Guy Barrington Staight

Guy Barrington Staight - Pelham Street

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 12 February 2019 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe services in accordance with the relevant regulations.

Are services effective?

We found that this service was providing effective services in accordance with the relevant regulations.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this service was providing responsive services in accordance with the relevant regulations.

Are services well-led?

We found that this service was providing well-led services in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

CQC inspected the service on 14 November and 6 December 2017 and asked the provider to make improvements to address breaches of regulations 12 (Safe care and treatment), 17 (Good governance) and 18 (Staffing). We checked these areas as part of this comprehensive inspection and found this had been resolved.

Guy Barrington Staight - Pelham Street (also known as The Staight Practice) is a private doctors service.

This service is registered with CQC under the Health and Social Care Act 2008 in respect of some, but not all, of the services it provides. There are some general exemptions from regulation by CQC which relate to particular types of service and these are set out in Schedule 2 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At The Staight Practice services are provided to patients under arrangements made by their employer with whom the service user holds a policy (other than a standard health insurance policy). These

Summary of findings

types of arrangements are exempt by law from CQC regulation. Therefore, at The Staight Practice, we were only able to inspect the services which are not arranged for patients by their employers with whom the patient holds a policy (other than a standard health insurance policy. The lead doctor is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Forty-nine people provided feedback about the service by completing comments cards. The feedback was entirely positive about the practice, its staff and the care and treatment received

Our key findings were:

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients' feedback indicated they were satisfied with care and treatment, facilities and staff at the practice.
- The practice ensured that care and treatment information was appropriately shared when people moved between services. When patient consent, their NHS GP if they had one was kept informed of the care and treatment they received.
- There was a strong focus on continuous learning and improvement among the clinical staff, and learning and development had improved among non-clinical staff since our last inspection.

There were areas where the provider could make improvements and should:

Review their arrangements to ensure staff continue to receive the training and professional development that are necessary for them to carry out their role and responsibilities.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Guy Barrington Staight - Pelham Street

Detailed findings

Background to this inspection

Guy Barrington Staight - Pelham Street (also known as The Staight Practice) is a private doctor's practice situated close to South Kensington tube station. The practice premises are located within a building that is primarily made up of residential apartments. The practice premises are located below street level and accessible via stairs only. The practice offers general medical services to adults and children, usually between 8.30am and 6.30pm on Mondays to Fridays. There are three doctors, two are part-time. One of the three doctors are female.

Our inspection team comprised a CQC lead inspector and a GP specialist adviser.

Before visiting, we reviewed a range of information we hold about the service. During our visit we:

- Spoke with the staff - the doctors, and reception and administrative staff.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients shared their views and experiences of the service.
- Reviewed service policies, procedures and other relevant documentation.
- Inspected the premises and equipment in use.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

We found that this service was providing safe services in accordance with the relevant regulations.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. Staff received safety information from the service as part of their induction and refresher training. The service had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff, locums. They outlined clearly who to go to for further guidance.
- The service had systems in place to assure that an adult accompanying a child had parental authority.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. Clinical staff had received training in safeguarding children and vulnerable adults relevant to their role, to adult and child safeguarding level three. At our last inspection, we found that non-clinical staff had not completed formal training in safeguarding people from abuse. At this inspection, some non-clinical staff had still not completed the training. We highlighted this to the provider and the new that had been recently published guidance on roles and competencies for healthcare staff in safeguarding children and young people. Following our inspection, the provider gave us assurances that the non clinical staff had now completed the relevant training.
- Staff knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The lead GP provided us with evidence of Legionella risk assessments carried out on the air conditioning system, but there were no legionella risk assessments of the water system in the premises. However they provided us with a copy of the cleaning and disinfection certificate for the building's water system.
- The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for agency staff tailored to their role.
- Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. They knew how to identify and manage patients with severe infections, for example sepsis.
- When there were changes to services or staff the service assessed and monitored the impact on safety.
- There were appropriate indemnity arrangements in place to cover all potential liabilities.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

Are services safe?

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

The service had reliable systems for appropriate and safe handling of medicines.

- The systems and arrangements for managing medicines, including vaccines, controlled drugs, emergency medicines and equipment minimised risks. The service kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there is a different approach taken from national guidance there is a clear rationale for this that protects patient safety.
- There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium). However, we found that patients prescribed lithium were being reviewed on a six monthly basis, rather than the current recommendation of three monthly reviews. The practice did not write to the usual GPs for the patients prescribed warfarin with their current prescribed dose and their next required test date. We highlighted these matters to the lead doctor, who assured us they would make improvements to fall in line with guidance and good practice, with immediate effect.
- Processes were in place for checking medicines and staff kept accurate records of medicines.
- There were effective protocols for verifying the identity of patients including children.

Track record on safety

The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The service monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and took action to improve safety in the service.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was providing effective services in accordance with the relevant regulations.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance relevant to their service.

- The provider assessed needs and delivered care in line with relevant and current evidence based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines.
- Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.
- Clinicians had enough information to make or confirm a diagnosis
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. We saw evidence of the clinicians participating in quality improvement initiatives, peer review and continuous professional development events. The practice GPs attended joint meetings with another practice every two months, where they regularly invited consultants and specialists to give talks on various conditions, guidelines and updates. They also discussed complex cases at these meetings.
- The service made improvements through the use of completed audits. Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to resolve concerns and improve quality. The practice provided the summary of a clinical audit completed in the last two years, where the improvements made were implemented and monitored. The audit, initiated following clinical guidelines changes, was a review of the patients treated with Thyroxine, a medicine used to treat an underactive thyroid. The audit found 64 patients were being treated with the medicine, and following the first cycle of the audit 24 patients (or 38%) had their dosage increased according to the new guidelines. The audit found on the second cycle that the patients who had had their dosage increased had improved thyroid stimulating hormone (TSH).

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.
- Relevant professionals (medical) were registered with the General Medical Council (GMC) and were up to date with revalidation
- Staff whose role included immunisation and reviews of patients with long term conditions had received specific training and could demonstrate how they stayed up to date. All staff (clinical and non-clinical) in the service completed annual basic life support training.
- The provider have made investments in the development and learning needs of staff since our last inspection. The provider had made available online training in a range of relevant topics to the staff team. Staff had completed some of the training topics available, but there was no prioritisation of relevant topics to ensure the most important and pertinent ones were completed first.
- Since our last inspection, the provider has formalised their system of appraisals. Staff meetings were being held and we saw minutes confirming this, as well as staff feedback of their attendance.
- A technician was employed in the practice, and carried out duties to support the clinicians such as audiometry, electrocardiogram (ECGs), lung function tests, measure fitness by rate of oxygen use, patient biometrics such as height, weight, percentage fat and blood pressure. Training had been on the job, led by the lead GP. At our last inspection, we found that the practice website and documentation within the practice referred to the

member of staff as a practice nurse. Following receipt of the draft report of the inspection, the provider updated their website to refer to the member of staff as a healthcare assistant. The lead GP also confirmed that the member of staff did not undertake any nursing duties.

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.

- 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.
- The practice contracted out pathology services to a medical laboratory provider. We saw there were systems and processes in place for the collection of samples from the practice, and electronic sharing of test results.
- We saw evidence that where appropriate, 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. Where appropriate we saw there was correspondence with other health care professionals 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.
- We saw examples of how patients, with their consent, had information shared with their usual GP about the care and treatment they received. However we found that the practice did not write to the usual GPs for the patients prescribed warfarin with their current prescribed dose and their next required test date. We highlighted this matter to the lead doctor, who assured us they would make improvements to fall in line with guidance and good practice, with immediate effect.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care.
- The practice offered cervical screening to women in the appropriate age range. The practice also provided patients with bowel and breast cancer screening. There were failsafe systems to ensure results were received for all samples sent and the practice followed up patients with abnormal results.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support. Patients had access to appropriate health assessments and checks, which were usually part of their initial consultations as new patients. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.
- Where patients needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

The service obtained consent to care and treatment in line with legislation and guidance.

- Staff understood the requirements of legislation and guidance when considering consent and decision making.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients.
- The service gave patients timely support and information.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

- Patients told us through comment cards, that 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.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff we spoke with during the inspection understood and respected people's privacy and dignity needs. The practice had arrangements in place to provide a chaperone to patients who needed one during consultations.
- 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.
- Information about people was treated confidentially

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing responsive services in accordance with the relevant regulations.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider understood the needs of their patients and improved services in response to those needs. There were longer appointments available for patients who had that need, such as people with complex health needs or patients whose first language was not English.
- Home visits and same day appointments were available
- Patients could download the practice registration form, and request a repeat prescription from their website.
- The facilities and premises were appropriate for the services delivered.
- There was restricted access into the practice premises, as there was a flight of stairs descending to the entrance door from street level. The reception staff told us they would help patients as much as possible if they needed that support accessing the premises.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, home visits were offered by the service.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- The practice was open Mondays to Fridays from 8.30am to 6.30pm. When the practice was closed, a doctor was available (on-call) to provide any necessary assistance. The telephone answering service directed patients how to contact the on call doctor.
- Appointments were available booked in advance or on the same day. The practice offered appointments of 15 or 30 minutes, and patients were able to choose their preferred appointment length. Home visits were available to patients who had that need or preference.
- Patients' feedback from completed comments cards indicated that they could get appointments when they needed them. Patients reported that the appointment system was easy to use.
- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Referrals and transfers to other services were undertaken in a timely way.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- It had a complaints policy and procedures in place
- 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. This included staff being able to signpost patients to the complaints process.
- The practice had not received any complaints in the last 12 months.

Are services well-led?

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

Our findings

We found that this service was providing well led services in accordance with the relevant regulations.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- The Staight practice has been at its current site since 1994. In more recent years, the lead doctor has been joined by two GPs; one of whom has been working in the practice for 13 years and the other for three years.
- The lead doctor had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- The lead doctor and GPs were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- The lead doctor was visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

Vision and strategy

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

- The practice had a statement of purpose in place, which defined among its aims and objectives to provide high quality private general medical care for all patients registered with them.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

The practice had a supportive culture towards staff and patients

- Staff told us they felt supported and valued by the practice leadership. They told us the leadership was approachable and listened to them if they wanted to raise any matters.
- The practice had a policy in place in relation to Duty of Candour. The policy sought to encourage a culture of candour, openness and honesty.
- Clinical staff were supported to meet the requirements of professional revalidation where necessary.
- Since our last inspection, the practice has implemented processes for providing non-clinical staff with the development they need. This included staff appraisal and training.

Governance arrangements

The practice had governance arrangements in place as follows:

- The provider had suitable arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had a range of policies and procedures in place, which were followed by the staff team.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The lead GP was the information governance lead, with responsibilities for ensuring confidentiality, integrity and availability of data. The practice had a protocol in place for the management of patient data, and staff we spoke with could describe how they would ensure patient data was kept secure.

Engagement with patients, the public, staff and external partners

- The practice had a protocol in place for raising staff concerns, which referred to a monthly meeting held in the practice. However they were only able to provide

Are services well-led?

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

minutes of two meetings from the past 12 months. Staff told us the lead GP was very approachable and they would raise any issues with him, at the time they occurred. Matters discussed at practice meetings included appointments, staff cover and fees changes. The lead GP also told us that members of staff discussed issues in the practice on a daily basis due to them being a small team. They told us they had regular informal meetings between both the doctors and other staff, but that not all these meetings had minutes recorded for them.

- We saw meeting minutes which indicated that the clinical staff held regular joint meetings, every two months, with another practice. Guest speakers were regularly invited to these joint clinical meetings and they had given talks on a range of topics, guidelines and updates, including on CQC registration and inspection, pain management and shoulder problems.
- The practice did not formally seek patient views, but they told us they received individual written compliments periodically. No complaints had been received in the 12 months prior to our inspection.

Continuous improvement and innovation

- Clinicians in the practice were engaged in continuous professional development.
- Clinicians in the practice participated in regular joint clinical meetings for peer support and professional development.
- Since our last inspection, the provider has formalised the training and appraisal processes for their staff. We saw evidence of staff appraisals completed in December 2018. Staff training was made available through an online training provider and we saw evidence that staff had completed some topics. But there was no prioritisation of relevant topics to ensure the most important and pertinent ones were completed first.