St Lukes 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.

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Summary of findings

Overall summary

St Lukes Medical Centre is a GP practice providing primary care services for people in Brixham. It offers a range of services including health screening, immunisations, and management of long term conditions. Local community teams support the GPs in provision of maternity and health visitor services. The practice has a total of four GPs supported by a nursing team and an administration team, for approximately 6500 registered patients. Opening hours are between 8.15am to 6pm with an extended surgery from 7.30am to 8am on Monday, Tuesday and Thursday mornings. Outside normal surgery hours the emergency cover is provided by another service.

St Lukes Medical Centre has one location at 17 New Road, Brixham, Devon, where we carried out our announced inspection visit on 10 July 2014.

We spoke with 12 patients attending appointments on the day of our inspection. We received comments cards from 27 patients. We also spoke with GPs, nurses, reception and administration staff and the practice manager, who were working on the day of our inspection.

We found that St Lukes Medical Centre to be a well led practice that was caring, effective and responsive to patients' needs. The practice showed they were open, fair and transparent with the management team showing clear leadership. The patients, clinical and administrative staff we spoke with all told us they felt the practice was well led, they were approachable and demonstrated good working relationships with other health care professionals.

We discussed a treatment currently being undertaken by the practice for a very small number of patients (10) who were prescribed medicine as treatment that was emerging, rather than established. Whilst no harm to patients had occurred, this was outside national guidelines and therefore must gain, for example, local ethics committee approval.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the practice was safe, however some improvement is required.

Staff were aware of the significant event reporting process and how they would escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small with the team as a whole, for example, identifying where a patient had become aggressive. The GPs and practice manager demonstrated knowledge that following a significant event, the practice would undertake a significant event analysis (SEA) to establish the full details of the incident and the full circumstances surrounding it, although the nursing team were not always included in this process.

There was good liaison between the practice and the hospital in relation to establishing a new treatment for a very small minority of particular patients, however, this required further evaluation and action by the partnership regarding clinical and research governance. More formal clinical supervision and liaison with local experts should be undertaken, and agreement obtained from organisations such as the local ethics committee and Department of Primary Care Research when treatment falls outside nationally recognised guidelines, to help ensure patient safety.

The practice did not have a risk assessment in place for areas of the building, such as the steep staircase, that were a potential risk to the health, safety and welfare of the patients, staff and visitors.

Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. However, risk assessments were not in place to clarify why some staff had not had a criminal record check.

Fire alarm testing and evacuation procedure had not been undertaken in the past 12 months, so staff were not up to date with procedures. Portable appliance testing (PAT) had not been undertaken on all electrical equipment to verify safety. This posed a potential fire risk.

There was a system in operation that encouraged and supported most staff to learn from any significant events or incidents. Safeguarding policies and procedures were in place that helped identify and protect children and adults who used the practice from the risk of abuse.

Summary of findings

Are services effective?
The practice was effective.

The practice worked closely with other services to achieve the best outcome for patients who used the surgery. Patients said they were happy with the care and attention they receive from all the staff at the surgery.

Staff employed at the practice received appropriate training, support and appraisal. Appraisals of GP partners had been completed annually.

The quality of care was monitored by audits, significant events learning and patient feedback.

We saw that the practice had health promotion material available within the practice and on the surgery website.

We found the practice was effective in meeting the wide range of patient needs. There was a system in place to ensure the right skill mix and numbers of staff were in place to provide an effective service at all times. Information about individual patients was appropriately shared with other healthcare providers such as the out of hours service, midwives and community nursing teams, and drug and alcohol services. This supported the continuity of the patient care.

Are services caring?
We found the practice was providing a caring service. Patients' needs were met in a compassionate and caring manner. The practice achieved this by involving their patients in discussion about their health care, providing continuity of care as much as possible, and offering a holistic and patient-centred approach. GPs and nursing staff were opportunistic in undertaking routine health checks and screening. Patients were referred appropriately to other support and treatment services. The Out of Hours (OOH) service was notified of any pertinent information about individual patients with whom they were likely to come into contact.

Patients spoke positively of the care provided at the surgery. This was reflected in the surgery annual survey as part of the practice's quality assurance system. Patients all told us how well the staff communicated with them, either about their health, health education or what was happening at the surgery. There were opportunities for people to provide feedback about the care and treatment they had received.

Summary of findings

Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by both clinical and administrative staff. They told us that staff were excellent, patient, good listeners and they never felt rushed during appointments.

The staff told us patients who required urgent appointments were seen on the day and patients we spoke with confirmed this.

Are services responsive to people's needs?

The practice was responsive to patients' needs.

Patients' individual needs were met without unavoidable delay. Staff were aware of arrangements in place for responding to medical emergencies that may arise. There was an open culture within the practice with a clear complaints and feedback system in place. The practice involved patients, their representatives and external agencies in planning its services, and routinely learned from people's experiences, concerns and complaints, to improve the quality of care.

Are services well-led?

There were organisational structures in place with lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice told us they promoted an open and fair culture. Some clinical governance measures were not in place, which may compromise patient safety.

New staff and trainee GPs received regular supervision opportunities to discuss their performance and issues relating to their role. St Luke's surgery is a training practice. There was no trainee GP (registrar) at the time of this inspection. Two of the GP partners provided registrar training and the practice's last training visit was in August 2013. The practice was described by the Deanery to be well organised despite the physical constraints of the building.

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

From April 2014, all patients aged 75 and over had a named GP who had overall responsibility for the care and support that the practice provided.

The named GP had overall responsibility for the care and support that the practice provided to the individual. They also worked with other relevant health and care professionals, who were involved in the care, to ensure that the care package met the individual needs.

Our accompanying GP specialist advisor spoke with the registered manager and the other GP's about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. St Lukes Medical Centre had 670 patients over 75 years of age.

We saw the practice supported patients in residential care homes and nursing homes by making home visits as well as visiting elderly patients in their own home. We saw how one GP had a responsible role for palliative care and how they supported elderly patients nearing the end of their life.

The older people we spoke with were appreciative of the GPs and nurses. They felt they were treated in a professional and kindly manner. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer people to local services such as dementia screening clinics and falls assessment clinics.

People with long-term conditions

St Lukes Medical Centre cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. There were also designated clinics held for patients with long term conditions. These included diabetes, coronary heart disease and respiratory clinics. The nurses attended educational updates to make sure their knowledge and skills were up to date and involved healthcare specialists for advice where appropriate. Patients told us they felt their care and treatment was good.

St Lukes Medical Centre worked to the Quality and Outcomes Framework (QOF) which is a voluntary incentive scheme for GP

practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. St Lukes Medical Centre achieved higher than the national average in relation to enhancing the quality of life for people with long term conditions, for example, the percentage of patients with coronary heart disease whose blood pressure readings were acceptable.

The practice routinely carried out reviews, audits and checks to ensure patients with long term conditions were receiving the correct medicines. The practice followed best practice guidance to ensure it was meeting and protecting patients' medical needs and complying with other statutory guidance issued by, for example, the Department of Health.

Mothers, babies, children and young people

Expectant mothers attended the practice to be seen for their initial antenatal assessment and then referred to the midwife. The practice worked closely with community midwives and health visitors.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young people.

We spoke with two parents who said they were satisfied with the care and treatment their families received. Parents talked of an efficient childhood immunisation programme and caring doctors.

Effective systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert for a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of child neglect. GPs and health visitors monitored these families with escalation to the relevant agencies as needed. They were also aware of the impact of poverty on patients and provided signposting information to various services.

The practice provided sexual health services for people and promoted national screening programmes including cervical smears and chlamydia screening.

The working-age population and those recently retired

The patients of working age we spoke with considered a telephone call from a GP was generally as effective as a visit to the practice. They were also confident the GP would see them on the same day if this was necessary.

Summary of findings

The majority of the patient population registered at St Lukes Medical Centre was of working age. The practice tried to accommodate working patients' needs outside working hours. The practice provided longer, extended opening hours from 7.30am to 8pm three days a week.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs.

Patients of working age who were considered or known to be at risk of significant harm were identified on their individual patient record, so staff were immediately aware.

A telephone triage was available for patients at work and flexible length appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and supporting information was displayed within the waiting areas.

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

People in vulnerable circumstances who may have poor access to primary care were well supported by St Lukes Medical Centre. People within vulnerable communities, for example the travelling community or the homeless were registered at the practice.

Primary care was provided when required and liaison sought with other professionals when required. Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to ensure that people with mobility limitations had access to care.

People experiencing poor mental health

St Lukes Medical Centre offered support and treatment for patients of all ages experiencing mental ill health. The practice arranged access to a crisis intervention team and also referred people to appropriate local support services for assessment and treatment. Patients experiencing mental ill health were identified on their patient record so that staff were alert to patients with less visible needs.

The practice communicated well with the local community mental health teams both informally and through monthly meetings, where treatment plans were discussed. Patients with depression had access to counselling services in conjunction with other treatment plans.

Summary of findings

What people who use the service say

We spoke with 14 patients throughout the day. They were satisfied with their treatment and complimentary about the care and attention they received.

Systems were in place to meet the demand for appointments. The patients we talked with all said they did not have any trouble getting an appointment. They said if it was urgent they could see the duty GP . The duty GP for the day saw people needing urgent appointments, supported if necessary by another GP. Telephone triage was operated daily. Most patients we spoke with were happy with the opportunity to speak with a GP on the telephone.

A patient survey was carried out in March 2014 by the practice. The survey showed high levels of patient satisfaction with the services provided. For example, 100% of the 41 patients who responded were satisfied they could get an appointment when they needed one.

During our inspection all of the 14 patients told us the services they received were excellent and they had a high level of satisfaction , whether provided by the GPs, the nursing team or from the reception and administrative staff. Patients commented they were able to see the GP of their choice at a time which suited them and that they received treatment in a safe and effective way. They also commented that the environment was always clean and tidy and where they had suggestions for service improvement that these suggestions were listened to.

At the time of this inspection the practice did not have a patient participation group to act as a voice for patients at the practice. There were plans for a group to be re-established.

We received comment cards from 27 patients, 26 of which provided positive comments about the practice . One patient described how appointments were often late starting. On the day, we saw appointments were on time.

Areas for improvement

Action the service MUST take to improve

We found that one aspect of safety was compromised at the practice. A small number of patients (10) were prescribed medicine as a treatment that was emerging rather than established and this was outside National Institute for Health and Care Excellence guidelines. Any care or treatment for patients outside of nationally recognised guidelines needs the review of the local ethics committee and the Department of Primary Care Research.

The recruitment and selection process for staff must include full and relevant checks for all staff prior to commencing work in the practice, and include a risk assessment for roles deemed not to require a criminal record check.

Action the service SHOULD take to improve

All staff should be clear about the way significant events and incidents are used to monitor quality and improve safety, and be kept informed or included in the meetings where significant events are discussed.

Staff should be up to date with all fire procedures. Portable appliance testing should be completed on all electrical equipment.

St Lukes Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP, and a second CQC inspector.

Background to St Lukes Medical Centre

St Lukes Medical Centre is a GP practice providing primary care services for people in Brixham, offering a range of services including health screening, immunisations, and management of long term conditions. Local community teams support the GPs in provision of maternity and health visitor services. GPs are supported by a nursing team and an administration team for approximately 6500 registered patients. Opening hours are between 8.15am to 6pm, with an extended surgery on Monday, Tuesday and Thursday mornings from 7.30am.

Outside normal surgery hours patients are directed to an Out of Hours service delivered by another provider.

St Lukes Medical Centre has one location at 17 New Road, Brixham, Devon where we carried out our announced inspection visit on 10 July 2014.

Why we carried out this inspection

We inspected this out-of-hours 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 poor mental health.

Before visiting, we reviewed a range of information and asked other organisations to share their information about the service.

We carried out an announced visit on 10 July 2014 between 09:00am and 17:00pm

During our visit we spoke with a range of staff, including GPS, the practice manager, administrative and reception staff, registered nurses and health care assistants.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Our findings

Overall the practice was safe, however some improvement is required.

There was good liaison between the practice and the hospital in relation to establishing a new treatment for a small minority of particular patients, however, this required further evaluation and action by the partnership regarding clinical and research governance. More formal clinical supervision and liaison with local experts should be undertaken, and agreement obtained from organisations such as the local ethics committee and Department of Primary Care Research when treatment falls outside nationally recognised guidelines, to ensure patients safety.

Staff were aware of the significant event reporting process and how they would escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small with the team as a whole, for example, identifying where a patient had become aggressive. The GPs and practice manager demonstrated knowledge that following a significant event, the practice would undertake a significant event analysis (SEA) to establish the full details of the incident and the full circumstances surrounding it. However, the nursing team were not always included in this process.

The practice did not have a risk assessment in place for areas of the building, such as the steep staircase, that were a potential risk to the health, safety and welfare of the patients, staff and visitors.

Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent. However, risk assessments were not in place to clarify why some staff had not had a criminal record check.

Fire alarm testing and evacuation procedure had not been undertaken in the past 12 months, so staff were not up to date with procedures. Portable appliance testing (PAT) had not been undertaken on all electrical equipment to verify safety. This posed a potential fire risk.

There was a system in operation that encouraged and supported most staff to learn from any significant events or incidents. Safeguarding policies and procedures were in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were suitable arrangements for the management of medicines.

The practice was visibly clean. Arrangements were in place that ensured the cleanliness of the surgery was to a high standard and there were effective systems in place for the retention and disposal of clinical waste.

Safe patient care

We found that one aspect of safety was compromised at the practice. A very small number of patients (10) were prescribed medicine as treatment that was emerging, rather than established, and whilst no harm to patients had occurred, this was outside of nationally recognized guidelines. Once this had been highlighted, the practice stopped this particular treatment regime.

The practice did not have a risk assessment in place for areas of the building, such as the steep staircase, that were a potential risk to the health, safety and welfare of the patients, staff and visitors.

The GPs and nurses we spoke with told us about how they reviewed the care patients for patients with long term conditions and their medicine reviews. The patients we spoke with confirmed these reviews took place. Patient care was provided by GPs and nurses who routinely updated their knowledge and skills from a variety of sources, for example, attending learning events provided by the clinical commissioning group, completing online learning courses and reading journal articles.

Alerts were placed on the electronic patient records to indicate significant medical concerns about patients as well as allergies or the need for additional support. These alerts appeared immediately when the patient record was opened to alert the GPs or nurses to anything significant relating to the patient and their care. Routine recall appointment alerts were entered onto the system to ensure patients were reminded to have their medical conditions reviewed.

All of the patients we spoke with said they felt safe at St Lukes Medical Centre. Patients told us they received prompt treatment and diagnosis. Patients also talked of their on going treatment, screening and health promotion.

Are services safe?

Staff we spoke with were aware of their responsibilities to identify and report incidents and were able to accurately explain how they would report any incidents or concerns. The practice GPs met on a weekly basis to discuss patient safety.

Learning from incidents

Staff were aware of the significant event reporting process and how they would escalate concerns within the practice. All staff we spoke with felt very able to raise any concern however small with the team as a whole, for example, identifying where a patient had become aggressive. The GPs and practice manager told us they would undertake a significant event analysis (SEA) to establish the full details of an incident and the circumstances surrounding it. However, the nursing team were not always included in this process which meant that not all staff were able to learn from an incident once it had been discussed and evaluated. One GP was the clinical governance lead and described the system of capturing and recording a significant event analysis. There had been very few incidents relating to the practice.

Safeguarding

The practice had appointed a GP as the safeguarding lead, who had received training and updates in safeguarding vulnerable adults and level three training in safeguarding children. Monthly multidisciplinary meetings had been held with the school nurse, health visitors and midwives to discuss cases on the child protection register and other vulnerable children. These discussions had been minuted. Patient medical records and those of relevant family members were updated after the meetings. A flagging system was used on records for children at most risk to alert, for example, other health and social care professionals.

Monitoring safety and responding to risk

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency. These were checked regularly by the practice nurses, records showed that the equipment was working and medicines were in date so that they would be safe to use when required. The practice had an automated external defibrillator (AED) and staff had been trained in its use. An AED may be used in the emergency treatment of a person experiencing a cardiac arrest (heart attack).

Emergency life support training had been given to all members of staff. Reception staff were able to describe their training and felt confident that they could respond appropriately to an emergency in the waiting room.

We were told that any safety alerts or guidance relating to equipment was communicated during the staff meetings or directly to relevant staff. Regular checks were conducted on most equipment used in the practice. However not all electrical items had been tested within the past two years to check they were safe.

Fire alarm testing and staff evacuation procedure had not been undertaken in the past 12 months, so staff had not received an annual update. We saw that fire extinguishers were in place and had been checked.

Monthly multidisciplinary team meetings were held to discuss the care of particular or vulnerable patients, to coordinate, plan and review their care. This included district nurses, mental health nurses, health visitors and community matron.

Nurses attended study days to ensure professional development was up to date. Nurses had also accessed national websites for current information, for example, guidelines on travel vaccinations. Staff at the practice used policies and procedures which contained all the up to date information they needed. Nurses received medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager.

Medicines management

Staff managed medicines at the practice using systems for receipt, administration and storage of medicines, immunisations, emergency medicines and emergency equipment. However, there was no record of what medicines had been disposed of.

Patients said getting repeat prescriptions was straightforward. They appreciated the variety of ways this could be organised. For example people could order over the telephone, in person, via their chemist or on-line using the practice website.

The storage facilities for medicines and immunisations were organised, clean and not over stocked. Vaccine fridges were not hard wired but socket plugs were taped over to prevent them being accidently turned off. Fridge temperatures had been regularly monitored and were within safe limits.

Are services safe?

Patients were given information leaflets with their medicines and also given specific advice should it be required. For example, one person told us they had been given advice about when they should take their medication for optimal benefit.

The computer system highlighted high risk medicines, and particular medicines where more detailed monitoring was required. Patient records were updated following hospital discharge and systems were in place to highlight any changes made to patient's medicines so they could be authorised by the prescriber.

Cleanliness and infection control

Patients said the practice was always very clean. There was an infection control policy and a dedicated infection control lead member of staff who was up to date with training. There was guidance available for staff about infectious diseases, this included information about when staff needed to report infections to relevant agencies.

The treatment and consulting rooms appeared very clean, tidy and uncluttered. The staff all knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, clinical cleaning wipes, aprons and coverings.. This was used to reduce the risk of cross infection between patients. Antibacterial gel was available in the reception area for patients to use upon entering the practice. Communal areas, for example the public toilets had antibacterial hand wash, hand washing guidance and paper towels available.

There was a system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company. There were cleaning schedules in place and an infection control audit system in operation. Treatment rooms had hard flooring to simplify the clearance of spillages. Staff had received updated training about infection control. Staff were clear about their responsibilities in relation to infection control. For example, all staff knew who the lead for infection control was, knew where to find policies and procedures and were aware of good practice guidance. Nursing staff were responsible for managing clinical spillages and had spillage kits available for use. Infection control audits were undertaken. No issues had been identified.

Staffing and recruitment

Patients were cared for by suitably qualified, skilled and experienced staff because the practice had completed the relevant checks on staff before they started work. There was a recruitment and selection policy in place. All relevant checks on GPs and nursing staff had been completed before they started work at the practice, including criminal record checks using the disclosure and barring service to help ensure that patients were looked after by suitable staff. However, administration staff had not had a criminal record check and there were no risk assessments in place to confirm why this decision was made. All the staff files had updated contracts containing terms and conditions of their employment. The practice manager had checked that GPs were included on the performers list, which showed their fitness to practise. Staff registrations with the General Medical Council and the Nursing and Midwifery Council were up to date and had not expired.

Dealing with Emergencies

Equipment was available to deal with an emergency, for example if a patient should collapse. The staff we spoke with all knew where to easily locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medication and equipment had not expired. All staff, including administration staff had received training in emergency medical or first aid procedures.

Equipment

The practice had arrangements in place to ensure most equipment was maintained and safe to use. However portable appliance testing had not been completed on all equipment. Staff told us equipment was calibrated where required and on an annual basis, records showed calibrations had been completed accordingly. Staff told us they felt they had sufficient equipment to carry out their role effectively and safely.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective.

The practice worked closely with other services to achieve the best outcome for patients.. Patients said they were happy with the care and attention they receive from all the staff at the practice.

Staff employed at the practice received appropriate training, support and appraisal. Appraisals of GP partners had been completed annually.

The quality of care was monitored by audits, significant events learning and patient feedback.

We saw that the practice had health promotion material available within the practice and on their website.

The practice was effective in meeting the wide range of patient needs. There was a system in place to ensure the right skill mix and numbers of staff were in place to provide an effective service at all times. Information about individual patients was appropriately shared with other healthcare providers such as the Out of Hours service, midwives and community nursing teams, and drug and alcohol services. This supported the continuity of the patient care.

Promoting best practice

Most patients received care and treatment according to national guidance including guidelines from the National Institute for Health and Care Excellence (NICE), best practice professional guidelines and the Mental Capacity Act 2005 (MCA). The MCA is a framework which supports people who need help to make decisions. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. The GPs and nursing staff were aware of the consenting principles needed for children, so they had a clear understanding of their treatment. Parents or guardians were asked to sign consent for babies.

In the event of GPs or nurses being unsure if a patient who did not speak English had understood or had capacity to understand, they would seek a second opinion from a colleague and use a translation service accordingly.

We discussed with GPs at the practice the results of the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for how well they care for their patients. The results have been published annually. The GPs told us that as a practice they regularly discussed and reviewed the findings of their QOF data.

Staff told us they felt the various practice meetings they attended were useful and informative and they commented they always felt able to discuss any changes or ideas on how to carry out procedures more effectively. They said they felt able to raise any issues and felt they would be listened to regardless of the topic, and their ideas and suggestions would be treated seriously

Management, monitoring and improving outcomes for people

The practice operated a quality improvement process that ensured ideas for improvements to patient care were regularly reviewed and acted upon. Staff told us the practice held meetings with different groups of staff such as GPs partners, nurses and administrative staff to discuss the continual improvement of issues relating to patient care and business needs.

The practice was keen to ensure that staff had the skills to meet patient needs. For example, the nursing team had specific lead roles and had updated their skills to ensure best practice was being followed in relation to diagnosis, medicines management and care. There were nurse led clinics for patients with respiratory disease, diabetes and for those in need of wound care.

Annual checks had been carried out and health action plans created for patients living with learning difficulties. These were managed by the learning disabilities lead nurse at the practice.

The practice completed clinical audits to ensure patients continued to receive the right care and appropriate treatment for their needs. The practice took time to review the results of these audits, measure performance and put in place any improvements. This resulted in a continual improvement in patient care, treatment and service.

Staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation of their qualification over a five-year cycle. The three GPs we spoke with told us these appraisals have been appropriately completed. Nursing

Are services effective?

(for example, treatment is effective)

and administration staff received an annual formal appraisal and kept up to date with their continuous professional development programme, documented evidence confirmed this process.

There were staffing and recruitment policies to ensure staff were recruited and supported appropriately. Most staff had been employed by the practice for many years. Paper and computer staff records demonstrated that staff had been recruited and employed in line with the practice policy. Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development. However, not all staff had an existing disclosure and barring service certificate to show they had received a criminal record check, nor had this been risk assessed to clarify why this had not been necessary.

Staff told us they all received an annual appraisal and attended regular staff meetings to enable information sharing. Nursing staff received clinical supervision from the GP partners. The GPs and nursing staff had meetings to discuss clinical issues and patient diagnoses. All staff told us they had access to training related to their roles. Staff were alerted by the practice manager about official notifications regarding concerns about faulty equipment.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with other services

The practice had effective working arrangements with a range of other services such as the community nursing teams, the local authority, local nursing and residential services, the hospital consultants and a range of local and voluntary groups.

The practice was involved in various multidisciplinary weekly meetings involving palliative care nurses, health visitors, social workers and district nurses to discuss vulnerable patients at risk and with complex health needs, they also looked at how hospital admissions could be reduced. The lead GP for safeguarding children attended monthly multidisciplinary meetings with the school nurse, health visitors and midwives to discuss cases on the child protection register and cases of other vulnerable children. The discussions were minuted. The multidisciplinary approach aimed to ensure each patient received the appropriate level of coordinated care.

The practice had a system to provide the Out of Hours and emergency services were provided with important information where a patient had complex health needs and was likely to make contact.

Health, promotion and prevention

New patients were given a screening assessment. If they presented with more complex illnesses or diseases they were offered an appointment for a review. This enabled the GPs and nursing staff to recommend lifestyle changes to patients and promote health improvements which might reduce dependency on healthcare services.

A range of information and health promotion leaflets were available in the waiting areas of the practice. There were sexual health leaflets displayed in the patient toilets which encouraged patients under the age of 25 years to take a sexual health screening test.

The practice website provided further information and advice to patients who may be suffering from minor illnesses such as colds and flu, sore throats , diarrhoea and vomiting. The website also included other information to help patients understand, for example, why they may need to attend accident and emergency unit, or why patients may be prescribed antibiotics.

Are services caring?

Our findings

The practice was providing a caring service. Patients' needs were met in a compassionate and caring manner. The practice achieved this by involving their patients in discussion about their health care, providing continuity of care as much as possible, and offering a holistic and patient-centred approach. GPs and nursing staff were opportunistic in undertaking routine health checks and screening. Patients were referred appropriately to other support and treatment services. The Out of Hours (OOH) service was notified of any pertinent information about individual patients with whom they were likely to come into contact.

Patients spoke positively of the care provided at the surgery. This was reflected in the surgery annual survey as part of the practice's quality assurance system. Patients all told us how well the staff communicated with them, either about their health, health education or what was happening at the surgery. There were opportunities for people to provide feedback about the care and treatment they had received.

Patients told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by both clinical and administrative staff. Patients we spoke with said staff were excellent, patient, good listeners and they never felt rushed during appointments.

The staff told us patients who required urgent appointments were seen on the day and patients we spoke with confirmed this.

Respect, dignity, compassion and empathy

The waiting room and reception area are on the ground floor. The reception desk was open in style, so patients were able to see and speak directly with the reception staff. Telephone confidentiality was maintained by reception staff taking calls in the reception office, screened from the reception desk. Reception staff were mindful of individual patient needs and health conditions. Patients presenting with infectious conditions were discreetly asked to wait in a separate area to avoid putting other patients at risk.

The patients we spoke with told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team.

Patients were greeted in their preferred manner and conversations were held in a way which respected their privacy. There were curtains and blinds in the treatment rooms, this provided patients with privacy and dignity during examination or treatment. Also, the treatment room door was lockable and we observed treatment rooms being locked to maintain privacy. Staff told us the importance of not rushing patients and giving patients time to talk.

There was ramped access into the ground floor reception and waiting room. Consultations were offered to patients with disabilities in a ground floor room as there was no lift to the first floor treatment rooms. The limitations of the premises made it challenging to provide a service for some patients with disabilities. The GP surgeries and nurses' treatment rooms had curtains for screening and privacy when examinations were undertaken.

The practice offered a chaperone service. A chaperone is a member of staff who accompanies a patient during a medical examination or treatment. This was provided by one of the nursing team if a patient so wished, or on request of a GP.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP.

Patients were supported to understand the assessment process, any diagnosis given and their options for care and treatment. A patient told us they were given information leaflets about any potential treatment to aid their understanding of the treatment provided. Patients decided who they wanted involved in their care. A patient told us their wife was involved in their care and was welcomed by the GP in consultations. The practice had a system in place to identify patients where they wanted their partners or family involved in their care and decision making.

Are services caring?

Patients were communicated with in a way that they understood and was appropriate and respectful. The practice had used a translation service for patients for whom English was not their first language.

Decisions about or on behalf of patients lacking mental capacity to consent to their treatment decisions were made in the patients' best interest in accordance with the Mental Capacity Act 2005 and Gillick competence framework. The MCA is a framework which supports adults who need help to make decisions. The Gillick competence framework supports children who wish to make a decision without their parent or guardian present. Staff were aware of consent issues for children and had access to a policy for child consent for clarification of the process.

Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. For example, a best interest meeting had been arranged to decide if a patient, who lacked capacity, should have a flu vaccination. The practice had assessment of capacity forms, information on advocacy services and a policy for further guidance for staff.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was responsive to patients' needs.

Patients' individual needs were met without delay. Staff were aware of arrangements in place for responding to medical emergencies that may arise. There was an open culture within the practice with a clear complaints and feedback system in place. The practice involved patients, their representatives and external agencies in planning its services, and had learned from people's experiences, concerns and complaints to improve the quality of care.

Responding to and meeting people's needs

We received positive feedback from patients about their care and professionalism they had received from GPs and nurses.

Patients felt they were involved in their care and treatment. They confirmed they had time to think about the options and felt able to ask questions if they were unsure. People were offered additional information about their illness and other help and advice, one example being about arthritis.

Patients were able to access the GP of their choice during the opening hours of the practice. The GPs held their own patient lists which provided continuity of patient care and respected the choices made by patients. Appointment times varied based on patient needs, from a 5 minute telephone discussion appointment to a twenty minute consultation appointment. Longer appointments were available if required, for example if a patient needed to have an examination with the practice nurse. Emergency appointments were available each working day and the practice had extended working hours up to 7pm on three days each week.

Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They also provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood). Maternity services were provided by the GPs and the locality midwifery team based at the hospital.

We saw notices advising patients that self- testing kits were available on request to check for sexually transmitted diseases or they could see a practice nurse. Nursing staff told us they were opportunistic about monitoring patient's health. They offered routine appointments rather than run specialist clinics for patients with long term conditions. They said this had improved and increased patient access and choice about when they attended appointments.

Systems were in place to make sure urgent and routine referral letters were prioritised, written and sent promptly. There were also systems in place to follow up on, for example, blood tests, x-rays and scans, and letters from the hospital. Patients were able to request appointments with the same GP unless it was an emergency and their preferred GP was not available. This meant people received continuity of their care whenever it was possible.

Patients being referred to hospital were supported to choose a hospital or service that met their preference. A patient told us they felt supported when they were referred to hospital and supported in this process by the GP. They told us the practice had good links between the hospital and practice which enabled swift referrals.

The practice actively engaged with commissioners of services, local authorities and other health care professionals to provide coordinated and integrated pathways of care that met patients' needs.

Access to the service

Patients told us if they needed to see a GP there were urgent and emergency appointments available on the same day. Patients were able to book appointments by telephone or by using the online appointment service. The opening hours were clearly displayed in the practice and on their website and patient information leaflet. If patients required GP assistance out of practice hours then details of who to contact were clearly displayed in the practice, on their website and in the practice information leaflet.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred GP. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them.

Patients told us they were happy with the appointment system. They contacted the practice for an appointment, were given an appointment when needed and often saw their GP of their choice. Patients said they never had to wait long to be seen by the GP and were informed if there was a delay. On the day of our inspection, we saw patients had their appointment at the correct time.

Are services responsive to people's needs?

(for example, to feedback?)

Of the 27 comment cards we received, only one stated that they sometimes wait to get an appointment with the doctor of their choice; 26 stated that it is easy to get a same day appointment.

Concerns and complaints

Patients knew how to raise concerns or make a complaint. The practice complaints procedure was promoted on the patient notice board, in the practice's brochure and on their website. Patients had feedback that they were very satisfied with the service received.

The practice complaints procedure detailed how patients could complain and what they could expect. If they were unsatisfied with how the practice had dealt with the complaint, details of how to escalate their complaint through the relevant authorities was explained. Reception staff told us they tried to deal with issues if patients complained at the desk. However they would call the practice manager if a situation could not be resolved.

The practice continuously reviewed and acted on information about the quality of care received by patients. We saw the practice had received one complaint from April 2013 to March 2014. The practice manager had analysed complaints and had discussed them in a team meeting. Learning points had been raised and the practice had identified how any changes would be embedded.

Are services well-led?

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

Our findings

There were organisational structures in place with lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice told us they promoted an open and fair culture.

New staff and trainee GPs received regular supervision opportunities to discuss their performance and issues relating to their role. St Luke's surgery is a training practice. There was no trainee GP (registrar) at the time of this inspection. Two of the GP partners provided registrar training and the practice's last training visit was in August 2013. The practice was described by the Deanery to be well organised despite the physical constraints of the building.

Leadership and culture

The practice had vision and values which stated providing patients with high quality care was a top priority. Staff told us about the practice values and there were examples of compassion, dignity, respect and equality towards patients throughout our inspection.

The management team encouraged cooperative, appreciative and supportive relationships amongst staff teams and support services. Staff told us they felt supported, valued and motivated. Staff helped each other and worked as a team throughout our inspection. For example, the practice manager supported reception for early morning appointments to ensure there was adequate cover.

Governance arrangements

Governance arrangements supported transparency and openness. The provider had a range of governance policies and protocols that covered all aspects of the services it provided. However one issue was identified regarding the lack of clinical and research governance. Formal clinical supervision and liaison with organisations such as the local ethics committee and Department of Primary Care research had not been undertaken.

Staff were clear about what decisions they were required to make, what they were responsible for and the limits of their authority. Staff described situations of when they would need to refer specific decisions to another member of staff. For example, staff who were concerned about a child would go to the practice's named safeguarding lead for child protection. Staff who had an infection control concern would go to the infection control lead. Practice policies provided the lines of authority for staff to follow.

Regular meetings were held in the practice for all staff which ensured staff were updated and aware of who was responsible for decisions around provision, safety and adequacy of care provided. Meetings were held for all teams including administrators, team leaders and management, clinical staff.

Systems to monitor and improve quality and improvement

The quality of care was reflected in the practice achievements against the Quality and Outcomes Framework (QOF). There was a QOF lead in the practice and each clinician and practice nurses contributed to the practice achieving its current achievements. The clinical auditing system assisted in driving improvement.

Patient experience and involvement

Patients spoke highly of the service and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. The practice had begun to establish a patient participation group (PPG) to further improve practice development.

An annual patient survey was taken March 2014 which asked patients what they thought about the service provided, such as waiting times, information and consultation. The practice scored 90% satisfaction with the service provided.

Staff engagement and involvement

The voices of staff were encouraged, heard and acted upon. The practice manager had an open door policy. Staff told us they felt able to raise concerns either with the staff member involved or through their line management.

Staff meetings provided an open environment to raise concerns. For example, administration staff told us they felt able to raise concerns in front of the GPs and nursing staff. Staff spoke of practice staff who worked as a team, knew how each role had its own importance and how they needed to work together to provide good outcomes for patients.

Are services well-led?

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

Learning and improvement

Staff demonstrated awareness of the incident reporting policy and described a willingness to learn and an open culture in raising and responding to events.

We looked at the significant event reporting process and supporting documentation. The practice used a standard document for all significant event reports and use the same process for medication errors, complaints and near miss incidents. The practice manager told us the GPs discussed these significant events when they were identified, but also more formally at regular weekly meetings.

Identification and management of risk

We saw the practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. Risk assessments had been completed for some health and safety risks but there was not one in place which related to the building. The practice had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, computer power or system loss, or if the telephone lines at the practice failed to work.

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.

Our findings

From April 2014, all patients aged 75 and over had a named GP who had overall responsibility for the care and support that the practice provided.

The named GP had overall responsibility for the care and support that the practice provided to the individual. They also worked with other relevant health and care professionals, who were involved in the care, to ensure that the care package met the individual needs.

Our accompanying GP specialist advisor spoke with the registered manager and the other GP's about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. St Lukes Medical Centre had 670 patients over 75 years of age.

We saw the practice supported patients in residential care homes and nursing homes by making home visits as well as visiting elderly patients in their own home. We saw how one GP had a responsible role for palliative care and how they supported elderly patients nearing the end of their life.

The older people we spoke with were appreciative of the GPs and nurses. They felt they were treated in a professional and kindly manner. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer people to local services such as dementia screening clinics and falls assessment clinics.

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).

Our findings

St Lukes Medical Centre cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. There were also designated clinics held for patients with long term conditions. These included diabetes, coronary heart disease and respiratory clinics. The nurses attended educational updates to make sure their knowledge and skills were up to date and involved healthcare specialists for advice where appropriate. Patients told us they felt their care and treatment was good.

St Lukes Medical Centre worked to the Quality and Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. St Lukes Medical Centre achieved higher than the national average in relation to enhancing the quality of life for people with long term conditions, for example, the percentage of patients with coronary heart disease whose blood pressure readings were acceptable.

The practice routinely carried out reviews, audits and checks to ensure patients with long term conditions were receiving the correct medicines. The practice followed best practice guidance to ensure it was meeting and protecting patients' medical needs and complying with other statutory guidance issued by, for example, the Department of Health.

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.

Our findings

St Lukes Medical Centre cared for mothers, babies, children with young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

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.

Our findings

The patients of working age we spoke with considered a telephone call from a GP was generally as effective as a visit to the practice. They were also confident the GP would see them on the same day if this was necessary.

The majority of the patient population registered at St Lukes Medical Centre was of working age. The practice tried to accommodate working patients' needs outside working hours. The practice provided longer, extended opening hours from 7.30am to 8pm three days a week.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs.

Patients of working age who were considered or known to be at risk of significant harm were identified on their individual patient record, so staff were immediately aware.

A telephone triage was available for patients at work and flexible length appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and supporting information was displayed within the waiting areas.

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).

Our findings

People in vulnerable circumstances who may have poor access to primary care were well supported by St Lukes Medical Centre. People within vulnerable communities, for example the travelling community or the homeless were registered at the practice.

Primary care was provided when required and liaison sought with other professionals when required. Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to ensure that people with mobility limitations had access to care.

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.

Our findings

St Lukes Medical Centre offered support and treatment for patients of all ages experiencing mental ill health. The practice arranged access to a crisis intervention team and also referred people to appropriate local support services for assessment and treatment. Patients experiencing mental ill health were identified on their patient record so that staff were alert to patients with less visible needs.

The practice communicated well with the local community mental health teams both informally and through monthly meetings, where treatment plans were discussed. Patients with depression had access to counselling services in conjunction with other treatment plans.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **We found that one aspect of safety was compromised at the practice. A small amount of patients (10) were given treatment that was emerging rather than established and this was outside NICE guidelines.**