Dr King Stott and Pankhurst

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Dr King Stott and Pankhurst is also known as Emperors Gate Surgery. It is a teaching GP practice that provides GP primary care services to people living in the south of the borough of Kensington and Chelsea. It currently has just over 5000 patients registered. There are three partners at the practice who have up to four registrars working with them at any one time. They are registered to provide diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

All patients we spoke with were very complimentary about the service. There was a patient participation group (PPG) that met four times a year. We saw changes were made as a result of feedback.

The practice was responsive to patients needs. They worked well with other services to keep patients in the community and prevent hospital admissions. They had access to specialist advice such as psychiatrists and physiotherapists and met regularly with district nurses, health visitors and the palliative care teams. An Age UK support worker attended the practice to provide support and act as an advocate for older patients.

The practice was providing effective care. They used a range of resources to provide evidence based assessments and treatment, such as National Institutes for Health and Care Excellence (NICE) guidelines and clinical knowledge summaries (CKS) which provides information about best practice.

The practice was caring, however some improvements were needed. CQC feedback cards completed were extremely positive about the practice. Although most patients were happy with the service they received some patients had expressed concerns about lack of appointments outside working hours.

There were arrangements in place to ensure patients were safe, however some improvements were needed. Where potential risks were identified, risk management plans were drafted with clear actions to be taken to minimise or alleviate the risk. However, we found the practice did not have arrangements in place to risk assess non-clinical staff for whom they did not carry out criminal record checks with the Disclosure and Barring Service (DBS). Further, some staff had not attended adult safeguarding training and as such could not clearly identify signs of abuse.

The practice was well led, however some improvements were needed. Three partners and a practice manager formed the leadership team. All had clear areas of responsibility. However, there were no formal processes in place to gather feedback from staff.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice provided safe care, however some improvements were required. They had appropriate safeguarding policies and procedures in place and all staff knew what action to take if they had a concern. However, they did not carry out risk assesments for non-clinical staff who did not have DBS checks undertaken and some staff had not attended adult safeguarding training.

Patients could book appointments to see GP's in an emergency and practice ensured that patients received their medicines when needed. There were arrangements in place for repeat prescriptions.

There were processes in place to report significant events and incidents and there was evidence that there were clear processes for learning from incidents.

All staff had been trained in basic life support and how to deal with anaphylactic shock.

Are services effective?

The practice was providing effective care. They used a range of resources to provide evidence based assessments and treatment, such as National Institutes for Health and Care Excellence (NICE) guidelines and clinical knowledge summaries (CKS), which provides information about best practice.

All new patients underwent a physical health assessment before seeing the doctor. Weekly referral meetings were held which were attended by all the doctors in the practice and monthly MDT meetings attended by district nurses and health visitors.

Staff received appropriate development and support. Training was arranged according to job role to ensure that staff had the appropriate skills and knowledge to carry out their job.

Services available at the practice included clinics for diabetic, well woman, asthma, minor surgery and childhood immunisations.

Are services caring?

The practice was caring. Patients described the staff as respectful, extremely conscientious and caring. Patients could discuss all the concerns they had during one consultation. CQC feedback cards completed were extremely positive about the practice

However, although most patients were happy with the service they received some patients had expressed concerns about lack of appointments outside working hours.

Summary of findings

The practice had an active patient participation group (PPG) that met four time a year. Feedback from this group was discussed at practice meetings.

Are services responsive to people's needs?

The practice was responsive to patients needs. They worked well with other services to keep patients in the community and prevent hospital admissions.

There was a clear complaints policy. All comments and suggestions were considered at the monthly practice meetings.

The practice operated a triage system for those patients who wanted to see the doctor the same day. Phone consultation were carried out and if there was a need for the patient to see a doctor that day they would be booked in to see the duty doctor.

The practice had a complaints procedure and provided information for patients on how to make a complaint or comment about the service.

Are services well-led?

The practice was well led, however some improvements were needed. Three partners and a practice manager formed the leadership team. All had clear areas of responsibility. They promoted a culture of openness and transparency.

There were partners meetings every three weeks, which were also attended by the practice manager and monthly practice meetings were held, which were attended by all staff

The practice had a Patient Participation Group (PPG) to seek patient's views. The group met quarterly. However the practice recognised that the membership was not totally reflective of their patient group

Staff said they felt comfortable about making suggestions or recommendations at the practice meetings or to any of the leadership team. However, there were no formal processes in place to gather feedback from staff.

The practice had systems and audits in place to ensure that all equipment used was regularly serviced and maintained in accordance with the manufacturer's instructions. There were systems in place for identifying and managing risk.

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 employed a support worker to provide both practical and emotional support to older patients who lived on their own.

The practice also works closely with palliative nurses to ensure older patients with terminal illnesses were supported appropriately at home.

People with long-term conditions
The practice provided in-house services for people with conditions such as diabetes. They also worked closely with respiratory and heart failure nurses to provide care and treatment to people with these conditions in their own homes.

Mothers, babies, children and young people
The practice provided weekly clinics for mother's babies and young children. They also worked closely with health visitors to ensure this group receive appropriate support at home.

The working-age population and those recently retired
The practice offered phone consultations and opened late two evenings in the week to enable working patients to have access to GP's.

People in vulnerable circumstances who may have poor access to primary care
We were told patients whom they had identified may fall in this group would have access to language line and would receive home visits by either GPs or health visitors.

People experiencing poor mental health
The practice provided some in-house services for people suffering from anxiety or depression. They could also refer people directly to psychiatric consultants at the local hospital.

Summary of findings

What people who use the service say

We spoke with six patients and received sixteen completed CQC feedback cards.

All the patients we spoke with during the inspection were very complimentary about the service they received. When asked to give the practice marks out of ten people gave nine or ten. They told us the staff were friendly, polite, proactive and caring.

We looked at the CQC feedback cards that had been completed and all were exceptionally positive about the practice. Patients felt all the doctors gave enough time during consultations and listened to their views.

Areas for improvement

Action the service COULD take to improve

The practice did not carry out criminal record checks with the DBS for non-clinical staff at the practice.

Non-clinical staff had not attended any adult safeguarding training and some staff we spoke with were unable to give examples of the types of adult abuse they might come across through the course of their work.

The practice had a Patient Participation Group (PPG) to seek patient's views. However, the practice recognised that the membership was not totally reflective of their patient group.

Good practice

Our inspection team highlighted the following areas of good practice:

A counsellor was available at the practice three days a week to provide counselling sessions to people who they thought would benefit from talking therapies.

Dr King Stott and PankhurstDr King Stott and Pankhurst

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The inspector was accompanied by a GP and an Expert by Experience.

Background to Dr King Stott and Pankhurst

Dr King Stott and Pankhurst is also known as Emperors Gate Surgery. It provides GP primary care services to people living in the south of the borough of Kensington and Chelsea. It currently has just over 5000 people registered. They do not have an upper limit therefore registration is always open. They are a teaching practice and have up to four registrars working with them at any one time. There are three female permanent doctors; however a male doctor carries out a surgery once a week, two nurses, a practice manager and four reception staff. They have one surgery located on the first floor of Emperors Gate medical centre which also houses a Chronic Obstructive Pulmonary Disease (COPD) clinic, district nurses and health visitors.

The Royal Borough of Kensington and Chelsea is a west London borough of Royal Borough status. It is an urban area, and one of the most densely populated in the United Kingdom. There is a far higher proportion of 20-39 year old people living in Kensington and Chelsea as compared to other part of London. It had the highest population of people with severe and enduring mental illness known to GPs in the country in 2012/13. 23.8% of the population belong to non-white minorities (England average 12.3%).

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This practice had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

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

- Older people

Detailed findings

- People with long term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing mental health problems

Before our inspection, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 14th May 2014. During our visit we spoke with a range of staff (doctors, registrars, practice nurse, practice manager and receptionist) and spoke with patients who used the service. We reviewed policies and procedures, records, various documentation and comment cards where patients shared their views and experiences of the service.

Are services safe?

Summary of findings

The practice provided safe care, however some improvements were required. They had appropriate safeguarding policies and procedures in place and all staff knew what action to take if they had a concern. However, they did not carry out risk assesments for non-clinical staff who did not have DBS checks undertaken and some staff had not attended adult safeguarding training.

Patients could book appointments to see GP's in an emergency and practice ensured that patients received their medicines when needed. There were arrangements in place for repeat prescriptions.

There were processes in place to report significant events and incidents and there was evidence that there were clear processes for learning from incidents.

All staff had been trained in basic life support and how to deal with anaphylactic shock.

Our findings

Safe Patient Care

There were processes in place to report significant events and incidents. Incident reports were completed immediately and passed to the practice manager, or the lead GP in their absence. They would then decide if immediate steps needed to be taken.

Patients could book appointments to see GP's in an emergency. The practice ensured that patients received their medicines when they needed. There were arrangements in place for repeat prescriptions. GP's told us they would warn patients of potential side-effects of the medication when it is first prescribed, and would ask about side effects periodically. We saw GPs would discuss alerts, best practice guidance and safety updates at the weekly clinical meetings.

Learning from Incidents

There was evidence that learning from incidents took place. The practice held a weekly staff meeting where complaints and incidents were discussed and appropriate changes were implemented.

The practice held significant events meetings once a month. We saw that incidents discussed included why there were sometimes delays in cancer diagnosis. The staff team looked at what could be done better in relation to referrals. The practice implemented a weekly referral meeting where GP's would discuss potential referrals. Where there was a need for an emergency referral the GP would refer immediately then discuss at the meeting. We were told this process had improved delays in referrals and diagnosis. However, the practice were continuing to monitor and review this area.

Safeguarding

The practice had safeguarding policies and procedures for adults and children and we found that these were in line with local guidance relating to multi agency safeguarding procedures. Flowcharts showing how to report concerns were displayed on various noticeboards throughout the practice. They had an identified safeguarding lead and all staff spoken to knew who the lead was.

All staff had attended child protection training to the level appropriate for their role. Reception staff had completed

Are services safe?

level one and GP's level three. However, non-clinical staff had not attended any adult safeguarding training and some staff we spoke with were unable to give examples of the types of adult abuse they might come across through the course of their work. This meant they may not be able to recognise signs of abuse in patients who attended the practice and take appropriate action.

The practice had a chaperone service available for patients who may wish to have someone of the same gender present during examinations.

Monitoring Safety and Responding to Risk

The practice had procedures in place to deal with medical emergencies. All staff had received training in basic life support. An emergency drugs box was kept in the medication room with a full range of emergency drugs. We inspected the box and found all drugs were in date.

The practice had arrangements in place for monitoring safety and responding to risk related to the operation of the premises. There was a fire alarm system and we saw the up to date annual checks and testing records for this. There was also monthly testing of the alarm system. Staff received training in fire safety and the practice had a named fire lead. The practice manager told us they had annual fire evacuation drills.

The landlord carried out annual building health and safety checks. We saw they produced an action plan with clear dates for completion for any repairs or maintenance issues identified.

Staffing and Recruitment

There were effective recruitment and selection processes in place. This included checking peoples work history and face to face interviews. References were sought prior to employment. New staff had an induction programme which included mandatory training in moving and handling, infection control and basic lifesaving. However, we found the practice did not carry out criminal records checks for its non-clinical staff and had not completed any risk assessments for these staff. This meant they could not be sure that staff employed did not present a risk to patients.

Medicines Management

The practice nurse was responsible for the management of medicines in the service. There were up to date medicines management policies and staff we spoke with were familiar with them.

Medicines were kept in a secure store and only clinical staff had access. We saw evidence that the medicines were checked monthly to check the contents were intact and in date. These checks included the emergency medicines and medical gases. We saw fridge temperatures were checked daily to ensure the fridge was always at the correct temperature to store vaccines.

Clear records were kept whenever any medicines were used. The records were checked by the practice nurse who reordered supplies when required

Cleanliness & Infection Control

The practice nurse was the lead for infection control. They had carried out out an annual audit in September 2013 and we saw there were no major concerns. Hand washing posters were displayed throughout the practice. The practice manager told us they had recently removed carpets from the doctor's surgeries as it was highlighted as a concern when the Primary Care Team (PCT) had carried out an infection control audit.

Dealing with Emergencies

Plans were in place to deal with emergencies that might result in not being able to use the building. The practice had a reciprocal arrangement in place with a doctor's practice a few minutes' walk from the practice. They would be able to have use of their surgery to see patients.

Equipment

The practice had equipment on the premises for dealing with emergencies, including oxygen, defibrillator and emergency drugs. The equipment was up to date and operational.

The practice had effective systems to ensure that patients who used the service were not harmed as a result of unsafe equipment. They kept maintenance and service logs for medical equipment such as the blood pressure monitors. Annual portable appliance testing had been conducted on all electrical equipment in the practice.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was providing effective care. They used a range of resources to provide evidence based assessments and treatment, such as National Institutes for Health and Care Excellence (NICE) guidelines and clinical knowledge summaries (CKS), which provides information about best practice.

All new patients underwent a physical health assessment before seeing the doctor. Weekly referral meetings were held which were attended by all the doctors in the practice and monthly MDT meetings attended by district nurses and health visitors.

Staff received appropriate development and support. Training was arranged according to job role to ensure that staff had the appropriate skills and knowledge to carry out their job.

Services available at the practice included clinics for diabetic, well woman, asthma, minor surgery and childhood immunisations.

Our findings

Promoting Best Practice

The doctors told us they would use clinical knowledge summaries (CKS) which provides primary care practitioners with a readily accessible summary of the current evidence base and practical guidance on best practice in respect of over 300 common and/or significant primary care presentations. They said other resources they used included National Institutes for Health and Care Excellence (NICE) guidelines, the Oxford handbook for medicine and patient.co.uk website. They said they also attended an annual GP update courses and had access to microbiologists and consultants. We saw notes from clinical meetings that showed the practice nurse led sessions on evidence based practice at the monthly meetings.

New patients underwent a physical health assessment before seeing the doctor. The assessment included past medical history, blood pressure, weight and height. We discussed with the doctors whether this health check could also include screening for asthma as information we received before the inspection stated the practice had a low record of detecting asthma. The doctors said this would be something they would consider for the future.

The practice held a weekly referral meeting to discuss all patients they were considering referring for hospital for tests. These meetings were attended by all clinical staff and the practice manager. All referrals were discussed at these meetings. Staff we spoke with felt these meetings were very useful as it made them think about other issues such as other medical conditions before making the referral.

The practice nurse was responsible for carrying out repeat prescription audits. The audit included why patients require it, were they using the right forms and had the doctors carried out a review in the past year. They would also look at frequency of requests and if they were too regular they would raise it with the relevant GP to explore why.

Management, monitoring and improving outcomes for people

The practice had carried out two clinical audits in the past year related to the effect specific medications had on

Are services effective?

(for example, treatment is effective)

patients with a cardiac history. The audits were carried out as a result of prescription and press alerts about increased risks of cardiac events where patients had past medical history of cardiac problems. Follow up audits were due to be carried out in October 2014.

The practice also used The Quality and Outcomes Framework (QOF) to inform them of areas where they needed to improve. The QOF is a voluntary incentive scheme for GP practices. There was a GP practice lead for all key areas in the QOF.

Staffing

All new staff received a comprehensive induction which included shadowing another staff member. Non-clinical staff also had to complete training, such as basic life support, handling clinical waste, fire safety and child protection.

Staff told us they had regular opportunities to hold discussions about their work. Clinical staff received monthly clinical supervision. Registrars were supervised by the GPs and the GPs were supervised by an external clinician. Patients we spoke with felt that staff at the practice were competent in their roles.

All staff received an annual appraisal where they discussed training opportunities. We saw annual appraisal meeting notes in staff records. Training was arranged according to job role to ensure that staff had the appropriate skills and knowledge to carry out their job.

The practice manager kept a training matrix for all staff employed in the practice to enable them to see at a glance when staff training was due. We saw all training was up to date.

Working with other services

The practice worked closely on a day to day basis with district nurses (DN) and health visitors (HV) as they were based in the same building. Monthly multi disciplinary (MDT) care meetings were held which were attended by the DNs, HVs, and the palliative care team.

A psychiatrist and a physiotherapist attended the practice at least once a month to give advice to the GPs about patients where they had concerns regarding their mental health. They also attended the MDT meeting on occasions.

Health Promotion & Prevention

Leaflets were available in the waiting room covering various topics such as nutrition advice, sexual health, diabetes, dementia and heart health.

Services available at the practice which included clinics for diabetic, well woman, asthma, minor surgery and childhood immunisations. We saw that these clinics were promoted in the waiting room and on the practice information leaflet.

One practice nurse had been trained in smoking cessation and the practice ran a weekly smoking cessation clinic. Information about the clinic was displayed in the waiting area.

Are services caring?

Summary of findings

The practice was caring. Patients described the staff as respectful, extremely conscientious and caring. Patients could discuss all the concerns they had during one consultation. CQC feedback cards completed were extremely positive about the practice

However, although most patients were happy with the service they received some patients had expressed concerns about lack of appointments outside working hours.

The practice had an active patient participation group (PPG) that met four time a year. Feedback from this group was discussed at practice meetings.

Our findings

Respect, Dignity, Compassion & Empathy

Consultations took place in private consultation rooms with an appropriate couch for examinations and curtains to protect privacy and dignity. The practice had a chaperone policy and procedure There were signs displayed in the waiting rooms encouraging patients to speak with the doctor if they wanted someone to be with them during examinations.

Patients we spoke with at the practice told us they felt they were always treated with dignity by all the staff and doctors. The reception area was in a large open waiting room. Staff told us there was always a room available to speak with patients in private when booking appointments or collecting results if they so wished.

Involvement in decisions and consent

The doctors we spoke with told us they would give patients information regarding their condition and possible treatment options in a way they could understand. They said they ensured patients understood what was being discussed and responded to any concerns, as their aim was to “educate and involve” patients. Written consent was obtained for minor surgical procedures and immunisations.

The practice had access to a translation service for patients for whom English was not their first language

Patients Feedback

Patients we spoke with said the GPs responded to all concerns and would ask for verbal consent before giving any examinations and carrying out other medical procedures. One person said I feel listened to” and “I don’t mind who I see, they all give me time and explain what’s wrong.”

We looked at the CQC comment cards giving views of patients who used the service. The comments were extremely positive about the service patients had received.

Feedback from NHS choices suggests the majority of patients who provided feedback were happy with the service they received. Some however expressed concerns about lack of appointments outside working hours and not

Are services caring?

being able to see the same doctor on occasions. The GP's told us they closed at 8pm twice a week and patients were always encouraged to see the same doctor, except in emergencies.

The practice had a Patient Participation Group (PPG) to seek patient's views. The group met four times a year. Feedback from this group was discussed at the practices monthly meetings

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients needs. They worked well with other services to keep patients in the community and prevent hospital admissions.

There was a clear complaints policy. All comments and suggestions were considered at the weekly practice meetings.

The practice operated a triage system for those patients who wanted to see the doctor the same day. Phone consultation were carried out and if there was a need for the patient to see a doctor that day they would be booked in to see the duty doctor.

The practice had a complaints procedure and provided information for patients on how to make a complaint or comment about the service.

Our findings

Responding to and meeting people's needs

The practice demonstrated an understanding of their local community, which they described as mainly older white middle class.

The practice was accessible for patients with mobility difficulties. Toilets were available for the public and were accessible to people in wheelchairs

The practice had access to an Age UK support worker to support older patients who lived on their own. Their role included befriending, attended patients homes to carry out small repairs like replacing light bulbs and changing plugs, making arrangements for equipment to be fitted - such as stair lifts, liaising with social services and acting as advocates.

The practice worked with other services to keep patients in the community and prevent hospital admissions. We saw an example of where they educated a carer to recognise symptoms of deterioration and to contact the district nurse or doctor rather than going straight to hospital. We saw that they had liaised with social services to ensure the patient were got the right support to meet their needs at home.

Most patients were referred to Chelsea and Westminster hospital for various tests to be carried out. The practice has access to their online results website and were able to get test results directly in circumstances where they did not receive them in the agreed time or when they needed them urgently.

Access to the service

Patients told us they found it quite easy to get an appointment to see the doctor both on an emergency basis or in advance. The practice would book appointments for one or two weeks in advance.

The practice operated a triage system for those patients who wanted to see the doctor the same day. The system was facilitated by the on call registrar who would have a phone consultation with all patients who requested on the day appointments. If there was a need for the patient to see a doctor that day they would be booked in to see the duty

Are services responsive to people's needs?

(for example, to feedback?)

doctor or a home visit would be arranged, which was also carried out by the duty doctor. The practice said they had found this system effective in reducing the amount of patients coming in to the surgery for minor concerns.

We found that one GP also operated a triage system for all their appointments booked in advance. All GP's at the practice offered phone consultations to patients.

Concerns & Complaints

The practice had a complaints procedure and provided information for patients on how to make a complaint or comment about the service. The complaint procedure was in the information leaflet available in the waiting room. There was also a complaints and comments box situated on the reception desk. Staff told us that complaints were discussed regularly in the practice meeting. We looked at a sample of complaints and saw that they had been responded to in line with their complaints procedure.

Are services well-led?

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

Summary of findings

The practice was well led, however some improvements were needed. Three partners and a practice manager formed the leadership team. All had clear areas of responsibility. They promoted a culture of openness and transparency.

There were partners meetings every three weeks, which were also attended by the practice manager and monthly practice meetings were held, which were attended by all staff

The practice had a Patient Participation Group (PPG) to seek patient's views. The group met quarterly. However the practice recognised that the membership was not totally reflective of their patient group

Staff said they felt comfortable about making suggestions or recommendations at the practice meetings or to any of the leadership team. However, there were no formal processes in place to gather feedback from staff.

The practice had systems and audits in place to ensure that all equipment used was regularly serviced and maintained in accordance with the manufacturer's instructions. There were systems in place for identifying and managing risk.

Our findings

Leadership & Culture

The practice was managed by three partners and a practice manager who had had clear responsibilities. Day to day operations were managed by the practice manager. All demonstrated a good understanding of their area of responsibility and tried to ensure high standards of service were maintained.

The practice had a clear business development strategy in place. They established a one to three year business plan which was reviewed annually at the practice away days.

Staff we spoke with told us the practice had a culture of openness, honesty and transparency.

Governance Arrangements

Each partner was the lead for different areas of the practice, such as infection control, risk and safeguarding.

We saw they held partners meetings every three weeks which were also attended by the practice manager. The meetings discussed both clinical and non-clinical operational issues. The helped the leadership team to keep informed of all issues affecting the practice and take appropriate action when needed. It was also an opportunity for them to review progress with the business plan.

Systems to monitor and improve quality

The practice had an organised programme of audits in relation to the quality of the services provided. They also relied on the Quality and Outcomes Framework to inform them of areas where they needed to improve.

Patient Experience and Involvement

The practice had a Patient Participation Group (PPG) to seek patient's views. The group met four times a year. Feedback from this group was discussed at the practices monthly meetings. However we were told that the practice recognised that the membership was not totally reflective of their patient group and was working with the PPG to recruit more patients from different backgrounds. We were told the PPG was consulted before the new appointment system was put into place at the practice.

Staff engagement & Involvement

Are services well-led?

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

Staff said they felt comfortable about making suggestions or recommendations and that they would be taken on board. The practice gained formal feedback from their staff annually during the appraisal process. All suggested changes were reviewed at the weekly clinical meetings. However, there were no formal processes in place to gather feedback from staff.

Learning and Improvement

Clinical staff were supported in completing continual professional development required to maintain their professional registration.

Identification & Management of Risk

One of the partners was the lead on 'risk'. We saw that where potential risks were identified risk management plans were drafted with clear actions to be taken to minimise or alleviate the risk.

We saw that the practice had systems and audits in place to ensure that all equipment used was regularly serviced and maintained in accordance with the manufacturer's instructions. We saw service contracts, weekly and daily checks and records which showed that all had been completed.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

The practice employed a support worker to provide both practical and emotional support to older patients who lived on their own.

The practice also work closely with palliative nurses to ensure older patients with terminal illnesses were supported appropriately at home.

Our findings

An Age UK support worker attended the practice three days a week, to support older patients who live on their own. Their role included befriending, attended patients homes to carry out small repairs like replacing light bulbs and changing plugs, liaising with social services and acting as advocates The support worker told us they also arranged for equipment to be fitted, such as stair lifts.

The practice also work closely with palliative nurses to ensure older patients with terminal illnesses were supported appropriately at home.

We asked the practice about Clinical Commissioning Group (CCG) statistics which indicated they had low rates of identifying and making referrals for patients with suspected dementia. We were told that they had a proportion of patients whom they thought may be displaying symptoms of dementia who did not want to be referred for tests. The GP's said these patients had the capacity to make these decisions for themselves.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

The practice provided in-house services for patients with conditions such as diabetes. They also worked closely with respiratory and heart failure nurses to provide care and treatment to patients with these conditions in their own homes.

Our findings

The practice operated a monthly clinic for patients who had diabetes. Where patients were unable to come to the clinic the practice worked closely with a dietician and community diabetic nurse who visited them in their homes.

The practice also had access to a respiratory and a heart failure nurse. Both visited patients at home to monitor their conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

The practice provided weekly clinics for mother's babies and young children. They also worked closely with health visitors to ensure this group receive appropriate support at home.

Our findings

The practice provides eight week checks and weekly immunisation clinics for mothers with babies and young children. They also work closely with health visitors to ensure that patients who were unable to come to surgery were provided with the appropriate support at home.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

The practice offered phone consultations and opened late two evenings in the week to enable working patients to have access to GP's.

Our findings

The duty doctors provided phone consultation for patients who could not come to the surgery during working hours. However some patients we spoke with told us that on occasions they would get a call back from the GP at inconvenient times, as when they called the receptionists were unable to give them a time when they would be called back. The practice also stayed open until 8pm two nights a week.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

We were told patients whom they had identified may fall in this group would have access to language line and would receive home visits by either GP's or health visitors.

Our findings

The practice said anyone identified as living in poor circumstances or as having poor access to primary care would have alerts put on their notes. We were told patients whom they had identified may be in this group would have access to language line and would receive home visits by either GP's or health visitors.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

The practice provided some in - house services for patients suffering from anxiety or depression and could refer patients directly to psychiatric consultants at the local hospital.

Our findings

We were told that most patients experiencing mental ill health problems were usually suffering from depression or anxiety disorders. The practice had an in-house counsellor, employed by the practice three days a week. Doctors were able to refer patients directly to them. We were also told they made use of services that provided Cognitive Behavioural Therapy (CBT). The doctors also referred patients directly to psychiatric consultants at Charing Cross Hospital.

Injections were provided at the practice for patients whose mental illness needed to be controlled with medication.