

Dr Parvinder Garcha

Quality Report

77 Lampton Road
Hounslow
TW3 4JX
Tel: 0208 572 1497
Website:

Date of inspection visit: 22 June 2016
Date of publication: 24/03/2017

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Parvinder Garcha on 22 June 2016. Overall, the practice is rated as Requires Improvement.

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

- Several of the systems and processes to address risks to patients were not implemented well enough to ensure patients were kept safe. For example, sharing of safety alerts, vaccines management, recruitment, health and fire safety, emergency medicines and basic life supporting training.
- There was insufficient management capacity and a small amount of nursing provision which had an impact on monitoring safety at the practice. The practice had identified these as areas that needed to be strengthened. They also mentioned high staff turnover, information technology issues, financial insecurity and a high workload as developments areas.
- The practice had a number of policies and procedures to govern activity; however, not all staff were aware of the duty of candour or whistleblowing policy.
- Same day appointments were available but access to non-urgent appointments was not effective. The practice told us they had addressed this by adding in additional Saturday clinics when needed.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Patients told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Improvements were made to the quality of care because of complaints and patient feedback. The practice had commenced the Productive General Practice Programme designed to help them deliver high quality care and respond to patient needs, whilst meeting increasing levels of demand.
- There was no longer a patient participation group (PPG) set up in the practice however, patients had been nominated for the locality PPG. The practice strengthened efforts to set up a PPG in conjunction with the local Clinical Commissioning Group, and did so successfully after the inspection.

Summary of findings

- The GP was the homeless lead for the locality and worked together with the outreach nurse and homeless charities.

We saw an area of outstanding practice:

- The GP took the lead in coordinating end of life care and would visit patients while in hospital, including those out of the practice area, on a weekly basis to provide support to the patient and their family as well as to assist in complex discharge planning. For these patients the GP also delivered prescribed medicines for those unable to attend the pharmacy; stood in for carers when they were not available by assisting family members to undertake personal care tasks for an end of life patient. Arrangements had been made so that these patients could contact him directly during normal working hours and out of hours. We saw examples where the GP attended to ill patients in the early hours of the morning instead of the out of hours GP, to ensure they received continuity of care.

The areas where the provider must make improvements are:

- Implement effective governance arrangements including systems for assessing and monitoring risks. This includes ensuring systems are in place to effectively monitor recruitment and staffing levels, staff

and induction training as well as ensuring that that all staff are aware of the policies and procedures in place at the practice and up to date records are kept of practice meetings.

- Ensure care and treatment is provided in a safe way for service users. This includes the timely dissemination of safety alerts to all staff, effective infection control procedures, fire and health and safety as well as medicines management for vaccines and emergency medicines within the service.
- Ensure recruitment arrangements include all necessary employment checks for all staff.

In addition the provider should:

- Monitor and improve outcomes for patients in relation to areas of high exception reporting.
- Review and improve the provision of non-urgent appointments to improve patient satisfaction.
- Take steps to improve patient satisfaction with the care and treatment provided by the nursing staff.
- Provide practice information in appropriate languages and formats and ensure notices informing patients of translation services are clearly displayed in the reception areas or television screen.

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?

The practice is rated as requires improvement for providing safe services.

- Several of the systems and processes to address risks to patients were not implemented well enough to ensure patients were kept safe. For example, vaccines management, recruitment, health and safety, fire safety, and emergency medicines management and staff training in basic life support.
- There was insufficient management capacity and a small amount of nursing provision which had an impact on monitoring safety at the practice. The practice had identified these as areas that needed to be strengthened and they had implemented mitigating actions.
- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. When things went wrong, lessons learned were communicated widely to support improvement.
- Arrangements were in place to safeguard children and vulnerable adults from abuse.

Requires improvement



Are services effective?

The practice is rated as requires improvement for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were mostly higher than the national average in most areas. However, there was higher than average exception reporting in several clinical domains. The practice was aware of their performance and they explained possible reasons for areas that deviated from local and national averages.
- There was evidence of personal development plans for all staff however, appraisals were overdue as a result of staff shortages and induction training did not cover all key training including fire safety training.
- Multidisciplinary working was taking place but was generally informal and record keeping was limited.
- Clinical audits demonstrated quality improvement.
- Staff participated in the quarterly education and training meetings attended by the multidisciplinary team.

Requires improvement



Are services caring?

The practice is rated as good for providing caring services.

Good



Summary of findings

- Data from the national GP patient survey showed patient satisfaction scores were comparable to local and national average for several aspects of care. Where scores were below average, the practice acknowledged this and had action plans in place to improve patient experience at the practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. One example was when one of the GPs would conduct several home visits in the early hours of the morning for end of life patients whose families would contact him directly.
- Information for patients about the services was available but not everybody would be able to understand or access it. For example, there were no information leaflets available in different languages despite the large number of ethnic minority patients on the practice list.
- We observed that staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example, the lead GP was the homeless lead for the locality and worked collaboratively with the outreach nurse and two homeless charities.
- The practice's former nurse offered a voluntary befriending service whereby she would visit the practice's elderly vulnerable and dependant patients living alone. This service enabled patients to have ease of access to the GP and allowed them to live independently at home where they normally would have been in residential care.
- Dependent patients and/or their carers as well as healthcare professionals involved in their care had direct access to the GP on his mobile number and were able to contact him during working hours and out of hours. In some cases, the GP would conduct a home visit in the early hours of the morning to provide continuity of care.

Good



Summary of findings

- The practice offered ad hoc appointments at the weekend according to patient demand and would often extend their opening hours on a Wednesday to cater for emergency appointments. There was evidence of continuity of care and urgent appointments were available the same day.
- The practice 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 practice responded quickly to issues raised and encourage patient feedback. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

The practice is rated as requires improvement for being well-led.

- The practice had a number of policies and procedures to govern activity; however, not all staff were aware of the duty of candour or whistleblowing policy.
- Arrangements to monitor and improve quality and identify risk were not effective. For example, there were weaknesses in governance systems such as ineffective monitoring of safety procedures.
- The practice held regular staff meetings; however, there were no minutes of meetings. They told us after the inspection that they had started to keep meeting minutes.
- The practice had commenced the Productive General Practice Programme designed to help them deliver high quality care and respond to patient needs whilst meeting increasing levels of demand.
- There was no active Patient Participation Group (PPG) in place at the practice due to underlying staffing issues that had an effect on this; however, patients had been nominated for the locality PPG. The practice established a PPG after our inspection, in collaboration with their local Clinical Commissioning Group.
- The practice proactively sought feedback from staff and patients, which it acted on.

Requires improvement



Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The provider is rated as requires improvement for the care of older people.

- The practice's former nurse offered a voluntary befriending service whereby she would visit the practice's elderly vulnerable and dependent patients living alone. This service enabled patients to have ease of access to the GP and allowed them to live independently at home where they normally would have been in residential care.
- The GP would visit end of life practice patients in hospital on a weekly basis and this included those admitted into hospitals outside the area. Arrangements were made to allow these patients or their carers to be able to inform him on admission to hospital.
- The GP was also accessible out of hours when there were arrangements for patients, their carers or healthcare professionals to be able to contact him.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- Outcomes for conditions commonly found in older people were higher than local and national average. For example, the percentage of patients with atrial fibrillation who were currently treated with anti-coagulation therapy was 100%, compared to the local average of 99% and national average of 98%.

Requires improvement



People with long term conditions

The provider is rated as requires improvement for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients with diabetes on the register who had received flu immunisation in the last year was 98%, which was comparable to the local Clinical Commissioning Group and national average of 94%. Where diabetes outcomes were lower than the local and national average, the practice had taken steps to improve.
- They undertook a mobile diabetes check last year and worked jointly with the diabetes specialist nurse.

Requires improvement



Summary of findings

- Outcomes for other long term conditions were mostly higher than local and national averages. For example, the percentage of patients with asthma on the register who had a review in the last 12 months was 87%, compared to the CCG average of 76% and national average of 75%.
- There was continuity of care and all these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, there were arrangements to allow them to contact the GP directly.
- The GP would visit practice patients in hospital long-term, on a weekly basis and this included those admitted into hospitals outside the area.
- The GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Longer appointments and home visits were available when needed.

Families, children and young people

The provider is rated as requires improvement for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of attendances to accident and emergency services.
- Two of the GPs at the practice specialised in female health and contraception as well as child health development. Together with the lead GP, they undertook a joint and collaborative management of families with complex issues.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. For example, new birth letters were sent out to new parents advising them of developmental checks and immunisations.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the local Clinical Commissioning Group average of 78% and national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies. Children under 10 years of age received priority access to appointments.
- We saw positive examples of joint working with midwives and health visitors.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The provider is rated as requires improvement for the care of working age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified. The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, they offered early morning and late appointments and the GP occasionally offered a Saturday service in response to high demand of appointments.
- 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.
- Email and telephone consultations were offered by the practice with training available for all staff regarding telephone triage.

Requires improvement



People whose circumstances may make them vulnerable

The provider is rated as requires improvement for the care of people whose circumstances may make them vulnerable.

- The practice was responsive to the needs of homeless patients and there was collaborative working with two homeless charities. The GP was the lead for homelessness and worked closely with the homeless outreach nurse to provide care for homeless patients. Homeless patients were also referred to the practice for care.
- They held a register of patients living in vulnerable circumstances including those with a learning disability. These patients were also offered longer appointments.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. For example, they would have domestic violence guest speakers attend their practice meetings.
- The practice offered HIV testing and substance misuse care including alcohol.
- The premises were suitable for disabled patients with disabled access on the ground floor.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- The practice also offered their own befriending service facilitated by their retired practice nurse. This service allowed vulnerable and dependent patients ease of access to the GP and allowed them to live independently at home where they would have normally been in residential care.

Requires improvement



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 and out of hours.

People experiencing poor mental health (including people with dementia)

The provider is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients with dementia.
- The percentage of patients with mental health conditions whose alcohol consumption was recorded in the last 12 months was 100%, compared to the local Clinical Commissioning Group average of 91% and the national average of 90%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Requires improvement



Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016 and contains data collected between January-March 2015 and July-September 2015. The results showed the practice was not performing in line with Clinical Commissioning Group (CCG) and national averages. Four hundred and nine survey forms were distributed and 108 were returned and this represented approximately 3% of the practice's patient list.

- 65% of patients found it easy to get through to this practice by phone compared to the CCG and national average of 73%.
- 64% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 71% and national average of 76%.
- 79% of patients described the overall experience of this GP practice as good compared to the CCG average of 80% and national average of 85%.
- 71% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 74% and national average of 79%.

The practice demonstrated an understanding of these low scores and there was evidence that they were taking action to address this. The GP had attended courses aimed at improving patient satisfaction, involvement,

and experience. There was an action plan in place to use patient surveys in a regular and consistent way for all practitioners including reception staff. They were seeking the assistance of their local health watch to help them facilitate this and achieve an effective way of ensuring greater quality of care. The GPs were also participating in the 'Productive General Practice' programme which ran over nine months and contained different modules regarding quality improvement and practice procedures.

As part of our inspection, we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 24 comment cards, 21 of which were positive about the standard of care received. Patients said they felt the practice offered a good service and staff were helpful, considerate caring and treated them with dignity and respect. Three of the comment cards highlighted issues with access to appointments with the GP of their choice.

We spoke with 11 patients during the inspection. The majority of patients felt the practice provided a good service and the GPs were kind and compassionate. Patients also felt there was improved staff attitude and consultation times were sufficient. Some patients highlighted issues with the attitude of staff members.

Friends and family test results for April 2016 showed 93% of patients were likely to recommend the practice to friends and family.

Dr Parvinder Garcha

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 an Expert by Experience.

Background to Dr Parvinder Garcha

Dr Parvinder Garcha is a single-handed (single partner) GP located in Hounslow, Middlesex and holds a General Medical Services contract and is commissioned by NHS England, London. Dr Parvinder Garcha is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, family planning, maternity and midwifery procedures, surgical procedures and treatment of disease, disorder, or injury at the Hounslow Family Medical Centre.

The practice is staffed by one lead male GP and five sessional male and female GPs who provide a combination of 18 sessions. The practice also employs one practice nurse who works 21 hours a week and a healthcare assistant who works 16 hours a week. Also employed are seven reception and administration staff including two apprentice staff.

The practice is an established learning and teaching practice for medical students from two medical colleges. The lead GP is a lead member of the Clinical Commissioning Group (CCG) and is the homeless lead for the locality. He sits on the councils of members and inputs for his GP colleagues in the specifications for the out of hospital service for homeless persons. He is also the clinical supervisor for the homeless outreach nurse whom he

works closely with. Part of his volunteer work includes working for 'Crisis at Christmas' four times a year, a charity set up to provide support for the homeless and reduce loneliness and isolation over the Christmas and New Year period.

The practice is open between 8.00am and 6.30pm on Monday, Tuesday, Thursday and Friday and between 7.00am and 2.00pm on Wednesday. Extended hours appointments are offered between 6.30pm and 7.30pm on Monday, Tuesday, Thursday and Friday. Occasional Saturdays appointments are offered according to demand. Outside these hours, the answerphone redirects patients to an out of hours provider.

The practice has a list size of 3,600 patients and provides a wide range of services including spirometry, chronic disease management, phlebotomy, immunisations, vaccinations, antenatal and postnatal care, child health development, HIV testing, mental health management and screening including substance misuse care and community detox.

The practice is located in an area with a relatively young population with a high proportion aged between 20-39 years of age and a high proportion of ethnic minority patients.

Why we carried out this inspection

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

Detailed findings

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.

The practice has not been inspected previously.

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 22 June 2016.

During our visit we:

- Spoke with a range of staff including two GPs, one practice nurse, a healthcare assistant and reception staff.
- Spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- 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.
- Reviewed documentation including complaints, significant events and practice policies.

- Made observations around the practice premises.

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 Care Quality Commission at that time.

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the GP of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an analysis of the significant events which were circulated to members of staff, discussed at their monthly practice meetings and placed in a significant event folder accessible to all staff.
- The practice had a safety alerts protocol in place but one member of the clinical team told us that patient safety alerts were not shared with them.

We reviewed safety records and incident reports and we saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, samples due for collection had been incorrectly regarded as waste and disposed of by the cleaner. An incident form was completed and guidance was sought from external organisations. Affected patients were informed of this incident, recalled and apologies were given. An email was sent to all staff with proposed changes which advised them that the practice nurse would now supervise the collection of samples. The practice nurse would ensure all samples leaving the practice were recorded by reception staff and checked at a later date if results had not yet been received. The smear protocol in place was updated and audits were undertaken.

Overview of safety systems and processes

The practice arrangements to keep patients safe were not all effective. They had clearly defined and embedded systems, processes and practices in place to keep patients safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GPs and the practice nurse were trained to child safeguarding level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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. The practice nurse was the infection control clinical lead. All staff had received up to date training in June 2016 and this was updated in October 2016. There was an infection control protocol in place. Infection control audits had been undertaken in 2014 and 2015.
- The arrangements for managing medicines, including emergency medicines in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The lead GP was the prescribing lead and the practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure

Are services safe?

prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction (PSD) from a prescriber. (PSDs are written instructions from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).
- The arrangements in place to monitor vaccines were not effective. The practice had experienced a potential break in their cold chain which had occurred five days prior to the inspection. This had affected both of their vaccines fridges. The practice became aware of this when reception staff, who undertook monitoring of the fridge temperatures raised this during their routine staff meeting; that they had been recording inadequate temperatures ranging between 2-14 degrees Celsius for some time. Following this, all immunisations were suspended with immediate effect although it was unclear how many patients had been affected. The manufacturers were contacted, the practice sought advice from the CCG's medicines management team. Further meetings were held with the CCG director and an incident was raised with NHS England as well as a serious incident investigation within the practice. Steps were taken to purchase a data logger to insert in both fridges. The practice ordered a new vaccines fridge three days after the incident so that they could continue to provide vaccines to patients; patients requiring immunisations were referred to the district nurses or to the hospital in the interim to receive vaccines until the new fridge was in place. There was no indication that the reception staff responsible for recording fridge temperatures were to receive training on the correct monitoring of fridge temperatures to avoid this incident

occurring again. After the inspection the practice told us that staff had received fridge monitoring training; they did not provide any documented evidence to demonstrate this.

- We reviewed five personnel files and found appropriate recruitment checks had not been undertaken for some recently employed permanent staff. For example, proof of identification for one member of staff and references, qualifications or registration with the appropriate professional body for two clinical staff. The practice told us they were unable to retrieve some documents following a failure of their computer system's server. They told us they had begun to keep hard copies of documents to prevent a similar occurrence.

Monitoring risks to patients

The procedures in place for monitoring and managing risks to patient and staff safety were not all effective.

- A health and safety policy identified the responsible person for health and safety within the practice as did a poster in the reception office. A health and safety audit had been carried out by an external company in the last month. This audit had recommended action to take and we saw action points raised in the audit such as undertaking regular electrical testing had been addressed. On the day of inspection, the practice told us that they had not yet taken action recommended by the audit, to secure cables regarded as trip hazards in the administration office.
- The practice had up to date fire risk assessments but did not carry out regular documented fire drills or weekly fire alarm testing. The nominated fire marshals as well as staff had not yet received fire safety training and this had been raised during the fire safety audit and fire risk assessment. The assessments identified several action points which included the lack of sufficient fire fighting equipment and the lack of a documented evacuation plan; however, this had not been completed at the time of inspection.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health were not available. A legionella assessment had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

Are services safe?

- The number of staff and mix of staff needed to meet patients' needs were insufficient. At the time of inspection, there was a reduction in nursing staff and the practice did not have a practice manager in post. The practice told us they had been actively trying to recruit a replacement for the practice manager, and that a new practice manager was to commence employment shortly after the inspection. The lack of a practice manager was impacting on the practice's ability to monitor safety processes. The practice had recently recruited two administration apprentices. A rota system was in place for all the different staffing groups to ensure enough staff were on duty for example, the staff provided cover for each other during sickness absence and holidays. Patients were also booked around nurse availability and GPs worked more hours in order to cover busy periods.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff apart from two non-clinical staff had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- 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 stored securely with the exception of prednisolone (a steroid used to treat inflammation) which had expired.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents with the exception of basic life support training.

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 and used this information to deliver care and treatment that met patients' needs.
- 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 were 93% of the total number of points available.

The practice had high exception reporting in several clinical domains such as chronic kidney disease (CKD) and chronic obstructive pulmonary disease (COPD). When we asked the practice to explain, they told us that this was due to coding issues. After the inspection, the newly appointed practice manager identified that he had uncovered these coding issues and had given a timeframe of up to six months to rectify the problem and develop a wholly functional procedure. The new practice manager following the inspection had met with a consulting practice manager to assist with resolving this matter. (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). However, for other clinical domains with high exception reporting, the practice were aware, for example:

- Exception reporting for the percentage of patients diagnosed with dementia whose care had been reviewed face to face in the last 12 months was 46%, higher than the local Clinical Commissioning Group

(CCG) average of 18% and national average of 8%. The practice was aware of this data and explained that the high exception reporting was due to dementia patients residing in a nursing home who had previously been cared for by the practice two years prior. Despite their continued registration with the practice, the GP no longer had any clinical input with these patients, as the nursing home was now a secondary care facility under the mental health trust.

- Exception reporting for the percentage of women aged 25-64 who had a screening test in the last 5 years was 14%, higher than the CCG average of 8% and national average of 6%. The practice explained that this was because of a large proportion of women declining the screening.

QOF data from 2014/2015 showed:

- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 78% and similar to the national average of 82%.
- Performance for diabetes related indicators was mixed when compared to the CCG and national average. For example, the percentage of patients with diabetes on the register who had normal blood pressure readings in the last 12 months was 68%, lower than the CCG average of 74% and national average of 78%. Whereas;
 - The percentage of patients with diabetes on the register who had a foot examination in the last 12 months was 95%, higher than the CCG average of 85% and national average of 88%.
- Performance for mental health related indicators was higher than the CCG and national average. For example, the percentage of patients with dementia who had received a face to face review in the last 12 months was 95%, compared to the CCG and national average of 84%.
 - The percentage of patients with mental health conditions who had a comprehensive agreed care plan documented in their record was 95%, compared to the CCG and national average of 88%.

The diabetes indicators were lower than CCG and national average in some domains. This data was disputed by the practice, as they produced evidence that showed they were one of the top three practices in the area for diabetes care, despite having the highest prevalence of diabetes in the

Are services effective?

(for example, treatment is effective)

area with over 10% of their practice population diagnosed with the condition. For those patients with poorly controlled diabetes, they undertook case finding exercises with the nurse. Patients who were at risk of diabetes were referred to an expert six week 'move away from pre-diabetes' (MAP) programme, after completing a checklist which included results of their glucose tolerance tests and average blood sugar level readings.

There was evidence of quality improvement including clinical audit.

- There had been four clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, the practice had undertaken a medicines audit after a safety alert was issued for two types of medicines used to lower cholesterol and widen blood vessels. This alert highlighted the increased risk of myopathy (muscle weakness) and rhabdomyolysis (breakdown of muscle fibres that occur due to muscle injury), when the medicine used to lower cholesterol was used in conjunction with another medicine used to treat high blood pressure. The concurrent use of these medicines would cause a significant increase in their blood levels. In the first cycle audit, the practice identified three patients who had been prescribed all three medicines and were at risk. These patients were immediately switched to a different medicine, used to block the production of cholesterol in all three cases to reduce this risk. No patients were identified during the second cycle audit undertaken a year later. Following this audit, the practice discovered that an alert would appear when initiating new prescriptions for these combined medicines, instead of appearing when issuing repeat prescriptions which these medicines were listed as in this case. On reflection, the practice had not expected to find any patients on this combination and this highlighted the need to undertake running audits on medicines particularly when alerts were sent out, as they were not always identified in a timely manner.

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as confidentiality and infection prevention and control. However, we found child safeguarding training did not occur within six months of commencing employment as per the practice's own child safeguarding policy; for example, one member of staff attended this training after 10 months of commencing employment. Fire safety training as well as health and safety was also not a part of their induction training.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, they were in the process of arranging nurse training for the healthcare assistant after this was identified as a personal development plan. For those reviewing patients with long-term conditions, their update training included diabetes, screening and immunisations. The GPs also attended yearly update NICE guidelines courses which also included the Scottish and overseas guidance on the management of long term conditions and other conditions.
- The practice also participated in the Hounslow educations and training meeting (HEAT) training meetings which were held every three months and attended by other members of the multidisciplinary team.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. 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 and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included on-going support, coaching and mentoring, clinical supervision and support for revalidating GPs. When we reviewed staff files, we saw appraisals for three non- clinical staff and

Effective staffing

Are services effective?

(for example, treatment is effective)

one clinical staff were overdue. The practice told us that they were due to commence once their new practice manager came into post which was within a week post inspection.

- Staff received training that included safeguarding and information governance but had not received fire safety training and two non-clinical staff had not received basic life support training. Staff had access to and made use of e-learning training modules and 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 and risk assessments, 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 and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The GP would also visit patients admitted into hospital on a weekly basis to offer his support to the patient and their family as well as to assist in complex discharge planning.

Due to staff shortages within the district nursing team, meetings with the district nurses and health visitors were not being held on a regular basis, although we found this did not have an impact on patient safety. The practice told us that they would sometimes hold meetings via telephone conference due to time restrictions. Meetings took place with other health care professionals at the hospital on a quarterly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- 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 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. For example:

- Homeless patients, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service. We saw evidence that for those receiving end of life care, the GP offered significant support for example, he assisted a family to undertake personal care tasks for a patient who was seriously unwell when their carers were unavailable.
- The GP supported patients suffering from mental and long term conditions to self-manage their care.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG average of 78% and similar to the national average of 82%. Exception reporting for the percentage of women aged 25-64 who had a screening test in the last 5 years was 14%, which was higher than the CCG average of 8% and national average of 6%. The practice explained that this was because of a large proportion of women declining the screening. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. Screening was also offered opportunistically during consultation.

- The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available.
- The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- There were fail-safe 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.

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were generally lower than the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 4% to 96% compared to the CCG average ranging from 3% to 90%. The immunisation rates for the vaccinations given to five year olds ranged from 57% to 87%, compared to the CCG average ranging from 61% to 91%. The practice explained the low immunisation rates were as a result of previous coding issues.

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

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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 they could offer them a private room to discuss their needs.

Twenty one of the 24 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered a good service and staff were helpful, considerate caring and treated them with dignity and respect. Three of the comment cards highlighted issues with access to appointments with the GP of their choice.

We spoke with 11 patients who had been invited by the practice to speak to the inspectors instead of the practice's Patient Participation Group which was no longer active. The majority of patients felt the practice provided a good service and the GPs were kind and compassionate. Patients also felt there was improved staff attitude and consultation times were sufficient. Some patients highlighted issues with the attitude of staff members.

Results from the national GP patient survey showed the majority of patients felt they were treated with compassion, dignity and respect. However, satisfaction scores on consultations with nurses were below the local and national averages. For example:

- 88% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 84% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG average of 80% and the national average of 87%.

- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 92% and the national average of 95%.
- 79% of patients said the last GP they spoke to was good at treating them with care and concern, similar to the CCG average of 79% and lower than the national average of 85%.
- 77% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 84% and the national average of 87%.

The practice had taken steps to improve patient satisfaction scores by attending courses aimed at improving patient satisfaction, involvement and experience. The practice demonstrated their care for patients by inviting patients including those who had made complaints against the practice to speak to inspectors on the day. Patients felt the GPs were kind and compassionate and described incidences when they demonstrated care and concern. This included when the GPs personally delivered prescriptions for seriously ill patients unable to attend the chemist. Additional examples included when they stood in for carers when they were not available by assisting family members to undertake personal care tasks for an end of life patient. Other examples included when patients' families would contact the lead GP in the early hours of the morning and he would conduct a home visit as a result in order to provide continuity of care.

Satisfaction scores for nurse consultations were low and the practice told us that this was due to underlying staffing issues that led to patient dissatisfaction and nursing shortages. They had a plan in place to train the healthcare assistant into becoming a nurse and they were also in the process of collaborating with other practices within the locality to share nurses across the practices in order to reduce the nursing staff shortages at the practice.

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. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed

Are services caring?

decision about the choice of treatment available to them. Patient feedback from the comment cards we received was mostly positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about GPs involving them in planning and making decisions about their care and treatment. Results were in line with local and national averages with the exception of nurse consultations. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the local Clinical Commissioning Group (CCG) average of 80% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and the national average of 82%.
- 70% of patients 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%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language although we did not see any notices displayed in the reception areas informing patients this service was available.

- Information regarding health services was displayed on the practice television screen however; there was no information available in different languages despite the high ethnicity at the practice.

Patient and carer support to cope emotionally with care and treatment

Patient information about how to access a number of support groups including those for mental health, was available on the television screen in the patient waiting area.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 58 patients as carers (2% of the practice list). Carers were offered flu immunisations and arranged for respite care if required. Written information was available to direct carers to the various avenues of support available to them.

The GP would visit practice patients in hospital and this included those admitted into hospitals outside the area. There were arrangements allowing them or their carers to inform him on admission to hospital.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. The GP also offered emotional support to families affected by bereavement. They were also offered psychological therapies during and after bereavement and they were given advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice 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. This included joint working with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the GP was the homeless lead for the locality and together with the outreach nurse and homeless charities for example, he worked for the 'Crisis at Christmas' homeless charity to provide support for the homeless during the festive season.
- The GP took the lead in coordinating end of life care and would visit patients while in hospital on a weekly basis to provide support to the patient and their family as well as to assist in complex discharge planning.
- The GP would visit practice patients admitted into hospital long-term on a weekly basis and this included those admitted into hospitals outside the area. Arrangements were in place for patients and their carers to contact the GP direct on admission to hospital.
- The practice offered late openings four times a week and occasional Saturday morning appointments with the GP or nurse, to accommodate demand and for working patients who could not attend during normal opening hours.
- The practice undertook voluntary visits to their housebound patients who were vulnerable and living alone. The retired practice nurse facilitated this and the service allowed these patients to have ease of access to the lead GP and live independently at home where they would have normally been in residential care.
- There were longer appointments available for a range of patients including those with a learning disability, new patient health checks, the elderly and those undergoing wound management.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Dependent patients and/or their carers as well as healthcare professionals involved in their care were able to contact the GP during working hours and out of hours. In some cases, the GP would conduct a home visit in the early hours of the morning to ensure the patient received continuity of care.
- Same day appointments were available for children and those patients with medical problems that required same day consultation. Children under 10 years of age were given priority access to appointments.
- New birth letters were sent out to parents advising them of immunisations and child development checks offered at the practice.
- There was online access to appointments and repeat medication. The practice offered a limited number of email consultations and telephone consultations were offered.
- Patients were able to receive travel vaccinations available on the NHS and were referred to other clinics for vaccines available privately.
- The practice offered HIV testing and substance misuse care including alcohol. Patients were also referred to the community detox programme.
- There were disabled facilities, a hearing loop and translation services available. Seven languages were spoken in-house and patients requiring interpreter services were offered longer appointments.
- The practice had planned to install a lift to improve access; however, this application was rejected. As a result, all disabled access was confined to the ground floor.

Access to the service

The practice was open between 8.00am and 6.30pm on Monday, Tuesday, Thursday and Friday and between 7.00am and 2.00pm on Wednesday. Extended hours appointments were offered between 6.30pm and 7.30pm on Monday, Tuesday, Thursday and Friday and ad hoc Saturdays according to patient demand. Appointments could be booked up to two months in advance, urgent appointments were also available for people that needed them and this included on Wednesday after 2.00pm.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment varied in comparison to local Clinical Commissioning Group (CCG) and national averages.

Are services responsive to people's needs?

(for example, to feedback?)

- 80% of patients were satisfied with the practice's opening hours. This was in line with the CCG average of 76% and the national average of 78%.
- 65% of patients said they could get through easily to the practice by phone. This was below the CCG and national average of 73%.
- 64% of patients said they were able to get an appointment to see or speak to a GP or nurse the last time they tried. This was below the CCG average of 71% and the national average of 76%.

People told us on the day of the inspection that they would usually have to wait between five days and two weeks to get routine appointments with a GP of their choice. The GP also acknowledged that access was an issue and had taken steps to change the telephone system in place, although it was too early to determine the impact. They had also highlighted difficulties with staff shortages particularly replacing their nursing staff that had an impact of appointment availability.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

All home visit requests were passed onto the nurse, who would then telephone the patient or carer to gather information to allow an informed decision to be made on prioritisation according to clinical need. The nurse would then update the GP on what the clinical need is. In cases where the urgency of need was so great that it would be

inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice 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 practice. The GP would also occasionally invite the complaints officer from the locality to their complaint meetings. Patients who had raised complaints with the practice were also invited to speak with the inspectors on the day of inspection.
- We saw that information was available to help patients understand the complaints system for example, summary leaflet.

We looked at nine complaints received in the last 12 months. We found they were satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and from analysis of trends. Action was taken as a result to improve the quality of care. For example, changes were made to improve the telephone system after complaints from patients with regards to telephone access and reception staff training in response to complaints about staff attitude.

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 vision to deliver high quality care and promote good outcomes for patients.

- The practice staff understood the values and the vision of the practice.
- The GP had begun succession planning to recruit a GP partner into the practice.
- The practice had identified areas of the service that required further development. These included staffing levels, financial stability, managing workload, and improving staff training.
- The practice had commenced the Productive General Practice Programme designed to help them deliver high quality care whilst meeting increasing levels of demand. This would enable them to put the patient and the practice at the centre of improvement to create a timely, appropriate and dependable response to patient needs.

Governance arrangements

There were systemic weaknesses in governance systems such as ineffective monitoring of procedures. For example:

- There was ineffective monitoring of safety procedures. The lack of management resource and the reduction of nursing staff had an impact on ensuring the practice had effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, in relation to medicines management, fire and health and safety, staff training and recruitment checks.
- There were ineffective monitoring procedures in relation to staff appraisals and record keeping. For example, there was no documented evidence to demonstrate that information relating to the running of the practice had been discussed with staff due to the lack of meeting minutes.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. The practice had recruited two administration apprentices within the practice and a new practice manager was to commence employment following the inspection.

- Clinical and internal audit were used to monitor quality and to make improvements where required.
- Practice specific policies were implemented and were available to all staff. However, not all staff were aware of the whistleblowing policy.

In December 2016 the provider sent us an action plan detailing actions they had taken to improve the system for fire safety, staff training, sharing safety alerts, recruitment, and conducting regular staff appraisals.

Leadership and culture

There was a strong focus on delivering high quality care and the practice was undertaking the Productive General Practice Programme in order to achieve this. We saw evidence that the doctors in the practice prioritised compassionate care. For example, the lead GP undertook weekly hospital visits to offer support to patients and their families and this included patients who were in hospitals out of the practice area.

The partners encouraged a culture of openness and honesty and they were aware of the requirements of the duty of candour; however, the systems in place were not effective, as not all staff were aware of this policy. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).

The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

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

- Staff told us the practice held regular team meetings attended by guest speakers including those working with victims of domestic violence.
- 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 and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the doctors in the practice. All staff were

Are services well-led?

Requires improvement 

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

involved in discussions about how to run and develop the practice, and the GPs encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

Although the practice encouraged and valued feedback from patients, the public and staff, the process in place for seeking feedback was not always effective. For example:

- There was no patient participation group (PPG) in place at the time of inspection. The practice told us that there previously was an active PPG; however, it stopped after the previous practice manager left. The lead GP told us that they had put patients forward to attend the locality PPG instead. The locality PPG was set up by the Clinical Commissioning Group, consisting of patient members from each of the practices in the locality to ensure they had their say in how new services were delivered in their locality. The television screen at the practice continued to invite patients to join this group. The practice

strengthened efforts to establish a PPG and did so successfully after the inspection; the new PPG consisted of four members and the practice set themselves a membership target of between eight and 12.

- Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. However, there were no examples provided of when staff had given feedback that the practice had acted upon.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice was part of a new joint project with the homeless outreach team that would ensure an outreach nurse was clinically supervised within the practice. This supervision within local primary and secondary services would enable the outreach nurse to take referrals from and refer to local services, thereby maximising the impact on aiding the homeless population to engage with primary health care.

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 Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met:</p> <p>The provider had not ensured care and treatment was provided in a safe way:</p> <ul style="list-style-type: none">• The provider did not ensure safety alerts were shared with all staff.• The provider failed to assess, monitor and mitigate the risks relating to the health, safety and welfare if service users and others that may be at risk.• The provider failed to ensure effective fire safety arrangements were in place.• The provider failed to ensure that medicines were appropriately and safely managed. <p>This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>How the regulation was not being met:</p> <p>There were systemic weaknesses in governance processes at the practice. We found:</p> <ul style="list-style-type: none">• The provider failed to assess, monitor and improve the quality of the services provided in the carrying on of the regulated activities.• The provider failed to evaluate the performance of staff members.

This section is primarily information for the provider

Requirement notices

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

How the regulation was not being met:

- The provider failed to ensure that all staff had received training appropriate to their roles.

This was in breach of regulation 18 (1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity

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

Regulation

Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed

How the regulation was not being met:

- The provider failed to ensure recruitment procedures were established and operated effectively.

This was in breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.