Stanhope Mews Surgery

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

Stanhope Mews Surgery is a general medical practice providing the regulated activities: diagnostics and screening procedures; family planning; maternity and midwifery; treatment of disease disorder or injury and surgical procedures to around 9,400 patients in the High Street Kensington area of Central West London.

We carried out an announced inspection of the service on the 14 May 2014. The team, led by a CQC inspector, included a GP, CQC Inspector Manager and another CQC Inspector.

We found that the practice was effective, caring, responsive and well-led and required improvement to be safe. We made a compliance action regarding staff recruitment procedures to include complete reference checks.

Systems were in place to ensure the appropriate infection control procedures were followed. Vaccinations and other injections were stored in refrigerated conditions that were monitored effectively. Regular checks of the environment were undertaken to ensure that it was a safe place for patients to visit and staff to work in. The practice had working relationships with other local allied health professionals to ensure effective care and treatment was delivered to patients. Measures were in place to meet the varying needs of the registered patient population.

The practice was involved in continued professional development with annual staff appraisal and they discussed and learned from significant incidents and complaints to improve the service for their patients. The leadership team was visible and staff understood their roles and responsibilities.

All the patients we spoke with praised the practice and the services provided and spoke highly about the care and treatment they received 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 had formal pre-employment checks in place to ensure staff were suitable to work in a healthcare setting. However, we found that the process checks in place did not appear to be consistently followed. There was a system followed for the recording, reporting and investigating of serious incidents. Staff had received appropriate training in child protection and safe guarding vulnerable adults from harm and could describe the correct processes to follow. However, staff were less clear about whistleblowing procedures.

Infection control processes were in place and measures were taken to ensure the environment was safe for patients and staff. Vaccinations and other injections were stored in refrigerated conditions that were monitored effectively. The practice had appropriate staff training and equipment available to deal with medical emergencies.

Are services effective?

Care was delivered in line with current best practice guidelines and the practice GPs kept up to date with new evidenced based medicine at weekly clinical meetings. The practice undertook regular audit to ensure that care delivered met recommended standards and implemented change where needed to improve service delivery. The practice supported continued professional development of their staff with annual staff appraisal.

There was evidence of co-ordinated care with the wider multi-disciplinary team with monthly meetings attended by a range of allied health professionals to ensure the needs of patients were met effectively. The practice belonged to a network learning forum involved in developing integrated care pathways for patients with complex needs within the local area.

The practice had measures in place to promote healthy lifestyle choices for patients including access to support services.

Are services caring?

We observed that staff were kind, courteous and approachable when dealing with patients in the surgery. Patients we spoke with felt the staff were respectful and polite The practice had a policy for supporting patients and families through bereavement. Patients were involved in making decisions about their care and the practice GPs supported them to make informed choices.

Summary of findings

Are services responsive to people's needs?

The practice had measures in place to meet the needs of a varying patient population including the frail and elderly, patients experiencing poor mental health and mothers, babies and young children. The practice ensured care was accessible to the patient population by providing flexible appointment time slots, daily walk in emergency clinics and access to telephone consultations and online booking. The premises were accessible for patients with physical difficulties and for children transported in prams.

Are services well-led?

The practice had a clear ethos that all staff were aware of. There was visible leadership and staff understood their roles and responsibilities. Staff described an open and honest culture within the practice. The practice sought feedback from their patients via a patient forum and patient feedback questionnaire. Changes had been implemented to improve the service as a result of patient feedback. The practice had measures in place to record, investigate and learn from complaints and serious incidents. Action plans and learning from these incidents were disseminated to all staff at the practice.

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 provided care to meet the specific needs of older patients within the registered patient population. Older patients at risk of hospital admission were identified and invited for comprehensive assessment including physical checks, memory checks and screening for depression and anxiety. For patients unable to attend the surgery the assessments were carried out in their own home.

People with long-term conditions
Patients with long term conditions had a named GP as the primary point of contact to discuss their health needs. There were monthly multi-disciplinary team meetings to discuss and plan care for patients with complex medical needs.

Mothers, babies, children and young people
The practice held weekly child health and well-baby clinics to support the needs of families with young children's. Family planning and maternity services were also available at the practice. Walk-in emergency appointments were available daily.

The working-age population and those recently retired
The practice had procedures in place to ensure working age patients could book and attend appointments outside of usual working hours.

People in vulnerable circumstances who may have poor access to primary care
The practice had measures in place to ensure vulnerable patients had access to care and treatment including wheelchair access and assistance for patients with hearing impairment and language barriers.

People experiencing poor mental health
The practice had processes in place to support patients experiencing poor mental health. These included an initiative to encourage patients to attend the practice for annual checks. There was a system in place to alert the community mental health team if a patient missed a scheduled appointment.

Summary of findings

What people who use the service say

All the patients we spoke with during the visit praised the service they received at the practice. Patients told us the surgery was well run and staff were approachable and respectful. They were particularly pleased with the appointment system and emergency walk-in service.

Areas for improvement

Action the service MUST take to improve

Staff recruitment procedures must be improved to include complete reference checks.

Good practice

- Pro-active assessments for frail elderly patients.
- Primary care navigator to assist patients aged 55 years and over in accessing health, social care and voluntary sector services in the community.

Stanhope Mews Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The lead CQC inspector was accompanied by two further CQC inspectors and a GP specialist advisor. The specialist GP advisor was granted the same authority to enter Stanhope Mews Surgery as the CQC inspectors.

Background to Stanhope Mews Surgery

Stanhope Mews Surgery is a GP practice within the Kensington and Westminster Clinical Commissioning Group area. As of March 2014, 9402 patients were registered at the practice, of these approximately 30 percent of patients are over 75 years of age and 18 percent aged 55-74. There are three GP partners and two salaried GPs at the practice. The service is a training practice and employs trainee GP registrars on rotation. The practice is open Monday to Friday 8am - 6pm with extended opening hours on a Tuesday, Wednesday and Thursday. The practice provides primary care services including diagnostics and screening, family planning, maternity care and minor surgical procedures. The practice is spread over three floors with disabled access and a through floor lift to access upper floor consultation rooms.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider 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?

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before our inspection we reviewed a range of information we hold about the practice from our Intelligent Monitoring System. We met with NHS England, NHS West London

Detailed findings

Clinical Commissioning Group and Healthwatch Central West London and reviewed the information they gave to us. We looked at the practice website for details of the staff employed and the services provided.

We carried out an announced inspection on 14 May 2014.

During our inspection we spoke with a range of staff including GPs, trainee GP registrars, nurses, management and reception staff. We also spoke with patients, a representative of the patient forum group. We looked around the building, checked storage of records, medicines and cleaning materials. We checked records of health and safety checks, infection control audits, clinical audits, significant events, staff recruitment and training records, meeting minutes and complaints. We observed how staff greeted and spoke with patients attending appointments and when telephoning the surgery. We reviewed comment cards completed by patients who attended the surgery on the day of our visit.

Are services safe?

Summary of findings

The practice had formal pre-employment checks in place to ensure staff were suitable to work in a healthcare setting. However, we found that the process checks in place did not appear to be consistently followed. There was a system followed for the recording, reporting and investigating of serious incidents. Staff had received appropriate training in child protection and safe guarding vulnerable adults from harm and could describe the correct processes to follow. However, staff were less clear about whistleblowing procedures.

Infection control processes were in place and measures were taken to ensure the environment was safe for patients and staff. Vaccinations and other injections were stored in refrigerated conditions that were monitored effectively. The practice had appropriate staff training and equipment available to deal with medical emergencies.

Our findings

Safe Patient Care

The practice had systems in place to ensure safe patient care. We saw there were processes in place for recording and reporting any significant safety issues. Staff we spoke with were familiar with these processes and knew who to discuss any concerns with. We saw evidence of staff training applicable to their roles including training in infection control and safeguarding.

Learning from Incidents

The practice had a system for the recording, reporting and investigation of serious incidents. Staff we spoke with were familiar with the reporting process and described the actions that took place following a serious incident. Records we reviewed demonstrated that serious incidents were recorded and included a summary of the incident, the key risk issues, actions required and learning outcomes to improve the safety of the service. We saw evidence that incidents were discussed and included as a regular agenda item at weekly clinical team meetings.

Safeguarding

Staff received the appropriate training, support and information needed to act on concerns if it was considered that a patient may be at risk of harm. The practice had safeguarding policies and procedures in place to guide staff about their role in protecting children and vulnerable adults from harm. We saw that safeguarding information was displayed throughout all service areas, including contact details of the local authority safeguarding teams. There was a designated GP safeguarding lead in the practice whose role was to support staff and act as a point of contact for them to raise and discuss any concerns.

Training records evidenced that all clinical and non-clinical staff were trained to an appropriate level for child protection and had also received training in safeguarding vulnerable adults. Staff we spoke with demonstrated understanding and knowledge in recognising potential signs of abuse and described the processes they would follow to report any concerns. We saw that the electronic patient record system alerted staff when a child protection plan was in place. Records showed that safeguarding cases were a standing agenda item for discussion at weekly clinical team meetings.

Are services safe?

However we found through our discussions with staff, less understanding of whistleblowing procedures. Whistleblowing is when a worker reports suspected wrongdoing at work and is referred to as 'making a disclosure in the public interest'. Some staff were unclear about the processes to follow or were unaware of the external organisations to contact if they wanted to raise a concern. We observed that whistleblowing was not included in the induction training delivered to new staff when they commenced work at the practice.

Monitoring Safety & Responding to Risk

The building which housed the practice appeared to be generally in good repair. We found that the practice undertook regular checks of the environment to ensure that it was a safe place for patients to visit and staff to work in. We saw that a Health and Safety (H&S) risk assessment had been completed in May 2014 and that identified risks and actions taken had been recorded. Other records demonstrated that a legionella risk assessment had been completed in June 2013 and that monthly water outlet temperatures checks had been performed.

Medicines Management

Vaccinations and other types of injections held at the practice were stored in temperature monitored refrigerators. Temperature checks for the refrigerators were carried out daily to ensure that vaccinations were stored within the correct temperature range. Nursing staff we spoke with demonstrated that they were aware of the upper and lower temperature limits for the refrigerators when they did these checks. They were also aware of the process to follow if the refrigerator temperature ever breached the recommended range. The inventory and expiry dates for stored injections were monitored regularly by the senior practice nurse. The practice did not keep a supply of controlled drugs.

Cleanliness & Infection Control

There were protocols and procedures in place for the prevention and control of infection. Clinical staff received infection control training as part of an induction and mandatory training programme the practice had in place. The senior practice nurse was the infection control lead for the service. Infection control was discussed as a rolling agenda item at weekly clinical meetings.

We observed that a daily check cleaning protocol for tasks undertaken by nursing staff was followed. An external domestic cleaning company attended on a daily basis to ensure cleanliness of the environment was managed throughout the service. Contracted cleaning staff observed national colour coding standards for mops and buckets. Signed records of cleaning schedules confirmed that a comprehensive cleaning programme was in place. Appropriate personal protective equipment was available in all treatment and consultation rooms.

Procedures for the safe storage and disposal of sharps and clinical and domestic waste were evident. We observed good hand washing facilities throughout the practice and hand washing guidance was displayed to promote high standards of infection control. At the time of our visit the practice was developing audit systems for waste, sharps and hand hygiene.

These measures supported the practice to maintain good standards of hygiene.

Staffing & Recruitment

Some recruitment files we reviewed demonstrated that pre-employment checks took place prior to employment commencing. We saw that Disclosure Barring Service (DBS) checks had been completed for 18 out of 23 staff currently in post at the practice and a further five were being processed. However despite evidence to suggest pre-employment reference checks were sought before staff commenced work, we found no references in four of the six recruitment files we reviewed. We found one written and one email reference in the other two files. In the absence of formal references for some staff, this meant that the practice could not be assured that staff had been suitably vetted to work at the practice.

Staff training records we reviewed evidenced that staff completed induction training and mandatory training courses applicable to their roles.

Dealing with Emergencies

The practice had arrangements in place to deal with foreseeable medical emergencies. Staff we spoke with and records confirmed that cardio pulmonary resuscitation (CPR) training was delivered annually to all staff at the practice.

The practice retained equipment and medication for use in medical emergencies. We observed that a resuscitation trolley equipped with a defibrillator, oxygen and emergency medication was kept in the ground floor area of the practice. Systems were in place to reduce the risks associated with storage of equipment and medicines for

use in emergency situations, to ensure that they were fit and safe for use. Records maintained by the practice demonstrated that the defibrillator and oxygen were checked daily by nursing staff to ensure they were in working condition. Emergency medication was also checked regularly to verify that they had not exceeded the expiry date recommended by the manufacturer, to ensure their effectiveness.

We observed that basic life support and anaphylaxis protocol posters were displayed in all service areas and that a page alert alarm system was in operation. All staff we spoke with were aware of the location of the resuscitation trolley on the ground floor. However, staff were not aware of the time it would take to move the resuscitation equipment to the upper floors if required in an emergency.

Equipment

There was evidence that portable appliance testing (PAT) had been carried out and that annual calibration testing of all medical equipment had been conducted. We saw that fire extinguishers were validated and that weekly fire alarms and annual fire drills were undertaken. However we noted that a fire risk assessment had not been conducted, although this had been included as part of the general H&S risk assessment completed in May 2014. Staff received fire safety training for which the facilities manager kept records.

Are services effective?

(for example, treatment is effective)

Summary of findings

Care was delivered in line with current best practice guidelines and the practice GPs kept up to date with new evidenced based medicine at weekly clinical meetings. The practice undertook regular audit to ensure that care delivered met recommended standards and implemented change where needed to improve service delivery. The practice supported continued professional development of their staff with annual staff appraisal.

There was evidence of co-ordinated care with the wider multi-disciplinary team with monthly meetings attended by a range of allied health professionals to ensure the needs of patients were met effectively. The practice belonged to a network learning forum involved in developing integrated care pathways for patients with complex needs within the local area.

The practice had measures in place to promote healthy lifestyle choices for patients including access to support services.

Our findings

Promoting Best Practice

The practice provided care in line with National Guidance. GPs attended weekly clinical meetings in which current guidelines and protocols, including National Institute for Health and Care Excellence (NICE) guidance and Medicines and Healthcare products Regulatory Agency (MHRA) were presented and discussed. These meetings provided a forum for the GPs to discuss with their peers, any clinical problems they may have encountered and explore evidenced based solutions.

The practice regularly engaged in clinical audits in addition to the national quality outcome framework (QOF) requirements, to drive service improvement and ensure best practice care and treatment. We saw evidence of closed loop clinical auditing of prescribing practices. Closed loop clinical audit is a cyclical process that compares current practice against evidenced based standards and makes recommendations to improve practice which are implemented and then re-audited to measure improvement. One recent audit conducted by the practice reviewed prescribing of non-steroidal anti-inflammatory drugs (NSAIDs) and another on the use of anti-epileptic medicines and vitamin D treatment.

The practice encouraged trainee GP registrars to take part in regular audit. One of the trainee GP registrars told us they had recently completed an audit on urinary tract infections and antibiotic prescribing.

Management, monitoring and improving outcomes for people

The practice compared their clinical activities with that of other local GP services and findings were used as a focus to drive improvement. The practice on a monthly basis, as part of weekly GP partners meeting, reviewed data provided by NHS West London Clinical Commissioning Group (CCG) to compare their practice with other GP practices in the CCG area. This included benchmarking of audit results, for example comparing prescribing patterns with neighbouring GP practices in order to drive improvements.

Referral management meetings were held twice weekly at the practice to review referrals made by the GPs to other services. Referrals made by each GP were reviewed and where applicable re-directed to more appropriate services.

Are services effective?

(for example, treatment is effective)

For example re-directing referrals made to secondary care to alternative community services more suited to a patient needs. These meetings also provided the opportunity for the clinical team to learn about local services that could be accessed in the community. A trainee GP registrar we talked with spoke highly of the referral meetings and said, 'I find the weekly referral meeting invaluable'. We noted that the NHS West London Clinical Commissioning Group (CCG) had recommended the referral meetings as a reference model for other GP practices in the area.

Staffing

The practice was involved in the training and development of trainee GP registrars. Trainee GP registrars we spoke with talked highly of the training they received at the practice. One registrar said, 'the practice has been very supportive, if a trainer is not around then other staff are always ready to help'. The trainee GP registrars attended weekly joint clinics with their GP supervisor that enabled them to observe and learn from the experience of senior colleagues. Attendance at weekly clinical meetings allowed trainees to discuss and present clinical problems and review relevant guidelines. We saw there was a handbook for trainee GP registrars available on the intranet which provided up to date guidelines and information needed for working at the practice.

The practice had in place measures to ensure continued professional development of their staff. Staff received annual appraisals that included multi-source feedback that allowed clinical and non-clinical staff to provide constructive anonymous feedback about their colleague's performance. Staff we spoke with found this process useful.

Working with other services

The practice assessed patient's needs to tailor the delivery of care and treatment. There was evidence of collaborative work between the practice and a range of other allied health professionals. A multi-disciplinary team care plan meeting, 'putting people first and palliative care' was held monthly with the involvement of practice staff, social workers, district nurses and palliative care team. The meeting was used as a forum to discuss the care planning needs of high risk/high need patients and to generate action plans to address any gaps in care delivery.

One of the GP partners told us the practice belonged to a 'network learning forum' involved in developing integrated care pathways. The forum held monthly meetings and covered thirty local GP practices. It comprised of GPs, community nurses, mental health consultants and consultant geriatricians. The aim was to map out integrated care pathways to meet the needs of complex patients.

Health promotion and prevention

The practice had measures in place to support the needs of patients in health promotion. One GP told us the practice endeavoured to signpost patients to healthy lifestyle opportunities and that they discussed these during patient consultations. Healthy lifestyle literature and leaflets that informed about health promotion services were available at the practice, such as NHS health checks and nurse-led smoking cessation clinics were displayed in patient waiting areas.

It was noted that there was a low recording of smoking status in data collected by the practice. The GP partner we spoke with explained data on smoking status was often obtained 'ad hoc' when a patient attended for a consultation or an NHS health check. In addition recording data was low as the practice patient population were generally healthy and therefore infrequent attenders.

The practice was proactive in addressing the issue of obesity in their patient population with the practice nurse offering weight monitoring clinics and referral to local dietetics and bariatric services. One of the GPs we spoke with described the measures the practice had in place to support patients who had problems with alcohol excess. For example, an in-house counsellor was available with expertise in alcohol support and that liver function tests were regularly monitored.

We observed that a 'surgery pod' was accessible for patients to use at the practice without the need for an appointment. The 'surgery pod' is a touchscreen computer that enables patients without clinical supervision, to measure their own vital signs for example, blood pressure and pulse rate, or basic information including weight and height. It was configured to the practices electronic patient record system so that information was automatically recorded into the patient's medical record. An alert was built into the system to warn if vital signs fell outside the normal range and that required urgent review by the practice nurse or GP.

Are services effective?

(for example, treatment is effective)

GPs in the practice had developed an online local service directory available for the public to access to help patients identify the most suitable health service to meet their needs. One of the GPs we spoke with told us the site received 200 accesses per week.

All of these measures demonstrated that a wide range of patients with differing healthcare needs were supported to access services available to assist them in a healthy lifestyle.

Are services caring?

Summary of findings

We observed that staff were kind, courteous and approachable when dealing with patients in the surgery. Patients we spoke with felt the staff were respectful and polite. The practice had a clear policy for supporting patients and families through bereavement. Patients were involved in making decisions about their care and the practice GPs supported them to make informed choices.

Our findings

Respect, Dignity, Compassion & Empathy

During our visit we observed many interactions with patients and the practice staff. We saw that staff acted in a kind, courteous and approachable manner in their dealings with patients. We observed patients being welcomed by staff in a polite and professional way. However we did notice on a few occasions reception staff asking patients who contacted the practice by telephone if they could hold the line. We were aware that this had previously been raised as an unfavourable approach by several patients.

We discussed this with the practice manager who informed us that difficulties in patients accessing the service by telephone contact had been problematic since the migration of a new clinical system recently installed at the practice. We were told that reception staff were still mastering the new system and this may have contributed to delays in dealing with calls directly when received. The practice was in the process of identifying opportunities to improve inbound telephone call flow.

Consultations took place in appropriately equipped rooms that maintained patient's privacy and dignity. All of the patients we spoke with told us that they felt that staff were respectful and polite.

We were told and shown the processes the practice followed when they were aware of the death of one of their patients. This included notifying other agencies and professionals who had been involved in the patients care. This was to ensure they were made aware so that any planned appointments, home visits or communication could be terminated. This was in effort to prevent or cause relatives any additional distress. We observed that the practice also sent a written letter to the next of kin to offer condolence and support.

Involvement in decisions and consent

Individual patients told us they felt they had been involved in decisions about their own treatment. They were satisfied with the level of information they had been given and that their treatment options had been explained to them. We saw that these views reflected the findings of the General Practice Assessment Questionnaire (GPAQ) patient survey report March 2013. We observed that this report recorded very high satisfaction ratings.

Are services caring?

GPs we spoke with told us they supported patients to make informed decisions and respect their choices. One GP gave a recent example of a patient visited by the London Ambulance Service who refused admission to hospital. They told us that they discussed the options with the patient, documented the discussion and allowed the patients choice to prevail. GPs were involved in assessing patient's capacity to make informed decisions if this was necessary.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice had measures in place to meet the needs of a varying patient population including the frail and elderly, patients experiencing poor mental health and mothers, babies and children. The practice ensured care was accessible to the patient population by providing flexible appointment time slots, daily walk in emergency clinics and access to telephone consultations and online booking. The premises were accessible for patients with physical difficulties and for children transported in prams.

Our findings

Responding to and meeting patients needs

We saw evidence of the different measures the practice had in place to meet the various healthcare needs of registered patients. As part of an integrated care pathway pilot, patients over 70 years of age were invited to the practice, or were pro-actively visited at home for an annual health check. This included a physical check with weight and blood pressure measurements, hearing test, memory check and screens for depression and anxiety. Patients were identified for this pilot based on the risk of admission to hospital.

The practice was part of a mental health initiative which invited patients listed on the chronic mental health register for annual checks. The practice also had a policy for patients on long term anti-psychotic medications to ensure they attended for regular review and blood tests. If a patient missed a scheduled appointment or they had not had a recent review, the practice attempted to contact them. If this was unsuccessful the practice alerted the patient's relevant community psychiatric nurse. GPs at the practice also attended an annual meeting with consultant psychiatrists from Chelsea and Westminster Hospital to jointly review patients on the register and update treatment plans where necessary.

The practice ran a weekly child health and well-baby clinic with fixed appointments to support the needs of families with young children. We were told that as part of an NHS West London Clinical Commissioning Group (CCG) initiative, there were plans to develop a joint clinic with consultant paediatricians to further develop the service. Family planning; including emergency contraceptive advice, maternity care and gynaecological examinations; including smear testing, were also available at the practice for patients to access.

We observed that the practice had a designated Primary Care Navigator (PCN) who worked alongside the practice team three days a week. Although a member of the practice team, the PCN was employed by Age UK and funded by NHS West London Clinical Commissioning Group (CCG) and the Royal Borough of Kensington and Chelsea. We were informed that the PCN provided support to patients with complex physical and or mental health needs aged 55 years of age and over. Their role was to support patients to access a wide range of health, social care and

Are services responsive to people's needs?

(for example, to feedback?)

voluntary sector services in the community. They also played a role in the provision of information and advice, co-ordinating care, reducing social isolation and improving planned take up of services.

Access to the PCN service was made by referral from the clinical staff. The PCN attended monthly multi-disciplinary team (MDT) meetings at the practice to discuss cases and referrals. Several clinical staff at the practice commented highly about the PCN service and described many benefits of the PCN being in post. We saw records to demonstrate that quarterly monitoring of PCN referrals and uptake was undertaken by the commissioning organisations.

The practice had a chaperone policy that was displayed in all service areas. This explained to patients that they could request a chaperone during physical examinations if they wanted to. Patients could also request to be seen by a male or female GP.

Access to the service

The practice took steps to ensure that new patients were assessed and received care in a timely manner. New patients who registered with the practice completed a health questionnaire which provided important information about their medical history, current health concerns and lifestyle choices. They were then offered an appointment with practice nurse for a health check.

The practice ensured the service was accessible to varying patient groups. For example they provided walk-in appointment slots one day a week from seven am until eight am and twice weekly bookable appointments from six pm until eight pm. This provided patients who were unable to attend normal practice hour's access to the service. There were also walk-in emergency appointments available twice a day for two hour periods with a designated GP who lead the clinic. Twice daily nurse triage sessions by telephone were offered in addition to face-to-face appointments. Three bookable GP telephone consultations were available daily.

Appointments could be made by telephone or booked online through the practice website. The practice website could be used for a number of patient based services, for example registering online for new patients, ordering certain repeat prescriptions, accessing patient educational resources and email communication with clinical staff for non-urgent matters.

There was access to the practice for wheelchair users including lift access to the upper floors of the building. A hearing loop system was in place and the practice had access to an interpreting service. We were told that double time appointments were made for patients who required an interpreter for their consultation.

Concerns & Complaints

The practice had a complaints policy and there was an information leaflet available in the reception area to make patients aware of how they could complain. We saw evidence of learning from patient complaints and feedback. An annual meeting was held to review outcomes of patient complaints that had been resolved over the previous year. We observed that the practice investigated and responded to complaints posted on NHS choices website, including complaints posted anonymously.

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 had a clear ethos that all staff were aware of. There was visible leadership and staff understood their roles and responsibilities. Staff described an open and honest culture within the practice. The practice sought feedback from their patients via a patient forum and patient feedback questionnaire. Changes had been implemented to improve the service as a result of patient feedback. The practice had measures in place to record, investigate and learn from complaints and significant incidents. Action plans and learning from these incidents were disseminated to all staff at the practice.

Our findings

Leadership & Culture

We spoke with the practice manager who told us the motto of the practice was 'helping others to help themselves'. The motto of the practice was included in the practice handbook and on the homepage of the practice website. Staff we spoke with were able to articulate the motto and told us they were proud of the work ethos. Although the ethos of the practice was shared by staff we spoke with, we found there were no clear practice wide objectives set to drive and improve performance.

The practice manager told us leadership of the service was visible and staff roles and responsibilities were clear. There were lead roles for specific services, for example one of the partners was the lead for safeguarding. Staff we spoke with were able to describe the organisation structure of the service and were aware of their roles and responsibilities and who they reported to.

Governance Arrangements

We observed that governance arrangements were in place at the practice. Roles and responsibilities were clearly defined and any risks were identified and managed. The practice held weekly partners management meetings were issues such as complaints, significant incidents, prescribing, medical device alerts and NHS West London Clinical Commissioning Group (CCG) updates were regularly discussed. We saw minutes of these meetings that confirmed this.

Systems to monitor and improve quality & improvement

The practice regularly engaged in clinical audits, in addition to the national quality outcome framework (QOF) requirements, to drive service improvement and ensure best practice care and treatment.

The practice reviewed data provided by the CCG to compare their practice with other GP practices in the CCG area as part of the GP partners meeting. This included benchmarking of audit results, for example comparing prescribing patterns with neighbouring GP practices.

Patient Experience & Involvement

The main methods of patient feedback about the service were through the patient forum. The patient forum met quarterly and was open to all patients to attend. The main

Are services well-led?

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

aim of the forum was to ensure that patients were involved in decisions about the range and quality of services provided by the practice. The minutes from the patient forum meetings were published on the practice website.

We spoke with a representative of the patient forum who told us that they felt the practice was responsive to concerns raised. We were told about changes that had been made by the practice following feedback through the group. For example an out-of-hours service leaflet had been created to help sign post patients to services out of hours following feedback that this had previously not been very clear.

We were told that a recurring complaint was with telephone contact to the practice and patients' being put on hold until a receptionist was available to take the call. As a result of the feedback the practice manager told us that the practice was exploring different options to address the issue, including the promotion of the on-line booking service. Staff we spoke with told us they were aiming to develop the forum further by using text messaging to involve younger patients and become more representative of the practice population as a whole.

The practice used the General Practice Assessment Questionnaire (GPAQ) yearly to gain further patient feedback on the service. We saw the results of this survey were accessible to the public through the practice website.

Staff engagement & Involvement

Staff we spoke with described an open and transparent culture within the practice. Administration staff we spoke with felt that clinical staff were approachable and that they all worked as a team.

Team meetings attended by all staff were held quarterly or more frequently if required. Staff attended an 'Away Day' afternoon in which the pressures and concerns regarding appointments were discussed. This enabled individual staff to contribute from their own work perspective and gain the view point of their fellow colleagues. The noted agenda for the day included discussion about the issues that each staff group may have experienced and identification of potential solutions.

Learning & Improvement

There were processes in place to learn from significant incidents and complaints and to disseminate action plans and learning to all staff in the practice.

We found a culture of learning from patient experience, complaints and significant incidents that had occurred at the practice. The practice manager explained that learning and continuous improvement was important to the practice. Significant incidents were discussed weekly at the GP partners meeting and these were collated and reviewed annually to monitor trends. We reviewed the minutes of the annual review of significant incidents November 2012, which documented the significant incidents that had occurred over the previous year.

We saw that all incidents that had occurred were recorded along with the learning outcome and action plan for each episode. For example, there had been an incident when in an emergency a GP and a receptionist did not know where the emergency equipment was stored. In addition, the oxygen cylinder for use in emergencies was empty. The learning from this incident recommended that all clinical and non-clinical staff should be competent to access emergency equipment in response to any medical emergency. The subsequent action plan led to a resuscitation trolley, stocked with emergency equipment, being purchased and staff made aware of where the equipment was stored. A process for regular checks of emergency equipment had also been implemented including a daily check of oxygen cylinder supply. We reviewed the checking systems that had been put in place and found that checks had been made and were up to date.

In addition to learning from significant incidents, we saw evidence of learning from patient complaints and feedback. An annual meeting was held to review outcomes of patient complaints that had been resolved over the previous year. We observed that the practice investigated and responded to complaints posted on NHS choices website, including complaints posted anonymously.

Identification & Management of Risk

The practice had systems to identify, assess and manage risks of any potential significant disruption to service. The practice had a comprehensive business continuity plan in place including a 'buddy' surgery premises arrangement with another local GP practice. Public liability insurance was in place which covered the entire practice.

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 provided care to meet the specific needs of older patients within the registered patient population. Older patients at risk of hospital admission were identified and invited for comprehensive assessment including physical checks, memory checks and screening for depression and anxiety. For patients unable to attend the surgery the assessments were carried out in their own home.

Our findings

The practice had measures in place to assess and meet the needs of older patients in the patient population. As part of an integrated care pathway pilot, patients over 70 years of age were invited to the practice, or were pro-actively visited at home for an annual health check. This included a physical check with weight and blood pressure measurements, hearing test, memory check and screens for depression and anxiety. Patients were identified for this pilot based on the risk of admission to hospital.

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

Patients with long term conditions had a named GP as the primary point of contact to discuss their health needs. There were monthly multi-disciplinary team meetings to discuss and plan care for patients with complex medical needs.

Our findings

GPs we spoke with told us that patients with long term conditions had a primary nominated GP for that specific condition and all follow-ups and queries would be directed to this GP. There was a monthly multi-disciplinary team meeting to discuss patients with complex medical problems or high needs. At these meetings detailed care plans and integrated care pathways were made and these were relayed back to the patient and their named GP.

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 held weekly child health and well-baby clinics to support the needs of families with young children's. Family planning and maternity services were also available at the practice. Walk-in emergency appointments were available daily.

Our findings

The practice ran a weekly child health and well-baby clinic with fixed appointments to support the needs of families with young children. We were told that as part of an NHS West London Clinical Commissioning Group (CCG) initiative, there were plans to develop a joint clinic with secondary care consultant paediatricians to further develop the service. Family planning; including emergency contraceptive advice, maternity care and gynaecological examinations; including smear testing, were also available at the practice for patients to access. Walk-in emergency appointments were available daily.

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 had procedures in place to ensure working age patients could book and attend appointments outside of usual working hours.

Our findings

The practice provided walk-in appointment slots one day a week from seven am until eight am and twice weekly bookable appointments from six pm until eight pm for patients who were unable to attend normal practice hours. There were also walk-in emergency appointments available twice a day for two hour periods with a designated GP who led the clinic. Twice daily nurse triage sessions by telephone were offered in addition to face-to-face appointments. Three bookable GP telephone consultations were also available daily.

Appointments could be made by telephone or booked online through the practice website. The practice website could be used for a number of patient based services, for example registering online for new patients, ordering of certain repeat prescriptions, accessing patient educational resources and email communication with clinical staff for non-urgent matters.

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

The practice had measures in place to ensure vulnerable patients had access to care and treatment including wheelchair access and assistance for patients with hearing impairment and language barriers.

Our findings

The practice had wheelchair access to the premises and there was a lift available to reach the upper floors. A hearing loop system was in place for patients with hearing impairment. We saw that interpreting services were available for patients whose first language was not English and that consultation time slots were increased when an interpreter was involved. In addition to home visits the practice had bookable telephone consultation slots for those patients unable to attend the surgery.

We noted the practice had very few registered patients with learning disabilities.

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 had processes in place to support patients experiencing poor mental health. These included an initiative to encourage patients to attend the practice for annual checks. There was a system in place to alert the community mental health team if a patient missed a scheduled appointment.

Our findings

The practice was part of a mental health initiative which invited patients listed on the chronic mental health register for annual checks. The practice also had a policy for patients on long term anti-psychotic medications to ensure they attended for regular review and blood tests. If a patient missed a scheduled appointment or they had not had a recent review, the practice attempted to contact them. If this was unsuccessful the practice alerted the patient's relevant community psychiatric nurse. GPs at the practice also attended an annual meeting with consultant psychiatrists from Chelsea and Westminster Hospital to jointly review patients on the register and update treatment plans where necessary.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 21 (a) The practice does not have an effective recruitment procedure in place to ensure all staff are of good character Staff files did not all contain completed reference checks.

Regulated activity	Regulation
Family planning services	Regulation 21 (a) The practice does not have an effective recruitment procedure in place to ensure all staff are of good character Staff files did not all contain completed reference checks.

Regulated activity	Regulation
Maternity and midwifery services	Regulation 21 (a) The practice does not have an effective recruitment procedure in place to ensure all staff are of good character Staff files did not all contain completed reference checks.

Regulated activity	Regulation
Surgical procedures	Regulation 21 (a) The practice does not have an effective recruitment procedure in place to ensure all staff are of good character Staff files did not all contain completed reference checks.

This section is primarily information for the provider

Compliance actions

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 21 (a) The practice does not have an effective recruitment procedure in place to ensure all staff are of good character Staff files did not all contain completed reference checks.