices

The registered person did not do all that was reasonably practicable to ensure staff received such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

They failed to ensure that staff had regular performance reviews.