Knightsbridge Medical Centre

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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Overall summary

Knightsbridge Medical Centre provides GP led primary care services to around 8350 people living in the surrounding areas of Belgravia, Brompton, Knightsbridge and Kensington and Chelsea in South West London. The service is registered with the Care Quality Commission (CQC) to provide the following regulated activities: diagnostic and screening procedures; family planning; maternity and midwifery services; surgical procedures; and treatment of disease, disorder and/or injury.

We carried out an announced inspection on 11 June 2014. During the inspection we spoke with patients, the GP's, practice manager, a district nurse, health visitor, administrative and reception staff. Following the inspection we also had contact with the practice nurse who was not available on the day of inspection.

Patients told us they were happy with the care, support and treatment provided by the practice and said they felt listened to and involved in any decision making. Staff told us the practice provided a supportive environment where learning was encouraged.

Good systems were in place to monitor and manage individual patient care and safety. Effective systems were in place to monitor health and safety, infection prevention and control and medicines management in the practice. Audits were completed and the results adequately analysed to inform improvements to the service.

We found that some areas of the service required improvement such as storage arrangements for used sharps boxes and arrangements for the disposal of urine samples to ensure the spread of infection was prevented. In addition to this we found that the keys for the controlled drugs store were not secure and therefore did not prevent unauthorised access to these drugs. We found that some clinical cases were not included in the significant events log which could enhance learning within the practice. Arrangements for the chaperone service offered did not make clear the expectations of staff or adequately inform them of what was appropriate during an examination. There was no sign alerting people to the presence of oxygen which is highly flammable, and gaps in staff employment history were not always explored prior to employment.

Good systems were in place to provide effective, care, support and treatment for older people. These took account of patients' wishes and included joint working with other health and social care professionals.

Good systems were in place to identify and support patients with long term medical conditions. The practice was proactive in relation to offering appropriate health checks and patients were monitored to ensure their needs were met.

Mothers, babies, children and young people were effectively supported by the practice. There were systems in place to ensure children were immunised against childhood diseases and there was a baby clinic providing support to mothers and children under the age of five run by a local health visitor.

The practice had opening hours that made the service accessible to the working-age population. The practice was also in the process of offering set times for telephone consultations and was planning to provide an online appointment booking service which would also support working patients.

The practice worked effectively with multi-disciplinary teams to meet the needs of vulnerable patients. There were systems in place to monitor vulnerable individuals and to ensure appropriate information was shared with appropriate health and social care professionals to protect and support them.

Systems were in place to monitor and meet the needs of patients with a mental health diagnosis based on their individual needs and circumstances.

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 systems in place to identify, respond to and learn from patient safety issues. Significant events were reported, analysed and informed improvements in the practice to minimise future risks to patient safety. The practice had dedicated children and adult safeguarding leads and good systems were in place to respond to concerns about vulnerable children and adults that included multi-disciplinary information sharing and joint working. Staff recruitment processes protected patients from being cared for and treated by unsuitable staff.

Systems were in place to ensure the premises remained safe for patients and staff and there were appropriate plans in place to manage foreseeable emergencies. The practice was clean and infection prevention and control protocols were in place and being followed by staff and monitored by the practice nurse.

Medicines were effectively managed and appropriately stored. Emergency medicines and equipment were also available and checked at regular intervals and clinical equipment serviced and calibrated as required.

There were some areas where improvement was required. There was no sign identifying where the oxygen was stored to alert people that there was a flammable substance stored in the room. It was noted that there were additional clinical events that could have been included in the significant events log for staff learning. We found that the controlled drug cupboard key had not been securely stored. We found that sharps bins were being stored for collection in a treatment room where they could be accessed by patients, especially children and adequate arrangements had not been made for the disposal of urine samples. We found that gaps in staff employment history were not always explored as part of the recruitment process.

Are services effective?

The practice had effective systems in place for promoting and improving outcomes for patients. This included monitoring complex cases, ensuring patients with a new diagnosis had an appropriate plan of care and treatment in place and ongoing assessment of the needs of patients with long term conditions. Staff followed and promoted evidence based best practice and worked effectively with other health and social care professionals to meet patients' needs.

Summary of findings

Systems were in place for staff induction, supervision and appraisal. The practice is accredited as a GP training practice and therefore supported newly qualified doctors wanting to specialise in general practice. All staff received appropriate training and development opportunities to ensure they were able to fulfil their duties and meet the needs of patients.

The health and wellbeing of patients was promoted. Health checks were provided for new patients and advice and support was available to encourage patients to make healthy lifestyle choices. The practice was proactive in promoting and monitoring flu vaccinations for those at risk and childhood immunisations.

Are services caring?

All of the comments from patients were positive about the attitude and behaviour of staff. Patients told us that staff were always courteous, accommodating and respected their privacy. Patients said that they were supported to make informed decisions and we saw evidence that practice staff promoted this. Appropriate arrangements were in place to ensure patients gave informed consent to support and treatment and any information that was to be shared.

The practice had a well advertised chaperone service in place, however the protocol for this service was unclear in relation to the expectations of staff fulfilling this role and not all staff had received appropriate training to be able to carry out this role effectively.

Are services responsive to people's needs?

The practice was responsive to patients' individual needs. Appropriate steps had been taken to ensure that the practice was accessible to patients with a wide range of needs including mobility issues, sensory impairment and language barriers. The opening hours meant the practice could be accessed by the working-age population without any disruption to their working day.

There were good systems in place for patients to give feedback about the practice and we saw that changes had been made as a result of comments made by patients. Complaints were taken seriously and responded to appropriately and patients felt listened to.

Are services well-led?

There was a strong leadership presence in the practice and a clear vision and values that were demonstrated by all staff. The practice responded positively and proactively to patient and staff feedback in

Summary of findings

order to develop and improve. Staff had key areas of responsibility and demonstrated that they had the knowledge and expertise to fulfil these roles in order to provide good quality care, support and treatment for patients.

Good systems were in place to identify, monitor and manage risk and the practice analysed staff and patient feedback, complaints and significant events to improve the service. The practice engaged patients and staff in the operation of the service and ensured that staff had appropriate learning and development opportunities to enable them to effectively care for, support and treat patients.

Summary of findings

The six population groups and what we found

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

Older people
Good systems were in place to provide effective, care, support and treatment for older people. These took account of patients' wishes and included joint working with other health and social care professionals.

People with long-term conditions
Good systems were in place to identify and support patients with long term medical conditions. The practice was proactive in relation to offering appropriate health checks and patients were monitored to ensure their needs were met.

Mothers, babies, children and young people
Mothers, babies, children and young people were effectively supported by the practice. There were systems in place to ensure children were immunised against childhood diseases and there was a baby clinic providing support to mothers and children under the age of five run by a local health visitor.

The working-age population and those recently retired
The practice had opening hours that made the service accessible to working patients. The practice was also in the process of offering set times for telephone consultations and was planning to provide an online appointment booking service which would also support working patients.

People in vulnerable circumstances who may have poor access to primary care
The practice worked effectively with multi-disciplinary teams to meet the needs of vulnerable patients. There were systems in place to monitor vulnerable individuals and to ensure appropriate information was shared to protect and support them.

People experiencing poor mental health
Systems were in place to monitor and meet the needs of patients with a mental health diagnosis based on their individual needs and circumstances.

Summary of findings

What people who use the service say

Patients told us they were happy with the service they received. They commented on the knowledge and expertise and good care provided by clinical staff and the courteousness of reception staff who they said were very helpful and accommodating. Members of the Patient Participation Group told us that the practice staff listened to patients and were proactive in making changes to improve the service. The completed comment cards we received were all positive about the service provided and the staff working at the practice.

Areas for improvement

Action the service COULD take to improve

Used sharps boxes were stored in a treatment room that was accessible to patients and therefore did not protect patients and staff from the risk of the spread of infection.

Arrangements for the disposal of urine samples were inadequate and did not ensure the spread of infection was prevented.

The arrangements for storing the keys to the controlled drugs store did not prevent unauthorised access to these drugs.

Not all staff were adequately trained or equipped with the skills and knowledge to effectively fulfil the role of chaperone in the practice

Good practice

Our inspection team highlighted the following areas of good practice:

The practice worked effectively with other health and social care professionals to meet the needs of patients.

Robust systems were in place for safeguarding vulnerable children and adults.

Good systems were in place to ensure that the premises remained safe for patients and staff.

Knightsbridge Medical Centre

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 a GP. The GP was granted the same authority to enter Knightsbridge Medical Centre as the CQC inspector.

Background to Knightsbridge Medical Centre

Knightsbridge Medical Centre provides GP led primary care services to around 8350 people living in the surrounding areas of Belgravia, Brompton, Knightsbridge and Kensington and Chelsea in South West London.

The population demographics for the area included a higher proportion of 20-39 year olds living in the area and lower levels of children, young people and over 75's. The practice provides care and treatment to approximately 200 families from the local military accommodation and serves a diverse population in terms of culture, religion, race and socio-economic status.

The practice operates in a purpose built building that is accessible to people with mobility needs. Consultation and treatments are provided across the ground and first floor.

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 visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

Before visiting, we reviewed a range of information we hold about the service and asked other organisations including NHS England and the West London Clinical Commissioning Group (CCG) to share what they knew about the service. We carried out an announced visit on 11 June 2014. During our visit we spoke with a range of staff including GP's, the practice manager, a district nurse, health visitor, administrative and reception staff. We also spoke with patients who used the service and members of the Patient Participation Group. We observed how people were being cared for and reviewed comment cards where patients and

Detailed findings

members of the public shared their views and experiences of the service. We also reviewed the practice's policies and procedures and records relating to the operation of the practice. We had contact with the practice nurse following the inspection as she was unavailable on the day.

Are services safe?

Summary of findings

The practice was generally safe for patients and staff. The practice had systems in place to identify, respond to and learn from patient safety issues. Significant events were reported on, analysed and informed improvements in the practice to minimise future risks to patient safety. The practice had dedicated children and adult safeguarding leads and good systems were in place to respond to concerns about vulnerable children and adults that included multi-disciplinary information sharing and joint working. Staff recruitment processes protected patients from being cared for and treated by unsuitable staff.

Systems were in place to ensure the premises remained safe for patients and staff and there were appropriate plans in place to manage foreseeable emergencies. The practice was clean and infection prevention and control protocols were in place and being followed by staff and monitored by the practice nurse.

Medicines were effectively managed and appropriately stored. Emergency medicines and equipment were also available and checked at regular intervals and clinical equipment serviced and calibrated as required.

There were some areas where improvement was required. There was no sign identifying where the oxygen was stored to alert people that there was a flammable substance stored in the room. We found that the controlled drug cupboard key had not been securely stored. We found that sharps bins were being stored for collection in a treatment room where they could be accessed by patients, especially children and adequate arrangements had not been made for the disposal of urine samples. We found that gaps in staff employment history were not always explored as part of the recruitment process.

Our findings

Safe patient care

The practice was proactive in relation to patient safety and had good systems in place for identifying, reporting on and learning from patient safety issues. We saw an example of a prescribing error that had been addressed promptly with the patient and others that may have been affected and saw clear evidence of changes that had been made to prevent a recurrence. Staff were aware of their responsibility to report any concerns or incidents affecting patient safety and identified risks had been appropriately assessed and managed.

The practice had clear systems and operating procedures in place for areas such as infection prevention and control (IPC), medicines management, safeguarding, records management, recruitment and health and safety. These were readily available to all staff in hard copy and on computers and there were designated leads who took responsibility in these areas to ensure patient safety.

Learning from incidents

The practice had an open culture and encouraged learning from incidents. There was a clear reporting system in place for significant events that occurred at the practice and we reviewed this record. Detailed information was recorded about each event, what action was taken and the learning and changes that were implemented as a result. The senior GP partner took responsibility for monitoring significant events. We saw examples of changes that had been made to ensure continuity of service following a power failure that occurred at the practice and incidents where individual patient welfare concerns were identified. We found that the practice had acknowledged what went well, what did not go well and what could have been done better. The responses to these incidents demonstrated that the practice analysed significant events effectively to learn from them and minimise future risks to patient safety.

Safeguarding

The practice nurse was the child protection lead and we saw meeting minutes that confirmed she attended quarterly safeguarding lead forum meetings. Training certificates confirmed that all administrative staff had completed Level one child protection training and all clinical staff had completed Level three so that they had the knowledge and skills to identify children potentially at risk or suffering from abuse and respond appropriately.

Are services safe?

There were contact numbers for local safeguarding children teams clearly displayed in the practice and three monthly safeguarding meetings were held with other professionals such as a health visitor, school nurse and social worker. The senior partner for the practice provided an example of how the practice had responded to concerns about a child and shared information so that the family could be monitored and receive adequate support.

The senior partner for the practice was the vulnerable adult safeguarding lead. All staff had received training in safeguarding vulnerable adults and the reception staff demonstrated how they responded to the needs of vulnerable adults and passed on any concerns they had to the GPs. The senior partner gave examples and provided written documentation showing how the practice had worked proactively with multi-disciplinary teams and responded to the needs of vulnerable adults balancing the risks identified with the patient's right to make their own decisions. The senior partner also told us that 'best interest' meetings were held every one to two years for vulnerable elderly frail patients to ensure their needs were being met.

Staff were aware of their responsibilities in relation to reporting any concerns they had about a vulnerable child or adult. The practice 'flagged' any vulnerable patients on their notes and for the out of hours service and the list of vulnerable patients was regularly reviewed to assess if people's needs had changed. The district nurse and health visitor we spoke with said the practice was responsive and acted promptly when any concerns were raised about vulnerable patients.

Monitoring safety and responding to risk

The practice assessed potential risks to staff and patients and took appropriate action to minimise them. We found that risks to individual patients were responded to promptly and that patients own concerns and those of carers were taken seriously. Two patients gave us examples of times when they had visited their GP and been sent to the local accident and emergency department as a result of their condition and the concerns of the GP. The practice also had systems in place to review and monitor patients who had long term conditions such as diabetes, those with mental health diagnoses and new cases of cancer, myocardial infarction (MI) and stroke. These systems assisted the GPs and the nurse practitioner to promptly identify and address concerns.

The building was well maintained and annual health and safety risk assessments were completed to ensure the premises remained safe for patients and staff. The practice manager informed us that the premises had been recently rewired and that a new air conditioning and fire alarm system had also been installed. We saw records relating to fire drills that gave staff the opportunity to familiarise themselves with the procedure to follow in the event of a fire and we saw records confirming that the fire alarm system was checked at regular intervals.

The practice manager told us that a recent legionella risk assessment had been undertaken and there were no concerns but the report for this had not yet been received. We did note that there was not a sign alerting people to the presence of oxygen in one of the treatment rooms. This could pose a risk in the event of a fire as oxygen is highly flammable and fire authority staff would need to be aware of this risk.

Medicines management

The practice had protocols for the management of medicines in the practice. We saw evidence of low prescribing rates, low use of non-steroidal anti-inflammatory drugs (NSAID's), proton-pump inhibitors (PPI's) and benzodiazepine. We also saw that the practice had an effective system in place for monitoring the adverse side effects that long term use of medicines such as warfarin and disease-modifying anti rheumatic drugs (DMARD's).

We found that the storage and use of prescription pads was closely monitored to prevent unauthorised access and use and there was a clearly advertised system in place for repeat prescriptions.

Medicines were safely stored. We saw records of fridge temperatures that were checked twice daily to ensure medicines such as vaccines were stored at the correct temperature and remained safe to use. There were also appropriate arrangements in place for the storage of controlled drugs. However, during our inspection we found that the keys to the controlled drugs store were kept in an unlocked drawer in the same room as they were stored and were therefore not secure. We were informed that this would be addressed immediately. There was an appropriate controlled drugs record kept.

Are services safe?

Cleanliness and infection control

The practice nurse was the designated lead for cleanliness and infection prevention and control (IPC) and had recently undergone additional training. All staff had received training on IPC. An IPC audit had taken place in May 2014 and detailed if any action was required including additional training for staff. Appropriate personal protective equipment such as gloves and disinfectant wipes were accessible to staff in all consulting and treatment rooms. We also saw hand washing instructions above the sinks in these rooms to remind staff about the correct technique to use to ensure their hands were clean. There were appropriate arrangements in place for dealing with blood spillages.

The premises and non-clinical equipment were cleaned by an external cleaning company each weekday and also on some Sundays as the practice was also open at the weekend. We saw detailed cleaning schedules and colour coded cleaning equipment that was used to prevent cross-contamination between different areas of the premises. There was also a communication book used by the cleaner and practice staff so that any issues relating to cleaning could be addressed promptly. The patients told us that the practice was always clean.

An external contract was in place for the removal of clinical waste. We saw records relating to the collection of sharps boxes and generally these were appropriately stored in consulting and treatment rooms. However, we noted that there were six used sharps boxes waiting to be collected, stored in the practice nurse's room where patients were seen. This posed a risk as they were not locked away and were within easy reach of children as they were close to the floor. We discussed this with the practice nurse following the inspection who told us this was the central point of storage for collection but agreed for the boxes to be stored in a more secure area to ensure the safety of all patients.

We were also informed that the sinks in treatment rooms were used for the disposal of urine which was not appropriate as this could increase the risk of the spread of infection. The practice agreed to address this.

The practice manager showed us information and related tools that the practice had received from NHS England regarding external infection control audits. The practice had used this information to inform their infection prevention and control procedures.

Staffing and recruitment

There were clear staff recruitment processes in place to assess if applicants had the appropriate skills and knowledge to meet patients' needs. We looked at the recruitment files for four members of staff including two GPs, a member of reception staff and a health care assistant. Criminal record checks had been completed for each member of staff, references obtained and their identity and right to work in the UK verified. Each file contained a CV detailing the staff member's education and employment history. However, we noted that one person had a six month gap in their employment history that had not been explained or explored during their recruitment. We discussed this with the practice manager who said that gaps in staff employment history would in future be routinely explored.

We saw evidence of appropriate registration with professional bodies such as the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) where relevant and the practice had a policy in place for recruiting new GPs.

Dealing with Emergencies

All staff had received basic life support and anaphylaxis training (anaphylaxis is a severe, potentially life-threatening allergic reaction that can develop rapidly). There were clear protocols in place for dealing with emergencies and staff were able to demonstrate that they knew what action to take should an emergency arise. The practice had appropriate emergency equipment and medicines in place that were accessible to staff if required. Monthly checks took place to ensure that equipment was in good working order and that medicines remained in sufficient quantities and had not passed their expiry date. Doctors bags for attending home visits were well equipped and contained appropriate equipment for them to respond to patients' needs and these were also checked monthly.

There was a current business continuity plan so that foreseeable emergencies could be responded to in a planned way. The plan included events such as fire, flood, power failures and incapacity of staff. The practice manager and the senior partner kept copies of this in their home so that in the event of an emergency where they were unable to access to the building the plan would still be accessible.

Equipment

The practice ensured that clinical equipment was well maintained and in good working order and therefore safe

Are services safe?

and effective to use to care for and treat patients. We saw records that confirmed that clinical equipment such as spirometers, oxygen and minor surgery instruments had been regularly serviced, calibrated and checked for safety.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice had effective systems in place for promoting and improving outcomes for patients. This included monitoring complex cases, ensuring patients with a new diagnosis had an appropriate plan of care and treatment in place and ongoing assessment of the needs of patients with long term conditions. Staff followed and promoted evidence based best practice and worked effectively with other health and social care professionals to meet patient's needs.

Systems were in place for staff induction, supervision and appraisal. The practice was accredited as a GP training practice and supported newly qualified doctors wanting to specialise in general practice. All staff received appropriate training and development opportunities to ensure they were able to fulfil their duties and meet the needs of patients.

The health and wellbeing of patients was promoted. Health checks were provided for new patients and advice and support was available to encourage patients to make healthy lifestyle choices. The practice was proactive in promoting and monitoring flu vaccinations for those at risk and childhood immunisations.

Our findings

Promoting best practice

GPs at the practice attended the Clinical Commissioning Group (CCG) led Clinical Learning Sets (CLS), where local practices met to discuss current clinical and organisational performance and issues. Designated GPs within the practice took responsibility for leading on particular CLS areas of practice such as audits, peer review, community pathway uptake targets, referrals, prescribing, sexual health and alcohol abuse. Clinical audits took place within the practice and appropriate peer reviews were carried out to support GP learning and development.

Staff demonstrated that they understood issues around informed consent. There were systems in place to ensure that information was not shared without a patient's consent and children were only treated if accompanied by an adult who was able to give consent. Reception staff gave an example of where parents had been asked to provide written consent for their children to be brought to the practice by their nanny. Staff were also aware of issues of consent surrounding vulnerable adults who may not have the capacity to understand the choices available to them and make informed decisions.

We saw that legislation such as the Children Act 2004 and Mental Capacity Act 2005 was considered when developing protocols such as those relating to vulnerable adults and children. We also found that the practice followed guidance issued by the National Institute of Health and Care Excellence (NICE) to promote best practice in areas such as prescribing and end of life care.

Management, monitoring and improving outcomes for people

Systems were in place to monitor patients with long term conditions to ensure they received adequate support and their needs were met. Regular weekly case reviews took place to discuss the needs of individual patients and this included any new cancer diagnoses and palliative care cases. Annual reviews were held for people with a mental health diagnosis that included input from their consultant psychiatrist and/or their community psychiatric nurse. One patient told us that their diabetes was managed effectively by the practice and that they received annual reviews with their GP.

Are services effective?

(for example, treatment is effective)

The practice had previously had very low numbers of new diagnoses of conditions such as diabetes and asthma. The practice was proactive in responding to this. For example, a review took place and all patients over 40 were offered a diabetes check. During this review 1600 patients were seen, however very few additional cases of diabetes were identified.

We saw that new patients were offered a 30 minute appointment to discuss their medical history, review their medication and develop a plan of care and treatment. Children were initially seen with their parents and their immunisation status checked to ensure they were up to date.

Staffing

The practice had an induction process for clinical and non-clinical staff. This included shadowing experienced staff, familiarising staff with protocols and offering initial training. All staff completed a three month probationary period at the end of which they had a meeting to discuss their performance, any strengths and areas for improvement.

Training records for staff showed they had had completed training in areas such as safeguarding children and adults, equality and diversity, infection prevention and control, fire safety awareness, basic life support, conflict resolution and information governance.

The practice was accredited as a GP training practice and the GPs gave positive feedback about the opportunities they had been given to learn and develop their career.

Staff received regular supervision and peer review by a suitably qualified clinician where appropriate. We saw evidence of annual appraisals which included a self-assessment and an opportunity to identify areas for development and clear objectives for the year ahead. Staff said that they felt supported in their role.

Working with other services

The practice had established relationships and worked effectively with other services. The district nurse and health visitor said that the practice listened to concerns they raised about patients and kept them informed about any issues practice staff had identified.

Primary care team meetings were held on a monthly basis and included a health visitor and district nurse. We saw evidence of meetings with social services and mental health specialists where concerns about vulnerable patients had been discussed.

We also found that patients were promptly referred to other services in the local community if a need was identified. The practice had good links with some voluntary organisations who provided support to the elderly.

There were systems in place for sharing information with the out of hours service to ensure patients received appropriate care, treatment and follow up. Complex cases that included vulnerable people at risk were 'flagged up' on the system so that the out of hours service was aware of the needs of these patients. This included an arrangement where the out of hours service used the premises to provide an urgent walk in service for patients at the weekend.

Health, promotion and prevention

New patients were offered a health check that was completed by the health care assistant and included checking their weight and blood pressure whilst also giving them an opportunity to discuss lifestyle factors affecting their health and wellbeing such as smoking and drinking alcohol. The practice manager informed us that a new smoking advisor had started supporting patients by providing smoking cessation services.

Systems were in place to ensure that children received their childhood immunisations and letters were sent out about seasonal flu vaccinations for vulnerable groups. Parents with babies and small children could attend the weekly baby clinic to seek advice about their child's health and wellbeing.

Are services caring?

Summary of findings

All of the comments from patients were positive about the attitude and behaviour of staff. Patients told us that staff were always courteous, accommodating and respected their privacy. They were supported to make informed decisions and we saw evidence that practice staff promoted this. Appropriate arrangements were in place to ensure patients gave informed consent to support and treatment and any information that was to be shared.

The practice had a well advertised chaperone service, however the protocol for this service was unclear in relation to expectations of staff fulfilling this role and not all staff had received appropriate training to be able to carry out this role effectively.

Our findings

Respect, dignity, compassion and empathy

Patients told us that staff were courteous and treated them with respect. One patient said staff were warm, kind and understanding and another told us staff were compassionate and always willing to help. We observed reception staff taking time to fit an elderly patient in to see their GP as they had arrived late and missed their appointment, demonstrating empathy and consideration of the individual needs of the patient. Patients told us that the GPs listened to them and answered any questions that they had.

Patients said that staff respected their privacy at all times and their confidentiality was maintained in relation to their personal health records. There were privacy curtains in all consultation and treatment rooms and people told us that they could never hear what was being said in treatment rooms when they were sitting in the waiting areas in the practice. There were confidentiality slips on the counter at reception for people to write information down if they did not want to be overheard talking with staff and rooms were available for patients to talk to staff in private.

The practice had a chaperone service that was well advertised in the waiting areas and consultation and treatment rooms for people wanting to have another person of the same gender present for examinations. However, the protocol for this process was unclear as it did not state that the chaperone should remain with the patient during the examination so that they could observe what happened and remain in the room until the patient was dressed. Not all staff had received adequate training about what was appropriate and what was expected of them to enable them to fulfil this role effectively.

Involvement in decisions and consent

Patients told us that they were always involved in making decisions about their care and treatment. They said they were listened to and felt able to ask questions so that they understood the options available to them. Staff understood issues around mental capacity and were able to demonstrate that they had taken appropriate action to explore concerns about individual patients and their ability to understand the medical conditions affecting them and make informed decisions.

Are services caring?

There were protocols in place to ensure people consented to treatment and that information was only shared with individuals on behalf of patients after consent was received and verified. In relation to children, arrangements were in place to gain written consent from parents regarding who could attend appointments with their children.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' individual needs. Appropriate steps had been taken to ensure that the practice was accessible to patients with a wide range of needs including mobility issues, sensory impairment and language barriers. The opening hours meant the practice could be accessed by the working-age population without any disruption to their working day. Complaints were taken seriously and responded to appropriately and patients felt listened to.

Our findings

Responding to and meeting people's needs

Steps had been taken to ensure the premises were suitable for people with mobility difficulties. There was a lift to enable patients to access the first floor and disabled toilet facilities on the ground floor. There were also baby changing facilities available. Reception staff told us that they could access interpreting services promptly if needed and showed us the contact details for the service that were clearly displayed in the reception area. Staff told us that a slightly longer appointment time was given if an interpreter was present to allow enough time for the consultation and interpretation of the conversation. Reception staff told us that they were aware of the needs of regular patients and gave examples of patient who had requested the use of different communication methods to meet their individual needs.

Staff told us that half an hour appointments were made for patients who had recently been discharged from hospital so that their medical concerns could be discussed and plans made for their on-going care. Annual reviews were completed for confused older people and the practice took a close interest in the 200 army families based locally.

Patients with long term medical conditions were monitored and prompt referrals to other services were made where required.

Access to the service

Patients told us that they were always able to get an appointment on the same day they contacted the practice. They said that they could not always see their own GP, but staff always gave them a choice of waiting for an appointment on another day to see their GP or having a same day appointment with any GP. Telephone consultations were also available and the practice was in the process of formalising this so that telephone consultations would be available at set times during the day.

Patients said they were given a 10 minute appointment slot but said they never felt rushed and could take longer if they needed to. They told us they sometimes had to wait for a while before they were seen but said reception staff always told them if a GP was running late and would give them an indication of how long they would have to wait.

Are services responsive to people's needs?

(for example, to feedback?)

The practice opened late until 19:45 on three weekday evenings so that working patients could access appointments without taking time off work. Patients had access to a local out of hours service and this service used the premises at Knightsbridge Medical Centre to provide a walk in centre on Saturday and Sunday between 09:00 and 17:00.

Concerns and complaints

There was an effective complaints system in place. We saw the record of complaints for the last 12 months and found that complaints had been investigated and responded to appropriately. Members of the patient participation group said that they had spoken about the complaints procedure during one of their meetings and all of the patients we spoke with were aware of how to make a complaint. The complaints process was clearly advertised in the practice leaflet and also on the practice website.

Complaints were analysed to ascertain if any learning could be taken from them. The practice manager told us that he tried to speak to complainants initially to see if there was anything that could be done to resolve the matter promptly.

Are services well-led?

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

Summary of findings

There was a strong leadership presence in the practice and a clear vision and values that were demonstrated by all staff. The practice responded positively and proactively to patient and staff feedback in order to develop and improve. Staff had key areas of responsibility and demonstrated that they had the knowledge and expertise to fulfil these roles in order to provide good quality care, support and treatment for patients.

The practice had systems to identify, monitor and manage risk, analyse staff and patient feedback, complaints and significant events to improve the service. The practice engaged patients and staff in the operation of the service and ensured that staff had appropriate learning and development opportunities to enable them to provide effective care, treatment and support to patients.

Our findings

Leadership and culture

The practice was managed by two GP partners and a practice manager. There was a strong leadership presence in the practice and a clear vision and values which were demonstrated by all staff. We found an open culture that promoted 'candour' and learning and all of the staff said the practice was a supportive environment that promoted good practice at all times.

We saw that the practice was continuously looking at ways to develop the service and patient feedback was listened to and acted upon.

Governance arrangements

Staff had clear roles and responsibilities that included taking a lead role in key areas in the practice such as safeguarding children and adults, infection prevention and control, health and safety and areas of clinical expertise. Staff demonstrated that they had the knowledge and expertise to fulfil these roles in order to provide good quality care, support and treatment for patients.

Systems to monitor and improve quality and improvement

GPs at the practice carried out clinical audits and non-clinical audits were also taking place to ensure that the practice was operating effectively and maintaining patient safety. Staff continuously monitored practice performance through patient feedback and analysis of complaints and significant events. The practice was accredited as a GP training practice for qualified doctors training to specialise in General Practice and was therefore also subject to external checks to maintain this accreditation.

Patient experience and involvement

The practice had an active Patient Participation Group. We spoke with three members of the group who told us that they were encouraged to make suggestions about improving the practice and said they felt listened to. Annual patient surveys were undertaken and the results analysed and included in the annual patient participation report. The report included action points about improvements that were to be made at the practice as a result of the survey findings. This report was accessible to patients on the practice website.

Are services well-led?

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

Patients told us that the practice was open to suggestions and encouraged them to ask questions and that staff were receptive and said they felt listened to.

Staff engagement and involvement

Staff told us that they worked in a supportive environment. Informal peer support was available on an on-going basis and more formal arrangements were in place to assess staff performance and identify development needs on an annual basis.

Regular practice team meetings and weekly clinical meetings were held so that staff could express their views and raise any concerns. The provider had a whistleblowing policy for staff to access if they had concerns about the practice. We were informed that there had been no whistleblowing incidents reported.

Learning and improvement

Annual individual staff appraisals took place that included a self-assessment and personal development plan for the year ahead. Staff told us that they found this process supportive and that any training needs identified as a result of the process were followed up to support them in their role. GPs received appropriate appraisals and peer support arrangements were also in place.

Staff demonstrated that they were aware of their roles and responsibilities and had the skills, experience and expertise to fulfil them. There were good systems in place to monitor staff training to ensure training was refreshed at regular intervals to enable staff to maintain adequate skills and knowledge in particular topics.

Identification and management of risk

The practice had systems to enable staff to identify and manage risks to the practice and patients. Formal risk assessments were completed for areas such as fire safety, infection prevention and control and health and safety. Weekly clinical meetings were held during which risks to individual patients were discussed and plans made to manage these. We saw evidence of joint working and appropriate referrals in relation to individual cases which managed risks to patients whilst balancing their right to make their own decisions. There were plans in place to respond to foreseeable risks to the practice and patients and we saw evidence of how these had been updated following learning from significant events at the 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

Systems were in place to provide effective, care, support and treatment for older people. They took account of patient's wishes and included joint working with other health and social care professionals.

Our findings

The practice had a low number of older patients but some of them were very frail and had complex needs. Best interest meetings were held every one to two years with other health and social care professionals and family members to ensure their needs were being met.

Home visits were arranged for older patients who were unable to attend appointments at the practice and there was good joint working and information sharing between the district nurse and the practice to ensure patients received good care, support and treatment. We saw evidence that the practice was proactive in responding to the needs of older patients who had some loss of mental capacity. The practice acted in their best interests by involving others in assessing any risks to their health and wellbeing and involving the patients in making decisions which balanced the identified risks with their right to make their own decisions about their care and treatment.

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

Systems were in place to identify and support patients with long term medical conditions. The practice was proactive in relation to offering appropriate health checks and patients were monitored to ensure their needs were met.

Our findings

There were systems in place to support patients with long term conditions. One patient told us that their diabetes was monitored by the nurse and that they had an annual review with their GP. They said that since their diabetes had been managed at the practice they no longer had to attend hospital appointments for the condition.

Previously there had been concerns about the levels of diagnosis of conditions such as diabetes and asthma at the practice. In response to this the practice had completed a review and offered all patients over 40 a diabetes check. The senior GP partner told us that 1600 people had responded to this but very few new cases of diabetes were found.

New patients were offered a 30 minute appointment with the nurse and if they had any long term medical conditions an additional 30 minute appointment was scheduled with their GP to review their medication and develop a plan of care and treatment.

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

Mothers, babies, children and young people were effectively supported by the practice. There were systems in place to ensure children were immunised against childhood diseases and there was a baby clinic providing support to mothers and children under the age of five run by a local health visitor.

Our findings

The practice had a low number of mothers, babies, children and young people using the service. However, baby immunisation clinics were held by the practice nurse and a health visitor from a local clinic provided a baby clinic at the practice once a week. Systems were in place to monitor if children had received their immunisations and this was checked and discussed with parents when they registered their children with the practice.

We saw information leaflets about pregnancy and safe baby care in the waiting area and there were toys for children to play with.

All staff received child protection training and knew what action they should take if they had safeguarding concerns about a child or young person. We saw evidence that the practice staff appropriately shared information in relation to protecting children.

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

he practice had opening hours that made the service accessible to working patients. The practice was also in the process of offering set times for telephone consultations and was planning to provide an online appointment booking service in the near future which would also support working patients.

Our findings

The practice had lengthened the opening hours for the service on three days during the week so that working patients could attend appointments without disrupting their working day. The practice was also open from 08:15 Monday to Friday.

Patients told us that the reception staff always tried to accommodate them and make an appointment that was convenient for them.

The practice was also in the process of offering set times for telephone consultations and was planning to provide an online appointment booking service which would also support working patients.

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 worked effectively with multi-disciplinary teams to meet the needs of vulnerable patients. There were systems in place to monitor vulnerable individuals and to ensure appropriate information was shared to protect and support them.

Our findings

The practice worked effectively with multi-disciplinary teams to meet the needs of vulnerable patients. Appropriate information sharing meant that all professionals involved in supporting individuals worked together to monitor, support and treat patients.

The practice took a close interest in 200 families based locally in military accommodation as these families consisted mainly of women and children who were quite isolated. Staff also told us that the practice nurse supported four people with learning disabilities and we saw protocols in place with information for staff about how to support individuals with learning disabilities.

There was a system in place to 'flag up' vulnerable patients on the practice records and the out of hours service also had access to this information so they were aware of individual's needs if they required support outside usual practice hours.

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

Systems were in place to monitor and meet the needs of patients with a mental health diagnosis based on their individual needs and circumstances.

Our findings

All patients with a mental health diagnosis received an annual review that included their consultant psychiatrist and/or their community psychiatric nurse. Patient care was planned on an individual needs basis and patients were involved in decision making about their care and treatment.