

Dr Parvinder Garcha

Quality Report

Hounslow Family Practice
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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

Good



Are services safe?

Good



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



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, also known as Hounslow Family Practice, on 22 June 2016. The practice was rated as requires improvement for providing safe, effective, and well-led services, and good for providing caring and responsive services. Overall the practice was rated as requires improvement. The full comprehensive report on the June 2016 inspection can be found by selecting the 'all reports' link for Dr Parvinder Garcha on our website at www.cqc.org.uk.

This inspection was an announced comprehensive follow up inspection on 11 September to check for improvements since our previous inspection. The practice is now rated as good for providing safe, effective, caring, responsive and well-led services. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- There was evidence of kind and compassionate care, with the GP principal providing his direct contact number to palliative care patients and their families. The GP also visited these patients in hospital and liaised with hospital staff to ensure continuity of care was maintained.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.

Summary of findings

- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the GPs and management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

- Implement safety signage to indicate oxygen is stored on the premises.
- Review the system to monitor and assess performance for the childhood immunisation programme.
- Advertise that a translation service is available to patients on request.
- Raise staff awareness of the practice's updated complaints procedure.

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 good for providing safe services.

Good



- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.
- The practice used every opportunity to learn from internal and external incidents, to support improvement. Learning was based on an analysis and investigation.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents. Although, there was no safety signage to indicate where the oxygen was stored.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for staff, with the exception of one non-clinical staff member whose appraisal had been scheduled.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice ensured that patients with complex needs, including those with life-limiting progressive conditions, were supported to receive coordinated care. For example, the GP principal visited palliative care patients admitted to hospital and liaised with hospital staff to ensure continuity of care was maintained.

Are services caring?

The practice is rated as good for providing caring services.

Good



- We observed a strong patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care

Summary of findings

and worked to overcome obstacles to achieving this. For example, the GP principal gave his direct contact number to palliative care patients and their families. The GP also visited these patients when they were admitted to hospital and liaised with hospital staff to ensure continuity of care was maintained.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw 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 understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Although, we did not see the translation service advertised.
- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by the GPs and management. The practice had policies and procedures to govern activity and held regular practice meetings.

Good



Summary of findings

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, and attended staff meetings and training opportunities. Most staff had received annual performance reviews.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- The GP principal encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The practice worked collaboratively with other healthcare professionals in providing care and services to older people with complex needs. For example, utilising primary care coordinators to increase the quality in care planning and referring patients to community services.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- GPs and nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice had performed well on the Quality and Outcomes Framework (QOF) for managing long-term conditions. Unpublished and unverified data indicated that overall performance for diabetes related indicators had improved from 83% in 2015/16 to 96% in 2016/17.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

Summary of findings

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the care of families, children and young people.

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were comparable to CCG averages and below national averages. The practice told us about administrative errors which may have contributed to the low figures.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people.

Good



Working age people (including those recently retired and students)

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

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours from 6.30pm to 7pm on Monday and Thursday, 6.30pm to 7.30pm on Tuesday and

Good



Summary of findings

Friday, and 7am to 8am on Wednesday. The GP principal also offered ad-hoc Saturday appointments at the practice, and pre-booked appointments in the evening and at weekends at the local primary care 'hub'.

- The practice was proactive in offering online services to book appointments and order repeat prescriptions, as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice planned to introduce virtual consultations.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Good



- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The GP principal gave his direct contact number to palliative care patients and visited them when they were admitted to hospital.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- The practice had signed up to the 'caring for homeless patients' out of hospital service, aimed at people who were homeless and had difficulty accessing general practice care. There were currently 20 patients on the practice's homeless register. Staff were able to recognise the challenges faced by these patients in terms of access and communication with the practice, and offered a supportive and flexible approach when booking appointments and reviews. The GP principal was the locality

Summary of findings

lead for homelessness and worked closely with other health providers to offer care to homeless patients. The practice address could also be used by homeless patients for correspondence with the hospital or other care services.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- The practice held a register of patients living in vulnerable circumstances including those with a mental health illness.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. For example, the practice had signed up to the 'common complex and serious mental health' out of hospital service for monitoring and caring for patients with long-term depression and serious mental illness.
- In 2015/16, 88% of patients with a diagnosed psychosis had a comprehensive care plan in their records, which was comparable to the CCG and national averages of 89%.
- The practice carried out advance care planning for patients living with dementia. However, in 2015/16, 73% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months, which was below the CCG average of 86% and national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on 6 July 2017. The results showed the practice was performing in line with local and national averages for several aspects of care. Three hundred and eighty two survey forms were distributed and 107 were returned. This represented 3% of the practice's patient list.

- 86% of patients described the overall experience of this GP practice as good compared with the CCG average of 81% and the national average of 85%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 80% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with CCG average of 74% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 30 comment cards, 25 of which were positive and five which were partially positive about the standard of care received. The partially positive comments referred to the punctuality of appointments and communication from reception staff.

We spoke with three patients during the inspection and received feedback from a member of the patient participation group. All patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Results from the NHS Friends and Family test (last 12 months) showed 86% of patients would recommend the service to others.

Areas for improvement

Action the service **SHOULD** take to improve

The areas where the provider should make improvement are:

- Implement safety signage to indicate oxygen is stored on the premises.
- Review the system to monitor and assess performance for the childhood immunisation programme.
- Advertise that a translation service is available to patients on request.
- Raise staff awareness of the practice's updated complaints procedure.

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.

Background to Dr Parvinder Garcha

Dr Parvinder Garcha, also known as Hounslow Family Practice, provides NHS primary medical services to approximately 3,800 patients living in the surrounding area of Hounslow. The practice has a General Medical Services (GMS) contract (GMS is one of the three contracting routes that have been available to enable commissioning of primary medical services). The practice is part of NHS Hounslow Clinical Commissioning Group (CCG) and the Great West Road locality (comprised of ten practices).

The practice team consists of a GP principal (male) and three sessional GPs (two male and one female) providing 14 clinical sessions collectively. The GPs are supported by a practice nurse (21 hours); a health care assistant (16 hours); a practice manager (37.5 hours); and eight receptionists / administrators. The practice employs a consultant business manager on a temporary basis.

The practice is located in a converted residential property with two consulting rooms on the ground floor and two consulting rooms on the first floor. A third consulting room on the first floor is not currently being used for clinical purposes. There are administrative areas on the ground and second floors. The ground floor of the premises is accessible by wheelchair.

The practice is open from 8am to 6.30pm every weekday, with the exception of Wednesday when it closes at 2pm (From October 2017 the practice will be open on Wednesday till 6.30pm). Pre-booked appointments are available during these times. Extended hours appointments are available from 6.30pm to 7pm on Monday and Thursday, 6.30pm to 7.30pm on Tuesday and Friday, and 7am to 8am on Wednesday. Same day appointments are available for patients with complex or more urgent needs. The practice offers an ad hoc emergency clinic on a Saturday. When the practice is closed, patients are advised to use the local out-of-hours provider or are booked an appointment at the local primary care service 'hub'.

The practice population is characterised by average levels of income deprivation, employment rates and life expectancy. The practice has a higher percentage of patients aged 25 to 44 compared to the English average. The population is ethnically diverse.

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

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Parvinder Garcha on 22 June 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement for providing safe, effective and well-led services, and was rated as requires improvement overall.

Detailed findings

We issued requirement notices to the provider in respect of safe care and treatment, good governance, staffing, and fit and proper persons employed. The provider sent us an action plan which stated they would be compliant by June 2017. The full comprehensive report on the June 2016 inspection can be found by selecting the 'all reports' link for Dr Parvinder Garcha on our website at www.cqc.org.uk.

We undertook an announced comprehensive follow-up inspection of Dr Parvinder Garcha on 11 September 2017. This inspection was carried out to check for improvements since our previous inspection.

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 11 September 2017. During our visit we:

- Spoke with a range of staff including the GP principal, a sessional GP, practice nurse, practice manager, business manager, lead receptionist, and a receptionist.
- Spoke with three patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members.
- Reviewed a 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.
- Visited the practice location.
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

At our previous inspection on 22 June 2016, we rated the practice as requires improvement for providing safe services because several 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, emergency medicines management, and staff training in basic life support.

These arrangements had significantly improved when we undertook a comprehensive follow up inspection on 11 September 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager 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).
- From the sample of documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written or verbal apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a GP had left a blood test sample in the fridge without notifying reception staff, therefore the sample was not given to the courier for collection. The practice took action by contacting the patient, apologising for the error, and booking an appointment for them to have their blood test repeated. The outcome was for no samples to be kept in the practice after the last courier

collection. All GPs were to notify staff of any urgent samples left in the fridge as these would need to be taken to a neighbouring health centre that had a late collection of samples. The incident was discussed at a practice meeting and learning shared with staff.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. From the sample of documented examples we reviewed we found that the GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nursing staff were trained to child protection or child safeguarding level three, and non-clinical staff to level one.
- A notice in the waiting room and in consulting rooms 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. There were cleaning schedules and monitoring systems in place.
- The practice nurse was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Biannual IPC audits were

Are services safe?

undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the privacy curtains in consulting rooms had been changed following the last audit in August 2017.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed five personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. Fire evacuation procedures were displayed in throughout the practice.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as health and safety, infection prevention and control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had recruited a new practice manager who started on the day of our inspection, and a sessional female GP who was due to start the following month. A business manager had been recruited on a temporary basis to assist with practice management since the previous practice manager left in June 2017. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff, with the exception of a new member of staff who had been employed for two weeks, had received annual basic life support training. It was practice policy for this training to be completed within one month of the staff member's start date.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However, there was no safety signage to indicate where the oxygen was stored.
- 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.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage, and could be accessed remotely. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 22 June 2016, we rated the practice as requires improvement for providing effective services as the arrangements in respect of staff appraisals, clinical exception reporting, staff induction training, and record keeping from multidisciplinary working needed improving.

These arrangements had improved when we undertook a comprehensive follow up inspection on 11 September 2017. The practice is now rated as good for providing effective services.

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and the locality and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through 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 91% of the total number of points available compared with the clinical commissioning group (CCG) average and national average of 95%. Clinical exception reporting was 4% which was below the CCG average of 8% and national average of 10% (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).

Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, the

percentage of patients with diabetes, on the register, in whom the last blood pressure reading was 140/80 mmHg or less was 79% compared to the CCG average of 74% and the national average of 78%. Exception reporting was 3% compared to the CCG average of 8% and the national average of 9%.

- Performance for mental health related indicators was similar to the CCG and national averages. However, performance for dementia related indicators in 2015/16 was lower than the CCG and national average. For example, the percentage of patients diagnosed with dementia whose care plan had been reviewed in a face to face review in the preceding 12 months was 73% compared to the CCG average of 86% and the national average 84%. Exception reporting was 6% (two out of 32 patients) compared to the CCG average of 12% and the national average of 7%. Unpublished data for 2016/17 showed overall performance for dementia related indicators had improved to 100%, with 6% exception reporting (two out of 27 patients).

Unpublished and unverified data from the QOF 2016/17 showed results were 99% of the total number of points available, and clinical exception reporting was 6%.

There was evidence of quality improvement including clinical audit:

- There had been two clinical audits commenced in the last year. Both of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, an audit was carried out to improve prescribing for asthma patients. The criteria was determined and the standard set to 95% of patients on the asthma register should not be prescribed more than six bronchodilators in the last six months. The initial audit identified 10 patients which was 4.9% of the asthma register. Although within the standard set, the practice reviewed these patients to establish why the prescriptions were issued. All patients were seen by the GP principal for a medicines review and the nurse where appropriate. A second audit cycle identified three patients which was 1.5% of the asthma register, an improvement of 3.4%.

Information about patients' outcomes was used to make improvements. For example, the practice had a high

Are services effective?

(for example, treatment is effective)

prevalence of patients with diabetes (10% compared to the national average of 6%). The practice had focussed on diabetes management by monitoring monthly performance via the CCG diabetes dashboard, which looked at whether patients were receiving the recommended nine key care processes which included: foot checks; smoking status; weight check; blood pressure; eye test; urine test; and blood tests for cholesterol, kidney function, and HbA1c (glycated haemoglobin). Practice data from July 2017 showed 62% of patients had received the nine key care processes, compared with the CCG average of 56%. The GPs also met with a diabetes consultant to review complex cases. The QOF data for 2015/16 showed overall performance for diabetes was 83%. Unpublished data for 2016/17 showed an improvement to 96%.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. It was practice policy for induction training to be completed within one month of the staff member's start date.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines 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 online resources and discussion at practice and local 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 ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. A new member of staff had received a probationary review after three months of employment. Nursing staff and seven out of eight non-clinical staff

had received an appraisal within the last 12 months. One non-clinical staff member who was due an appraisal had an agreed date for their appraisal this month.

- Staff received training that included: safeguarding, fire safety awareness, infection prevention and control, basic life support and information governance. Although a new member of staff who had been employed for two weeks had yet to complete the mandatory 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.
- From the sample of documented examples we reviewed we found that 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 ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. For example, the GP principal visited palliative care patients admitted to hospital and spoke with hospital staff so that continuity of care was maintained.

Consent to care and treatment

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

Are services effective?

(for example, treatment is effective)

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Data from 2015/16 showed uptake rates were comparable to the CCG average and below national averages. For example, rates for the vaccines given to under two year olds averaged 84% compared to the national standard of 90%. Uptake for five year olds ranged from 75% to 88% (CCG 62% to 87%; national 88% to 94%). The practice disputed this data and told us it was as a result of administrative errors. For example, they showed us records to suggest the data for the childhood immunisation programme had not been fully submitted by the previous practice managers since 2015 despite immunisations being administered. The practice were in the process of submitting a retrospective claim for the immunisations they had carried out. Unpublished and unverified data for 2016/17 showed uptake rates for under two year olds averaged 92%, however uptake for five year olds remained below national averages and ranged from 68% to 80%. The practice told us they were aware of an administrative error whereby staff had documented immunisations received abroad within the child's medical record, but they had failed to code this on the practice system. Following this incident, staff had received IT training to ensure records were coded appropriately.

The practice's uptake for the cervical screening programme for 2015/16 was 78%, which was similar to the CCG average of 78% and the national average of 81%. The practice offered telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. Uptake rates for breast cancer screening from 2015/16 were comparable to CCG and national averages. For example:

- Females, 50-70, screened for breast cancer in the last 36 months was 71% compared to the CCG average of 68% and the national average of 73%.

Uptake rates for bowel cancer screening from 2015/16 were lower than the CCG and national averages. For example:

- Persons, 60-69, screened for bowel cancer within six months of invitation was 31% compared to the CCG average of 44% and the national average of 56%.

The practice were aware of this. They had yet to formalise an action plan but told us they aimed to be more proactive in carrying out searches to identify patients who required screening rather than offering screening on an ad-hoc basis. The GP principal had also undertaken further training within the clinical area.

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

At our previous inspection on 22 June 2016, we rated the practice as good for providing caring services.

When we undertook a comprehensive follow up inspection on 11 September 2017 we found the practice was providing caring services and therefore remains good for providing caring services.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

Twenty five of the 30 patient Care Quality Commission comment cards we received were positive and five were partially positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. The partially positive comments referred to the punctuality of appointments and communication from reception staff.

We spoke with three patients and received feedback from a member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey 2017 showed patients felt they were treated with compassion, dignity and respect. For example:

- 92% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%.

- 93% of patients said the GP gave them enough time compared to the CCG average of 82% and the national average of 86%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 81% and the national average of 86%.
- 83% of patients said the nurse was good at listening to them compared with the CCG average of 86% and the national average of 91%.
- 81% of patients said the nurse gave them enough time compared with the CCG average of 87% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 95% and the national average of 97%.
- 82% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared with the CCG average of 85% and the national average of 87%.

The practice had reviewed the most recent results from the national GP patient survey and analysed areas of good performance and areas for improvement. The findings were shared with staff during a practice meeting, and they planned to discuss the results at the next patient participation group meeting.

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 decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised. Children and young people were treated in an age-appropriate way and recognised as individuals.

Are services caring?

Results from the national GP patient survey 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 83% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 78% and the national average of 82%.
- 83% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 84% and the national average of 90%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared with 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 interpretation services were available for patients who did not have English as a first language, although we did not see this service advertised. Patients

were told about multi-lingual staff who might be able to support them, and we observed staff speaking to patients at reception and over the phone in languages other than English.

Patient and carer support to cope emotionally with care and treatment

Patient information notices displayed in the patient waiting area told patients how to access a number of support groups and organisations. Information about support groups was also available at reception on request.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 60 patients as carers (1.6% of the practice list). They used this register to improve care for carers. For example, carers were offered annual health checks and the flu vaccination. Written information was available to direct carers to the various avenues of support available to them.

There was evidence of compassionate care. For example, the GP principal gave his direct contact number to palliative care patients and visited them when they were admitted to hospital. Staff told us that if families had experienced 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 and by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 22 June 2016, we rated the practice as good for providing responsive services.

When we undertook a comprehensive follow up inspection on 11 September 2017 we found the practice was providing responsive services and therefore remains good for providing responsive services.

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours appointments from 6.30pm to 7pm on Monday and Thursday, 6.30pm to 7.30pm on Tuesday and Friday, and 7am to 8am on Wednesday for working patients who could not attend during normal opening hours.
- As a result of patient feedback and demand, the practice were due to change their opening hours on Wednesday afternoons and would be open from 2pm to 6.30pm from October 2017.
- The GP principal also offered ad-hoc emergency clinics on a Saturday to meet patient demand. The practice had provided two Saturday clinics per month for the last two months.
- There were longer appointments available for patients with a learning disability, poor mental health, carers, patients whose first language was not English and those with complex needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Access to a female GP was limited to one day a week. The practice told us they had recognised the need to

increase female GP provision and had recruited a female GP to provide additional sessions so that patients could access a female GP two days per week. The new GP was due to start in October 2017.

- The practice sent text message reminders of appointments.
- A sessional GP was in the process of reviewing the use of virtual consultations and planned to introduce this service for patients.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available. However, we did not see information to inform patients that this service was available. Staff spoke a variety of languages which aided communication with the patient population.
- Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services. For example, staff were able to recognise the challenges faced by homeless patients in terms of access and communication with the practice, and offered a supportive and flexible approach when booking appointments and reviews. The practice address could be used by homeless patients for correspondence with the hospital or other care services.
- The practice had signed up to provide 'out of hospital' services to their patients. These included caring for homeless patients; diabetes management; ambulatory blood pressure monitoring; spirometry; wound management; and common complex and serious mental illness.
- The practice also had access to a local primary care 'hub' where patients could be seen by a GP or nurse until 8pm on weekday evenings, and from 8am to 8pm at the weekend. The appointments could be remotely booked by the practice and were available for routine requests such as cervical screening and wound dressing.

Access to the service

The practice was open between 8am and 6.30pm every weekday, with the exception of Wednesday when it closed at 2pm (From October 2017 the practice would be open on Wednesday till 6.30pm). Pre-booked appointments were available during these times. Extended hours appointments were offered from 6.30pm to 7pm on Monday and Thursday, 6.30pm to 7.30pm on Tuesday and

Are services responsive to people's needs?

(for example, to feedback?)

Friday, and 7am to 8am on Wednesday. An ad-hoc Saturday clinic was available to meet patient demand. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey 2017 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%.
- 76% of patients said they could get through easily to the practice by phone compared with the CCG average of 69% and the national average of 71%.
- 86% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 80% and the national average of 84%.
- 81% of patients said their last appointment was convenient compared with the CCG average of 74% and the national average of 81%.
- 66% of patients described their experience of making an appointment as good compared with the CCG average of 71% and the national average of 73%.
- 31% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 49% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. 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 a system 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.
- We saw that information was available to help patients understand the complaints system. For example, in the practice leaflet and posters displayed throughout the practice.

We looked at three out of six complaints received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way, and with openness and transparency. However, we noted that one response had not been documented on the practice's new complaints template and did not include further information for the complainant on how to pursue the complaint if they were not satisfied with the response. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, a patient had not received an initial response to their complaint despite a GP looking into the issues. The practice acknowledged there was a lack of communication with the patient and a response with the actions taken had been sent to the patient. The patient was also given an appointment with the GP to discuss the issues. Lessons learned were shared at practice meetings.

Are services well-led?

Good 

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

Our findings

At our previous inspection on 22 June 2016, we rated the practice as requires improvement for providing well-led services as there were weaknesses in governance arrangements which led to ineffective monitoring of safety procedures, staff were not aware of some practice policies, and there was inconsistent evidence of practice meetings.

These arrangements had significantly improved when we undertook a follow up inspection on 11 September 2017. The practice is now rated as good for providing well-led services.

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Staff understood the values and the vision of the practice.
- The practice had a clear strategy which reflected the vision and values. The GP principal had begun succession planning to recruit a GP partner into the practice, to help deliver the practice's vision.
- The practice had identified areas for development. These included workforce stability, improving access, financial security, and managing workload.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as safeguarding, infection prevention and control, and caring for homeless patients.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.

- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, biannual infection control audits, and annual fire and health and safety risk assessments.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the GP principal demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. The GP principal had led the practice since 1991 and had a good understanding of patients' needs as well as those of the locality. The interim business manager provided support with quality assurance, practice governance and finance, whilst a practice manager was being recruited. The practice had appointed a practice manager with experience and knowledge of the local area. The practice told us they prioritised safe, high quality and compassionate care. Staff told us the GPs and managers were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of 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). The GP principal encouraged a culture of openness and honesty. From the sample of documented examples we reviewed we found that the practice had systems 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 and staff felt supported by the GP principal and management, despite recent changes in the management team.

Are services well-led?

Good 

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held monthly team meetings.
- 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. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. Staff were involved in discussions about how to develop the practice, and the GP principal and management 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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met quarterly and submitted proposals for improvements to the practice management team. For example, text messages to confirm appointments, and early appointments from 7am. These suggestions had been implemented by the practice.
- the NHS Friends and Family test, Healthwatch data, complaints and compliments received
- staff through staff meetings, appraisals and discussion. 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 to improve how the practice was run.

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 schemes to improve outcomes for patients in the area.

- The GP principal was the lead for the Great West Road locality, which comprised of 10 local practices. This helped to ensure practices were directly involved in planning, monitoring and improving services for patients. Practices also benefited from shared knowledge and learning.
- The GP principal was also the locality lead for homelessness and worked closely with other health providers to offer care to homeless patients.
- The practice was part of a clinical commissioning group (CCG) scheme to improve outcomes for patients in the area. A primary care coordinator provided administrative support to staff to enhance and improve pro-active care, prevention and self-care for patients including at risk groups, over 65s, patients with long-term conditions and those receiving health and social care support from multiple providers.