Dr Dineshwar Prasad

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

We carried out an announced comprehensive inspection at Dr Dineshwar Prasad on 20 January 2015. Overall the practice is rated as requires improvement.

We found the practice required improvement in providing a safe, effective and well-led service but was good at providing a caring and responsive service. In addition the practice required improvement for providing services for the six population groups; 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 and People experiencing poor mental health (including people with dementia)

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

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses.
- Data showed patient outcomes were average for the locality.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments usually available the same day.
- Fifty eight percent of patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice did not hold regular governance meetings but clinical issues were discussed at ad hoc meetings.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

The areas where the provider must make improvements are:

- Ensure the leadership structure operates effectively to ensure governance arrangements are effectively monitored to identify risk and deliver all improvements.

Summary of findings

- Ensure a safe and effective system is in place for the processing of patient test results.
- Ensure safeguarding processes are effective and known by all staff.

In addition the provider should:

- Improve the effectiveness of practice meetings ensuring all staff are involved.
- Ensure all staff who act as a chaperone to patients are suitably trained.
- Ensure arrangements are in place for the clinical supervision and annual appraisal of the practice nurse.
- Ensure there is a formal risk assessment in place to cover incidents of hypoglycaemia and epileptic seizure.
- Ensure all staff have an appropriate working knowledge of the Mental Capacity Act 2005 and consent.
- Ensure patient consultations are always conducted in private.
- Ensure the Legionella risk assessment covers all appropriate checks.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure formal arrangements are in place for access and use of an automated external defibrillator (AED).
- Ensure information available to patients on the practice website is relevant to those patients living in England.
- Ensure care plans contain all relevant information such as the patients health goals, future treatment plans and any specific care needs.
- Ensure all staff receive appropriate training in the use of the practice computer system to demonstrate competence in the recording and location of electronic documents as appropriate to their role and responsibilities.

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 practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However the practice did not have safe systems in place to ensure that learning from incidents were systematically shared and discussed with staff. The practice did not have a safe and effective system in place for the review and actioning of test results. In other respects the practice had systems and processes in place to monitor and identify risk.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Clinical staff kept up to date with current best practice guidance, and accessed guidelines from NICE. Data showed patient outcomes were at or below average for the locality. Clinical audit was being used to improve outcomes for patients. Multidisciplinary working was taking place. The practice nurse had not received an annual appraisal for the clinical aspects of their role. The practice did not have an effective system in place for the review and actioning of test results.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff maintained confidentiality and treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

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 that the practice responded quickly to issues raised.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had proactively sought feedback from patients and had an active patient participation group (PPG). Staff told us they received regular performance reviews and felt supported. The practice had an overall vision to deliver high quality care. The practice manager and principal GP worked in partnership to monitor and improve the operation and performance of the practice. All staff we spoke with were clear about their responsibilities in relation to the overall vision of the practice. The practice had a number of policies and procedures to govern activity and clinical issues were discussed at ad hoc meetings.

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people for example the diagnosis rate for dementia was higher than the national average for the year ending 31 March 2014. The practice was responsive to the needs of older people offering longer appointments and home visits when needed and had engaged with other local practices to look at and plan the improvement of services for this patient group. The practice held a register of older patients who were identified as being at high risk of admission to hospital. Care plans for these patients contained basic information about the patients' medical history and current medication. We noted that although there was some limited information on the patients' current situation there was no information on their health goals, future treatments or their specific care needs. as the practice is relatively small, the principal GP was able to speak to bereaved relatives on the phone. The principal GP provided support to bereaved relatives if needed which included referrals to counselling services.

People with long term conditions

Requires improvement

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

The practice nurse took a lead role in chronic disease management, diabetes and COPD. Patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. We were told that patients who were at high risk of clinical deterioration and admission to hospital had anticipatory care plans in place. These plans included documented resuscitation wishes and were reviewed every three months.

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Families, children and young people

Requires improvement

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

We were told there were systems in place to identify vulnerable children however at the time of our inspection visit there were no vulnerable children on this register. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours and a telephone triage system operated for requested same day appointments. The premises were suitable for children and babies. We were told that the practice had regular joint meetings with health visitors for children under the age of five.

Working age people (including those recently retired and students)

Requires improvement

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

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice extended its opening hours to 7.30pm on Monday evenings and 7.00pm on Friday evenings.

People whose circumstances may make them vulnerable

Requires improvement

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

The practice held a register of patients with a learning disability, some of whom had received an annual health checks. Staff knew

Summary of findings

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

The number of patients with dementia on the practice's list was comparable with other practices in the local Clinical Commissioning Group. We were told the practice referred patients to the memory clinic and worked with the local care home managers and patients' families when completing care plans. The national data for year ending 31 March 2014 showed that the percentage of patients registered with the practice experiencing poor mental health who had a comprehensive care plan in the preceding year was above the national average. The practice referred patients experiencing poor mental health to psychological / counselling services via IAPT (Improving Access to Psychological Therapies).

Summary of findings

What people who use the service say

We received 40 completed Care Quality Commission (CQC) comment cards and spoke to eight patients on the day of our visit. Most patients were positive about the service they received.

Patients told us they felt clinical staff were very caring and administrative and reception staff were very helpful.

Patients confirmed consent was always sought by clinical staff before undertaking a physical examination or treatment and all consultations and treatments were carried out in the privacy of a consulting or treatment room. Patients were aware of their right to a chaperone.

Patients felt the repeat prescription process worked well. The most recent national patient survey data from July to September 2014, regarding patient satisfaction showed the practice had scored 58% for patients feeling involved in making decisions about their own care and 67% of patients felt the GP was good at explaining their treatment and results. Although both these results were below the clinical commissioning group (CCG) regional average most patients we spoke with and those who completed comment cards felt they were given sufficient information by the doctor or nurse in an accessible format regarding their condition. Patients said they felt involved in making a choice about their treatment options.

Areas for improvement

Action the service MUST take to improve

- Ensure the leadership structure operates effectively to ensure governance arrangements are effectively monitored to identify risk and deliver all improvements.
- Ensure a safe and effective system is in place for the processing of patient test results.
- Ensure safeguarding processes are effective and known by all staff.

Action the service SHOULD take to improve

- Improve the effectiveness of practice meetings ensuring all staff are involved.
- Ensure all staff who act as a chaperone to patients are suitably trained.
- Ensure arrangements are in place for the clinical supervision and annual appraisal of the practice nurse.
- Ensure there is a formal risk assessment in place to cover incidents of hypoglycaemia and epileptic seizure.
- Ensure all staff have an appropriate working knowledge of the Mental Capacity Act 2005 and consent.
- Ensure patient consultations are always conducted in private.
- Ensure the Legionella risk assessment covers all appropriate checks.
- Ensure recruitment arrangements include all necessary pre-employment checks for all staff.
- Ensure formal arrangements are in place for access and use of an automated external defibrillator (AED).
- Ensure information available to patients on the practice website is relevant to those patients living in England.
- Ensure care plans contain all relevant information such as the patients health goals, future treatment plans and any specific care needs.
- Ensure all staff receive appropriate training in the use of the practice computer system to demonstrate competence in the recording and location of electronic documents as appropriate to their role and responsibilities.

Dr Dineshwar Prasad

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 advisor and an Expert by Experience who were granted the same authority to enter registered persons' premises as the CQC inspector.

Background to Dr Dineshwar Prasad

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before.

Dr Dineshwar Prasad is a single location practice which provides primary medical services through a Primary Medical Services (PMS) contract to approximately 2,700 registered patients in the Haringey area of North London. The patient population groups served by the practice include a cross-section of socio-economic and ethnic groups. Staff said many patients registered with the practice were from a Somalian, Jamaican, Greek, Turkish and East African background. There is a transient patient population of approximately 20 - 25 patients joining and leaving the practice each month.

The practice team was made up of a (male) GP undertaking six sessions a week, a (female) salaried GP undertaking 3 sessions a week and a (female) practice nurse who worked 15.5 hours a week. The team also included a full time practice manager, administrative and reception staff.

Dr Dineshwar Prasad provides the regulated activities; Diagnostic and screening procedures and Treatment of disease, disorder or injury. Dr Dineshwar Prasad is not a training practice.

The practice opening hours are:

8:30am – 7:30pm Monday

8:30am – 6:30pm Tuesday

9:00am – 2:00pm Wednesday

8:30am – 6:30pm Thursday

8:30am – 7:00pm Friday

GP appointments are available:

9:00am – 7:30pm Monday

9:30am – 6:30pm Tuesday

10:30am – 2:00pm Wednesday

9:30am – 6:30pm Thursday

9:30am – 7:00pm Friday

Extended hours operate Monday and Friday evenings. The practice is part of an 11 practice central collaborative which operates a Saturday service between 10am and 12noon for all patients across the 11 practices. A separate organisation provides an out-of-hours service for the practice's patients.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 January 2015. During our visit we spoke with a range of staff, two GPs, a practice nurse, the practice manager, six receptionist / administrators and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed CQC patient comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We were told that all staff received National Patient Safety Alerts via their electronic system. The clinical commissioning group (CCG) medicines management team sent the practice alerts and updates regarding any major medicine concerns. The practice manager told us that they were responsible for ensuring that all alerts were highlighted with the clinical staff, and any actions were then initiated by the principal GP.

Incidents and significant events had been recorded and learning had been identified from these. We were told by staff that these were discussed in practice meetings, however meeting minutes did not reflect this.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. However the principal GP was unable to explain the significant event policy or give an example of a recent significant event.

We looked at the records of significant events that had occurred between 29 September 2014 and 19 January 2015. Although these had been appropriately recorded and actions and learning points had been identified, the practice was unable to demonstrate that significant events had been shared and discussed with all staff. We looked at the five significant events which had been recorded and tracked these against the four corresponding practice meeting minutes and the ad hoc clinical meetings/ discussions between September 2014 and January 2015 but found these had not been discussed. The salaried GP told us that they could access relevant information about significant events on the practice intranet and that they discussed these with the principal GP and practice manager as appropriate, however they were not aware of an unexpected death in the community of a registered patient which had been recorded as a significant event in December 2014. We noted that the learning implemented from this significant event was recorded as discussed with other clinicians.

We looked at the practice meeting minutes dated for the last four months and found that although the complaints process had been discussed in December 2014, there was no evidence to demonstrate that the six complaints which had been received during this time had been discussed to promote learning. We noted and the practice manager confirmed, that practice meetings did not include any standing agenda items.

Reliable safety systems and processes including safeguarding

We looked at training records which showed that all staff had received relevant role specific training on safeguarding vulnerable adults and children within the last 12 months. Non-clinical staff had received child protection Level 1 or 2 and clinical staff Level 3. Staff knew how to recognise signs of abuse in vulnerable adults and children and all non-clinical staff were aware of their responsibility to report any concerns to the practice lead.

The principal GP was the lead for safeguarding vulnerable adults and children. They had received training in safeguarding vulnerable adults and Level 3 child protection. Although clinical staff said they would pass on any concerns, they were less clear on who was the allocated lead for the practice and what the formal reporting procedure was.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. We spoke to the principal GP about child protection and we were told that the practice did not have any children currently on the at-risk register. The GP said information was shared between the practice, social services and the health visitor as needed. Meetings were held at the practice with the health visitor every six weeks where any child safety concerns would be raised.

There was a chaperone policy, but it was unclear how consistently this was used by clinical staff. Some staff said they always offered a chaperone and another said they did not routinely offer a chaperone as patients knew them. (A chaperone is a person who acts as a safeguard and witness

for a patient and health care professional during a medical examination or procedure). Clinical staff said verbal consent was requested when a chaperone was offered or used but this was not recorded. We were told that reception staff were used as chaperones and we saw a Disclosure and Barring Service (DBS) check had been undertaken for these members of staff. Although staff who acted as a chaperone had varying levels of understanding of their role and responsibilities, none had received any formal training.

A chaperone notice was on prominent display in the waiting area of the practice, however this was only available in English.

The practice had a system in place to identify those patients who did not attend appointments. It was unclear however how follow up appointments were initiated and who took the clinical lead in this.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential electrical power failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of ad hoc clinical meetings which demonstrated that the practice took account of prescribing advice and changes to medicines management protocols.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that the nurse had received appropriate training to administer vaccines such as yellow fever.

There was a system in place for the management of high risk medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurse was the lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The training matrix recorded that all staff had received infection prevention and control training in November 2014. We saw evidence that the lead had carried out an infection control audit for each of the last two years and that improvements identified for action had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons, goggles and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. However we noted that hand get was not available in the vicinity of the patient self check in electronic touch screen.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice had undertaken their own legionella risk assessment in November 2012 and concluded that the likelihood of occurrence was low as the practice manager said the practice did not have a stored water or air conditioning facility. There were records available that demonstrated that all taps were checked for water flow

each week which staff told us was to reduce the risk of stagnant water. There was however no evidence that water temperatures were tested to ensure the Health and Safety Executive (HSE) recommendations were followed.

Equipment

Staff we spoke with told us that they had the equipment necessary to enable them to carry out diagnostic examinations, assessments and treatments. Records evidenced the calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, the fridge thermometer, nebuliser and pulse oximeters had been undertaken annually. We were told by the practice manager that all portable electrical equipment was routinely tested. The certificate on file was valid until 02/12/14 with the next retest planned for March 2015.

Staffing and recruitment

Records we looked at contained evidence that most of the appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification and criminal records checks through the Disclosure and Barring Service (DBS). However, not all records contained references and although we could see that references had been requested, those that had not been received had not been followed up. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. However this is not always being followed, as noted above.

The practice had arrangements in place to ensure the number and skill mix of staff was sufficient to meet patients' needs. The practice manager told us that administrative staff covered each other's annual leave and where needed locum and agency staff were arranged to cover for the nurse and GPs.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager informed us that they had access to locum staff should the need arise.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice manager was the allocated lead for health and safety and took responsibility for annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that risks had been discussed at a practice meeting in December 2014 which included the correct procedures to follow for both staff and patient safety.

We were told by the practice manager that patients who were at high risk of clinical deterioration and admission to hospital had anticipatory care plans in place to map out for patients and clinicians across other services what to do if they became unwell. We were told that these plans also included documented resuscitation wishes and were reviewed every three months. We were also told that the practice uses 'Coordinate my care' for patients receiving palliative care. (Coordinate my care is a system for recording patients' wishes regarding their care which is electronically available to other appropriate care services). However we were told that the practice had no palliative care patients at the time of our inspection visit.

All staff we spoke with understood their roles and responsibilities, however the system in place for the review and actioning of test results was inadequate and needed to be reviewed. We looked on the computer system and found a number of test results showing as 'not viewed' or 'not actioned' between 22 December 2014 and 17 January 2015. We noted that one of these was an abnormal result for an older patient with anaemia. The GP responsible for all test results who worked three sessions a week said it was sometimes unclear if incoming results which had been received in their absence had been looked at and/or actioned. We found no evidence that this had been addressed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Requires improvement

Are services safe?

Emergency equipment was available including access to oxygen. The practice did not have an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency), however a risk assessment was in place dated November 2014. This stated that an agreement was in place with another practice to share their defibrillator. We discussed this with the practice manager who said that since November, the practice had consulted with the local Clinical Commissioning Group (CCG) and the central GP collaborative in Haringey (a group of 11 GP practices which work together to meet the needs of patients and share good practice). We were told that the practice had decided to purchase their own defibrillator in the near future.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and bacterial meningitis. We were told that the practice did not routinely hold stocks of medicines for the treatment of hypoglycaemia or epileptic seizure. The practice protocol was to offer a sweet drink for hypoglycaemia and to call an ambulance in the case of an epileptic seizure. The practice nurse who was responsible for emergency medicines said this had been discussed with the GPs but there was no formal risk assessment in place. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in August 2014 that included actions required to maintain fire safety. All staff had completed an online fire training course and they were aware of their responsibilities and the evacuation procedure.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nurse stated that they were familiar with and kept up to date with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of meetings where new guidelines had been disseminated, the implications for the practice's performance and the impact on patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurse that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We were told that the GPs and practice nurse specialised in clinical areas such as diabetes, heart disease family planning, chronic obstructive pulmonary disease (COPD) and asthma, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice manager told us that data from the local clinical commissioning group (CCG) for the practice's prescribing of antibiotics showed they were comparable with similar practices in the CCG (the NHS monitors this data as part of their policy to reduce the amount of antibiotic prescribing to maintain the medicines effectiveness). The practice manager acknowledged that figures could be better and said that the practice was working on reducing this further.

The practice used computerised tools to identify patients with complex needs and those with high blood pressure. We were told that these patients received regular reviews and had a care plan in place.

We were told by the GPs that they each made their own referrals to secondary services, such as smoking cessation services, dieticians, hospitals, drug and alcohol support services and the local IAPT (Improving Access to Psychological Therapies) service. We saw evidence that the salaried GP referred patients appropriately, for example using the two week wait cancer patient system which guarantees people with symptoms which could be caused by cancer are seen within two weeks. The principal GP told us that they tasked the medical secretary to make their referral requests. The practice manger maintained a log of all the referrals the practice made and reviewed this log on a monthly basis to ensure referrals were being made in line with agreed referral pathways and in a timely way.

We were told that letters concerning hospital discharges were received twice weekly both electronically and by post and any changes to medication were actioned on the day received.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice showed us three clinical audits that had been undertaken during 2014. One of which was a completed two cycle audit which related to atrial fibrillation (a heart condition which causes an irregular and often abnormally fast heart rate). Following the audit, all patients diagnosed with atrial fibrillation had been reviewed and advised regarding the need to start anticoagulant therapy.

We spoke to the salaried GP who told us about an audit they had undertaken regarding emergency contraception. They were able to tell us about the process they had undertaken and their plan for re-audit.

The practice used the information collected for the quality and outcomes framework (QOF) to monitor and manage patient outcomes. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We examined the practices' QOF data for 2013/14. This indicated that the practice had a lower than expected take up for cervical smear tests at almost 10% below the national average; a lower than expected take up for influenza immunisations for patients

with diabetes at 17% below the national average; and a lower than expected ratio of reported prevalence for chronic obstructive pulmonary disease (COPD) which was 24% against 62% for the national average.

The practice manager told us that 6% of the patient population had been identified as having diabetes, and 75% of those identified had received an annual flu jab during 2014/15.

We saw minutes from the monthly Central Collaborative meetings, attended by 11 local practices and a representative of the CCG which showed the practices' QOF data had been discussed. For example, the practice's performance for antibiotic prescribing put them in the midrange for all practices within their CCG.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

We were told that the practice held multidisciplinary meetings which included where needed palliative care nurses to discuss the care and support needs of end of life patients and their families. The practice did not have any patients in receipt of end of life care at the time of our inspection visit.

The practice manager said the practice participated in local benchmarking. The practice was part of an 11 practice collaborative which met on a monthly basis to discuss local needs and compare local data. Benchmarking is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with mandatory training such as annual basic life support.

Both GPs were up to date with their yearly continuing professional development (CPD) requirements. Both GPs had been appraised in 2014. One had recently been revalidated and the other had a revalidation date for the end of January 2015. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All other staff undertook annual appraisals that identified learning needs from which action plans were documented. We were told by the practice manager that they also undertook the appraisal for the practice nurse. The practice manager recognised that they were not qualified to appraise the clinical aspects of the nurses work.

The practice nurse was expected to perform defined duties and they were able to demonstrate that they were trained to fulfil these duties. In addition they specialised in and held regular clinics for chronic disease management, asthma, diabetes and chronic obstructive pulmonary disease (COPD).

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. The practice received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a protocol outlining the responsibilities of all relevant staff in the administration and actioning of all correspondence, reports and test results relating to patient care. We noted however that there were no time scales identified for the completion of these tasks and not all results had been actioned in a timely manner.

The practice was commissioned for the new enhanced service 'avoiding unplanned hospital admissions' (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). As part of this service the practice had set up a process to follow-up on patients discharged from hospital to ensure timely coordination and delivery of care.

The practice participated in monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with multiple long term or chronic conditions. These meetings were attended by the community nursing team, social workers, palliative care nurses and consultants from local hospitals. Decisions

about care planning were documented in a shared care record which staff felt worked well. Staff also remarked on the usefulness of the forum as a means of sharing important information.

In addition the practice met with the health visitor every four to six weeks to discuss any concerns for children under five years of age who were registered with the practice.

We were informed that a representative from the CCG medicines management team visited the practice several times a year to advise on prescribing practices and undertake medicines audits, for example on the prescription of antibiotics.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and a small number of practice patients used the Choose and Book system for their hospital referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patient care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We asked the clinical staff about the Mental Capacity Act 2005 and their duties in fulfilling it. One staff member was unable to demonstrate sufficient understanding in this area to fulfil their role effectively, however others had a good understanding of their responsibilities and were able to give examples which they could evidence.

Clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

The practice had various policies and protocols on consent. We saw a consent form relating to medical treatment, immunisation, investigation or operation and another for adults who lack capacity to consent to investigation or treatment. The practice nurse and the salaried GP were able to show where they had recorded patient consent on the electronic patient record. The principal GP however seemed less aware of the practice's consent policy and said written consent was only obtained for injections. They were unable to show us any patient record where they had sought or been given patient consent, such as before an intimate examination of a female patient. The GP said they rarely carried out intimate examinations and would usually refer female patients requiring intimate examinations to the female doctor.

Health promotion and prevention

In response to the health needs of the local area which had been identified by the Joint Strategic Needs Assessment (JSNA) the Clinical Commissioning Group (CCG) for Haringey had set up a 'Central Collaborative' of 11 GP practices of which Dr Prasad's practice was one. The information provided by the JSNA is used to help focus health promotion activity.

The practice met monthly with members of the collaborative to discuss issues such as older patients' care, child obesity and support for people experiencing poor mental health. The collaborative had developed programmes to promote local health care services including a Saturday morning clinic. The practice had also identified 11 patients who were over seventy five years of age and on ten or more medicines to take part in a collaborative pilot scheme to regularly monitor and improve their care. For this scheme a nurse practitioner had been employed to undertake home visits for blood tests, foot and health checks and a pharmacist had been appointed to review their repeat prescription medicines.

It was practice policy to offer a health check with the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The GPs used their contact with patients to help maintain or

Requires improvement

Are services effective?

(for example, treatment is effective)

improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients and referring people experiencing poor mental health to the local community mental health team, smokers to a smoking cessation service, and those in need of sexual health services to the local genitourinary medicine clinic.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that only 14.3% of eligible patients within this age group had received a health check during 2014 - 2015. This compared with the average take up of 45% for 2014 – 2015 within Haringey.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. At the time of our inspection visit eight out of 17 patients registered with a learning disability had received an annual health. The practice had until 31 March 2015 to ensure the remaining nine patients received an annual health check.

Similar mechanisms for identifying 'at risk' groups were used for patients who were obese. The practice held a register of 269 patients identified as obese. We were told that these patients were referred to 'active for life' a local weight management service, dieticians and exercise clinics for additional support.

The practice's performance for cervical smear uptake was 70%, which was comparable with others in the CCG area although lower than the national average. There was a policy to telephone and send text reminders for patients who did not attend for cervical smears. There was also a named nurse responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, flu vaccinations and travel vaccines including yellow fever in line with current national guidance. We noted that although the practice website had a link under their services and clinics page to a travel clinic website, this was based in the United States and therefore the clinics a patient would be directed to were aimed at people living in America. Last year's Quality and Outcomes Framework (QOF) performance for all childhood immunisations was above average for the CCG and non-attenders were followed up by the practice nurse.

The practice held a register of older patients who were identified as being at high risk of admission to hospital. Older patients had a named GP and we were told that 3% of the practice population were over 75 years of age. We looked at a selection of care plans in relation to this patient group. The practice used a standard care plan template and had included basic information about the patients' medical history and current medication. Although there was some limited information on the patients' current situation there was no information on their health goals, future treatments or their specific care needs.

The practice had identified 2% of their patient population who were vulnerable, such as those at high risk of attendance at accident and emergency, those in receipt of dementia care and those with a learning disability. We were told that care plans were in place for all these patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Reception staff were always polite and this was confirmed on the CQC patient comment cards which we received.

We noted from our observations that patients were treated with respect, dignity, compassion and empathy. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a notice in reception stating that there was a room available for private conversations. We did note however that despite the discretion of office staff, it was possible to overhear the callers' conversation on the telephone.

The practice is relatively small and many patients were known by their first names and seemed comfortable with this. There was a welcoming and friendly atmosphere at the surgery. The practice manager also acted as the dignity champion to ensure patients and staff were treated with dignity and respect.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed comment cards the majority of which were positive about the service. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring. All felt they were treated them with dignity and respect. Seven comments were less positive, most of which related to appointment waiting time. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in the consulting and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We were told however by some patients that doors were not always closed during consultations.

We viewed the most recent data for the practice on patient satisfaction. This included information from the national patient survey, and the practices' own patient questionnaire completed by 20 patients in January 2014. Data from both these sources showed patients were generally satisfied with how they were treated, with 92% rating their overall satisfaction with the practice as good or above. Specific data from the national patient survey 2013/14 showed that 81% of patients rated their overall experience of the practice good or very good. However 58% patients said they would recommend the practice, which put the practice in the bottom 25% nationally of this rating.

Staff told us that if they had any concerns, observed any discriminatory behaviour or instances of patients' privacy and dignity not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. Practice meeting minutes evidenced that the complaints process had been discussed but there was no evidence to demonstrate learning from these.

The practice had a policy of zero tolerance for abusive behaviour, which was displayed on their website and within the practice.

We were told by staff that patients whose circumstances may make them vulnerable, such as those with a learning disability, the homeless and those experiencing poor mental health were able to access the practice without fear of stigma or prejudice. Staff said they would treat people from these groups in a sensitive manner. The training matrix showed that all staff had received training on how to deal sympathetically with all population groups.

Care planning and involvement in decisions about care and treatment

We looked at the most recent data from NHS choices. This showed that the practice had the lowest percentage score of the 11 practices within their collaborative in the following areas; 'explanations of tests and treatments' and 'involved in decision making by the GP'. The practice scored 63.7% and 55.9% respectively against the highest scores in the collaborative of 89.4% and 84.8%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Good

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the treatment they wished to receive. Patient feedback on the comment cards we received confirmed these views.

Staff told us that an on-line translation service was available for patients who did not have English as a first language and this information was shown on the practice website. The practice manager told us that this service had rarely been used as patients usually brought a family member with them, however they had recently re-engaged with this service. We were told that several different languages were spoken among the staff team and the practice had an electronic self check-in screen with twenty three relevant community languages available.

Patient/carer support to cope emotionally with care and treatment

We were told that the care provided by the practice often extended to emotional and psychological support for patients and their families during illnesses and life changing events. The practice referred patients to psychological therapy, bereavement counselling, and worked closely with the palliative care team when appropriate.

Notices in the patient waiting room and on the practice website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

The practice manager said that as the practice is relatively small, the principal GP was able to speak to bereaved relatives on the phone. They also attended funerals of patients and provided support to bereaved relatives if needed. We saw a letter template which the practice had recently introduced to send to recently bereaved families which offered condolences and information on support services. Family members were encouraged to arrange an appointment to see the GP to discuss issues around bereavement, such as sleeping difficulties and where to obtain further support such as counselling services and the Citizens Advice Bureau.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Most patients we spoke with who had been bereaved confirmed they had received this type of support and said they had found it helpful.

Staff also said that the size of the practice and the length of time the principal GP had been operating from the practice provided continuity of care for patients and reassurance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and prioritising service improvements.

In response to the health needs of the local area which were identified by the Joint Strategic Needs Assessment (JSNA) the Clinical Commissioning Group (CCG) for Haringey had set up a central collaborative of 11 GP practices of which Dr Prasad was one. The information provided by the JSNA is used to help focus health promotion activity.

The collaborative has developed programmes to promote local health care services including a Saturday morning clinic and a review of people over seventy five years of age who are on ten or more medications.

The practice meets monthly with other members of the collaborative to discuss issues such as smoking cessation, cytology and housebound patients. We saw minutes of meetings where these issues had been discussed and actions agreed to implement service improvements and manage delivery challenges to the patient population.

The practice had responded to feedback from the patient participation group (PPG). For example we were told by a member of the PPG that they believed the group had been instrumental in getting the practice to provide extended surgery hours. The practice had also implemented changes to the way it delivered services, such as the implementation of telephone consultations after patients expressed difficultly in securing emergency appointments.

We were told that the practice had held education sessions for those patients who had diabetes and fasted during Ramadan to help them manage their condition and avoid admission to accident and emergency departments during fasting.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services and staff members spoke a number of languages between them.

The training matrix showed that most staff had received equality, diversity and human rights training.

The practice was situated on the ground floor with a fully accessible toilet available for those patients with a physical disability or wheelchair users. A baby changing facility and automatic hands free taps had been installed.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

We spoke to staff about the practices' provision for homeless people. We were told that the practice did not have a register of homeless people and were not proactive in engaging this patient group, but would refer homeless people to other agencies such as social services. They said that homeless people could use the practice address and be temporarily registered if required.

Access to the service

Appointments were available from 9:00am – 7:30pm Monday, 9:30am – 6:30pm Tuesday and Thursday, 10:30am – 2:00pm Wednesday and 9:30am – 7:00pm Friday.

Comprehensive information regarding appointments was available to patients on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an automated message gave the telephone numbers they should ring depending on the circumstances.

An online booking system was available at the practice, alternatively patients could telephone or call in person to make an appointment. Patients could request repeat prescriptions on line, in person or by post.

Appointments were available outside of school hours for children and young people and extended opening hours were available for working age people.

We were told that home visits were available for patients over the age of 75, or those who were housebound. Longer appointments patients were available for those patients

Good

Are services responsive to people's needs?

(for example, to feedback?)

with a learning disability, those with long-term conditions and those experiencing poor mental health. Home visits were made to one local care home on a specific day each week, by a named GP and to those patients who needed one.

The practice's extended opening hours on Monday and Friday evenings was particularly useful to patients with work commitments and telephone consultations were available.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice, however some patients said they would like more appointments to be made available with a female GP.

We were told that the practice had introduced a telephone triage system to support families with young children and babies which enabled the practice to prioritise these patients and if necessary ensure appointments were given within 24 hours wherever possible.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedure was in line with recognised guidance and contractual obligations for GPs in England. There was a designated person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice website gave basic information on how to make a complaint and a complaints poster was on display in the reception/waiting area. In addition a comments and suggestions box was available at reception. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received four complaints in the last 12 months. We looked at the summary of complaints for 2014 and found they had been investigated, dealt with in a timely way and action and learning points had been identified as a result.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review, no themes had been identified and lessons learned from individual complaints had been acted on.

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

The practice had a statement of purpose which was to deliver high quality care and promote good outcomes for patients.

The practice vision and values were to offer an open, fair, respectful and accountable service to all patients and this formed part of their three year business plan. The practice had a written three year business plan dated January 2015 which included a statement about the practice vision and values. These were to offer an open, fair, respectful and accountable service to all patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and we were told that these were available to staff for downloading from a universal serial bus (USB) storage device which was given to all staff when they commenced work with the practice. We viewed a selection of these policies and procedures and saw that most of these had been reviewed within the last twelve months.

There were named members of staff in lead roles, for example, the nurse led on infection control and medicines management and the salaried GP led on patient test results. The principal GP was the lead for safeguarding vulnerable adults and children.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice was able to show us audits which had been undertaken. One was a completed clinical audit for Atrial Fibrillation. This audit had been undertaken in January 2014 in response to changes in NICE guidance and had been re-audited in September 2014. Another related to the prescribing of pregabaline for neuropathic pain patients and a third related to calcium and vitamin D therapy. These two audits had not yet been re-audited however so were not considered full two cycle clinical audits.

We spoke to the salaried GP about clinical audits and they told us that they had undertaken the first cycle of an audit relating to emergency contraception. They were able to describe the process they had undertaken to complete the audit and said they planned to re-audit to complete the clinical cycle.

The practice had arrangements in place for identifying, recording and managing risks. We viewed appropriate risk assessments which addressed a range of potential issues such as infection, fire and building damage.

The practice held monthly practice meetings and ad hoc clinical meetings. We looked at minutes from the last four meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

Most members of staff we spoke with were clear about their own roles and responsibilities. Staff we asked said they felt valued, well supported and knew who to go to in the practice with any concerns.

The principal GP was also the registered provider and was the named individual in day to day control of the practice. The practice manager led on all aspects of non-clinical practice which we found were well monitored and managed.

We saw from minutes that practice meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at these meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the disciplinary procedure and the induction policy which were in place to support staff. These were appropriate and had been reviewed. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had an active patient participation group (PPG) which had first been established in 2012, and we saw that this was actively promoted on a dedicated noticeboard in reception. We met with a representative of the PPG who told us that patients were empowered to contribute at meetings and were used appropriately as a

Are services well-led?

Requires improvement

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

'sounding board' for new ideas or proposed changes to the practice. The PPG met every six months and had 13 members which broadly represented the local patient population in terms of ethnicity and age.

The practice had gathered feedback from patients through patient surveys, a comments and suggestions box and complaints. The practice had also introduced the friends and family test (the friends and family test asks patients if they would recommend the practice to their friends and family). This information was available at the practice and on the practice website. We looked at the analysis of the last patient survey which had been undertaken by the practice in January 2014 which showed 92% of patients rated their overall satisfaction with the practice as good or above and 7% rated the length of time they had to wait to get an appointment as poor.

We looked at the latest results of the national patient survey (available on the NHS Choices website). This showed 95% of the practice respondents said the last appointment they got was convenient, this was 3.2% above the national average and 7% above the local clinical commissioning group (CCG) average. However only 91% of respondents had confidence and trust in the last GP they saw or spoke with, which was 2% below the CCG average and 1.2% below the national average

The practice had gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Although feedback from patients, public and staff had been sought by the practice manager, the principal GP was unaware of this.

The practice had a whistleblowing policy which was available to all staff, but some staff we spoke with were unaware of the specific purpose of a whistle blowing policy.

Management lead through learning and improvement

The practice manager and principal GP worked in partnership to monitor and improve the operation and performance of the practice. All staff we spoke with were clear about their responsibilities in relation to the overall vision of the practice. The practice had a number of policies and procedures to govern activity and clinical issues were discussed at ad hoc meetings.

Although significant events were recorded the practice was unable to demonstrate that appropriate learning had been shared and discussed with all staff. We asked the principal GP about the significant event policy but they were not able to tell us what this was or give any examples of recent significant events.

The salaried GP was the lead for test results and took responsibility for the reading and actioning of all patient results. We found a number of unread / unactioned results dating from 22 December 2014. There was no effective system in place to manage and monitor patient test results in the absence of the salaried GP.

Although the practice participated in local benchmarking and was part of an 11 practice collaborative which met on a monthly basis to discuss local needs and compare local data. The principal GP was unable to tell us how they performed against other practices locally.

Staff told us that the practice supported them to maintain their clinical professional development through training.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not established effective systems or processes to ensure good governance. This was a breach of regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider must establish and operate effective systems or processes to enable them to assess, monitor and improve the quality and safety of the services, identify and mitigate risks relating to the health, safety and welfare of service users and evaluate and improve practice in respect of these processes. Shortcomings in a number of systems were identified including staff awareness of safeguarding processes; staffing (chaperone training, practice nurse annual appraisal, working knowledge of the Mental Capacity Act 2005, pre-employment checks); and risk assessments (emergency medicines, Legionella). Regulation 17 (1) (2)

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care We found that the registered person had not protected people against the risk of receiving care and treatment which did not meet their needs. This was a breach of regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

The provider must ensure the care and treatment of service users is appropriate and meets their needs. The provider must ensure a clear and effective system is in place for the processing of patients test results. Regulation 9 (1)(a)(b)