St Lukes Surgery

Quality Report

St Luke's Close, Off Shamble Lane South, Hedge End,
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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.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of this service on 18 November 2014. We have rated the practice as good overall.

The practice delivered effective care and treatment to its patients. We saw clear management systems in place and staff were able to contribute to the running of the practice.

Our key findings were as follows:

- The practice was visibly clean and there were systems in place to maintain an appropriate standard of cleanliness and hygiene.
- Patient requirements were taken into account when services were planned and delivered. These included availability of appointments outside of working hours and home visits when needed.
- GPs and nurses received appropriate training and support to deliver care and treatment.
- The practice routinely assessed and monitored the quality of its service and took action when needed to improve.
- Patients with learning disabilities were routinely offered home visits and picture cards were used to assist in explaining what treatment was needed.
- The practice had links with a community health team who collected vaccines from the practice and administered them to patients registered with the practice, who were housebound or lived in care homes.
- Grandparents who looked after their grandchildren were offered a session on basic life support

We saw areas of outstanding practice including:

- The practice had developed a mobile telephone application which informed patients of appointment availability and with which GP.
- Patients with learning disabilities were routinely offered home visits and picture cards were used to assist in explaining what treatment was needed.

Summary of findings

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Must ensure that for locum GPs there is all required recruitment information.

In addition the provider should:

- Record medicine refrigerator temperatures as specified in their own policy

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice was rated as requires improvement for safe.

The practice used a number of sources of information and aimed to deliver safe care and treatment. There was a system in place for reporting, recording and monitoring significant events. Infection control systems were in place and regular audits were carried out to ensure that all areas were clean and hygienic.

Staff were aware of the signs to be aware of which might indicate that a patient was being abused. All staff had received appropriate training in safeguarding children and adults.

Recruitment procedures needed improvement to ensure that all required information and checks had been made and recorded prior to a new member of staff commencing employment.

Appropriate arrangements were in place in relation to obtaining medicines and vaccines. Emergency medicines and associated equipment was available for use and regularly checked to ensure it was in date and suitable for use.

Are services effective?

Good

The practice was rated as good for effective.

The practice had procedures in place to ensure that care and treatment was delivered in line with best practice guidelines and standards. Information was shared appropriately with other agencies and processes were in place to manage information received.

Staff were able to describe 'best interest' decision and the principles of the Mental capacity Act 2005, but had not received training in this area.

Staffing levels were suitable for the number of patients registered at the practice. Patients were able to access a range of clinics which were led by nursing staff.

Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatment they needed in a timely manner.

Are services caring?

Good

The practice was rated as good for caring.

Summary of findings

The patients we spoke with and the comment cards we received were positive about the care provided. Patients told us they were treated with respect and their privacy and dignity was maintained. Care was taken to ensure patients' confidentiality was protected.

Patients said they were given sufficient time to discuss their problems and treatment and were referred to other agencies when needed.

Arrangements were in place to support patients who were nearing the end of their life and regular contact was maintained with palliative care teams.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice was responsive to patients' needs and was continually reviewing processes in place to maintain and improve the level of service provided.

Arrangements were in place to ensure patients received urgent medical assistance when required and when the practice was closed.

The practice had a system for handling complaints.

Are services well-led?

Good

The practice was rated as good for well lead.

There was a clear vision and strategy for the development and running of the practice.

Staff were supported to carry out their role and there were clear lines of responsibility and duties.

The practice acted on feedback received from patients to monitor and improve the service provided.

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

The practice was rated as good for older people. Patients were offered annual flu vaccinations and shingle vaccination. Patients aged 75 years and older had a named GP and there was a register of patients who had carers. When needed home visits were offered, and if needed, routine tests such as blood tests were carried out in the patient's home. The practice worked with other agencies such as the community health team to provide vaccinations for patients who lived in care homes. Care homes that had patients registered with the practice had a named GP to provide continuity of care.

People with long term conditions

Good

The practice was rated as good for patients with long term conditions. The practice had annual recall systems in place for reviews of patients' conditions and care plans were in place for those patients. Nurse led clinics were available for those patients with long term conditions such as asthma and diabetes. The practice held a register of patients who required warfarin therapy and they carried out regular audits to ensure treatment was effective. Patients were able to use a blood pressure monitor in the waiting room to check their blood pressure.

Families, children and young people

Good

The practice was rated as good for the care of families, children and young people. Childhood vaccinations were offered in line with national guidance. These could be accessed via specific clinics or booked for a routine appointment. Walk in flu clinics were organised for young children who were eligible for the vaccine. The practice offered family planning services and shared ante and post natal care with local maternity services. Grandparents who looked after their grandchildren were offered a session on basic life support.

Working age people (including those recently retired and students)

Good

The practice was rated good for the care of working age people (including those recently retired and students).The practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice was rated good for the care of people whose circumstances may make them vulnerable. Care homes that had patients registered with the practice had a named GP to provide continuity of care. GPs made home visits to patients who were not able to attend the practice. Patients with learning disabilities were offered a comprehensive health check each year. Patients with learning disabilities were routinely offered home visits and picture cards were used to assist in explaining what treatment was needed.

People experiencing poor mental health (including people with dementia)

Good

The practice was rated as good for the care of people experiencing poor mental health (including dementia).The practiced had a nominated GP who was the safeguarding lead for vulnerable adults and children. Staff were able to explain how they would use the Mental Capacity Act 2005 to ascertain whether a patient was able to give informed consent. The practice also provided care and treatment for temporary residents in their catchment area.

Summary of findings

What people who use the service say

Two patients had completed CQC comments cards both were complimentary about the service provided by this practice and referrals onto other services. They considered that the practice was patient centred and GPs were caring and genuine. Comments about reception and nursing staff were also positive.

We spoke with six patients during our inspection. Three patients had booked an urgent appointment that day. All patients considered that they were able to have appointments at a convenient time and were always seen on the same day when needed. Patients also said that staff took time to explain their care and treatment and ensure they understood what was happening. Patients who had young children with them said that whenever their child was ill they were always seen on the same day.

Areas for improvement

Action the service MUST take to improve

- Must ensure that for locum GPs there is all required recruitment information.

Action the service SHOULD take to improve

- Record medicine refrigerator temperatures as specified in their own policy

Outstanding practice

- The practice had developed a mobile telephone application which informed patients of appointment availability and with which GP.
- Patients with learning disabilities were routinely offered home visits and picture cards were used to assist in explaining what treatment was needed.

St Lukes Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice manager.

Background to St Lukes Surgery

St Luke's Surgery is situated at St Luke's Close, Off Shamble Lane South, Hedge End, SO30 2US. A branch surgery is provided at Botley Health Centre, Mortimer Road, Botley, SO32 2UG. The practice is open at 8am to 6.30pm Monday to Friday, at the St Luke's Surgery site. Botley Road Surgery site is open on Monday, Tuesday and Thursday 8.30am to 12.30pm and 3pm to 6pm and 8.30am to 12.30pm on Wednesdays and Fridays. Patients are able to arrange appointments at either practice and GPs and nurses work across both sites.

The practice has 12,700 registered patients and has a higher number of patients aged between 35 and 49, when compared to the England average. There is also a higher percentage of young patients aged between 0 and 14 years old. The mix of patients' gender (male/female) is almost half and half.

The practice operates from a purpose built premises and currently has five GP partners and one salaried GPs. Three of whom are male and three of whom are female. In addition to GPs there are two nurse practitioners and five practice nurses. The practice also employed health care assistants. GPs and nurses are supported by a practice manager and reception and administration staff. The majority of staff work part time.

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. It has opted out of providing our of hours service to their own patients and refers them to another provider.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 18 November 2014 at St Luke's Surgery. During our visit we spoke with a range of

Detailed findings

staff which included GPs, nurses and reception staff. We spoke with patients who used the service. We reviewed two comment cards where patients and members of the public shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used information gathered both externally and internally to identify risks and improve quality in relation to patient safety. Polices and procedures in place showed that when an alert was received from an external body such as the Medicines and Healthcare Regulatory Agency (MHRA), these were disseminated to the appropriate staff to act on. GPs told us that they would review patients' medicines if an alert related to medicine concerns.

The practice had a system in place for reporting significant incidents and events on their computer system. We saw records which showed that these were discussed at weekly practice meetings and monthly significant event meetings. Action was taken to minimise risk of reoccurrence. We noted that reporting of significant events and incidents could be more detailed to demonstrate fully what actions had been taken and whether risk had been mitigated. For example, a GP was unsure of the correct dose for a patient's long term medicine and to resolve this the patient was seen four days later at home to ensure the correct dosage was prescribed.

Learning and improvement from safety incidents

The practice has a system in place for reporting, recording and monitoring significant events. All significant events were reviewed with the involvement of the GPs, nurses and management team. This usually occurred at the weekly practice meetings. Staff we spoke with confirmed this. Areas included in significant event reported included prescribing errors and computer issues where the system had been disrupted.

We found that an audit of INR monitoring was carried out following a significant event. (The INR is a test of blood clotting, which is primarily used to monitor warfarin therapy).This resulted in a warfarin medicine register being put into place and three monthly reports were produced to monitor the effectiveness of treatment for each patient.

Staff received feedback on learning points through a monthly staff meeting. They confirmed they were aware of the system for raising issues and felt encouraged to do so.

Reliable safety systems and processes including safeguarding

We reviewed the practice's policies and procedures for safeguarding adults and children. We found there were references to guidance, such as 'No Secrets'. Both policies detailed types of abuse and signs that staff should be aware of which might indicate that a patient was at risk. There was information on who to report concerns to and what should be documented. The policies did not contain information on how often training should be given. The lead GP for safeguarding had received training at the appropriate level child safeguarding and had also had training on safeguarding adults. Staff told us they knew who the safeguarding lead was and were able to approach them with any concerns. We reviewed staff files and found that all staff had received training in safeguarding children. Training had been provided on safeguarding adults in June 2013, We asked staff about safeguarding and they were able to describe the process they would take if they suspected a patient was a risk of abuse.

A chaperone policy was in place and there was information on the television screen in the waiting room about this. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Chaperones were provided from clinical staff members only, all of whom had had a criminal records check, such as via the Disclosure and Barring Service. GPs and nurses documented when a chaperone had been offered and either accepted (with the name of the chaperone) or declined by the patient; in the patient record using recognised recording codes.

Medicines management

There were systems in place for managing medicines within the practice. Suitable lockable cupboards were provided for medicines to be stored securely. There was a designated refrigerator for storing medicines which needed to be kept at a low temperature. We found that improvements were needed to ensure checks of the temperature of the refrigerator were made. Records we looked at showed the refrigerators were operating within safe limits, but there were gaps where the temperature had not been recorded. There were clear instructions detailing what actions staff should take if there was an interruption in the cold chain of vaccines.

GPs said they used a specific emergency bag whose contents, which included medicines, were checked by one

of the practice nurses and recorded. The said that if they needed to take prescriptions pads with them then they were required to complete a record of the batch numbers they had taken. Prescriptions which were not used were returned for storage at the practice and documented. Prescriptions were seen to be securely locked away when not required.

The practice had a prescribing clerk who monitored repeat prescriptions and was able to authorise new ones. This member of staff had received training to undertake this role and followed protocols developed by the practice. We looked at the protocols and saw there was clear guidance on how and when repeat prescriptions could be authorised and who was responsible for authorising them. We noted that specific clinical checks were required prior to the prescribing clerk authorising repeat prescriptions and there was guidance on what to do if these checks had not been carried out. For example patients who were on cholesterol lowering medicines had to have had a blood test in the preceding 15 months If this had not been done then an appointment was requested for a blood test and sufficient medicine would be prescribed until the result of the blood test was known, before authorising for another year.

Cleanliness and infection control

The practice was visibly clean and free from odour. There was hand cleansing gel available in reception and at other strategic points in the premises, such as consulting rooms. We noted that reception staff had gloves for use when dealing with specimens. Specimens were collected twice daily form both sites, and cold storage was available if specimens had to be stored overnight.

We saw the practice had suitable arrangements in place for managing clinical and general waste. There were colour coded sharps bins for needles and syringes, and different coloured bags for waste bins to separate clinical from non-clinical waste. We saw that disposable equipment was used when carrying out minor surgery procedures. Minor surgery clinics carried out monthly by one GP, with the assistance of a health care assistant and recorded. Spillage kits for bodily waste were available for use by reception staff if needed.

The practice had comprehensive policies and procedures in place which included references to relevant guidance. Also included were procedures for managing needle stick injuries and effective hand hygiene.

Arrangements were in place to ensure that the environment was maintained. Staff said that the practice was cleaned out of hours by contract cleaners. Some aspects of the clinical areas were cleaned by nursing staff. We saw cleaning schedules and checklists that were completed to indicate that cleaning had been carried out. However, there were some missing entries on the records we viewed and it was not clear whether the cleaning schedule had been adhered to.

A nurse had been nominated as the infection control lead and had carried out an audit of infection control practices in July 2014. They told us that they met monthly with the cleaning contractors and undertook daily and weekly checks of the premises. Any areas identified which needed improvements were acted upon as a result of these processes. The training records showed that all staff who worked at the practice received infection control training appropriate to their role.

Equipment

Equipment checks were carried out in line with the manufacturers' recommendations. For example portable electrical equipment had been tested. We also saw records which showed that clinical equipment had been maintained and calibrated. (Calibration is when a piece of equipment is tested to ensure it measures accurately).

Staffing and recruitment

The practice staff consisted of five GP partners plus one salaried GPs. There was also one nurse practitioner and five practice nurses who worked between the two surgeries. The practice had recruited another nurse practitioner and were waiting for them to finish working for their current employer.

We looked a sample of recruitment files and found that appropriate checks, such as a criminal records check through the Disclosure and Barring Service (DBS) and satisfactory evidence of employment in previous jobs had been obtained. All GPs and nurses had DBS checks completed and also administration staff who assisted with immunisation clinics.

Nurses' registrations were regularly checked to ensure they were current. The practice completed General Medical Council checks on GPs and locum GPs, but did not keep a record of the locum GP checks and ensure all relevant checks had been carried out prior to a locum starting employment.

Requires improvement

Are services safe?

Staff considered that they were supported to carry out their role and were provided with opportunities to maintain their registration and skills and had regular appraisals.

Monitoring safety and responding to risk

The practice was situated in premises which were leased from a private landlord. The practice was responsible for carrying out Legionella checks and fire safety assessments. The practice also undertook local health and safety checks, for example we saw records related to handling of chemicals and whether protective equipment was in place to use. We saw that when needed action had been taken to minimise risk. For example, disposing of chemicals safely which had passed their use by date. Other local guidance in place included phlebotomy protocols, which detailed how patients' blood should be taken and what equipment was needed.

We found that there was employer's liability insurance in place. The practice had an emergency box containing medicines and equipment to use and an automatic external defibrillator (this is use d to try and restart the heart). The equipment and medicines were checked to ensure they were in date and safe to use on a regular basis.

Arrangements to deal with emergencies and major incidents

All staff had received training in basic life support within the previous two years. Staff were able to tell us where emergency equipment was located. The practice had emergency equipment which included emergency medicines and automatic external defibrillator (AED) (this is a machine used to try and restart the heart when it stops). This equipment had been checked monthly to ensure medicines were in date and the AED worked and had sufficient battery life.

The practice has a disaster recovery plan that included arrangements about how patients would continue to be supported during periods of unexpected and /or prolonged disruption to services. For example, a power cut, adverse weather or high rates of staff sickness.

The plan had instructions for staff to follow if there was an interruption or failure of the IT system and who to contact in the event of a power failure. There was also information on where the surgeries would take place if one of the premises was unavailable for use.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

We observed patients using the blood pressure monitor in the waiting room. Patients said that results were given to the GP and action was taken if needed. There were clear instructions for patients to follow when carrying out blood pressure readings.

The practice used a software system that had assessment and treatment templates based on best practice guidance. They said that if needed they were able to add additional information to the patient record about treatment given.

Management, monitoring and improving outcomes for people

We spoke with two GPs who each confirmed that they followed evidenced based practice protocols. They also added that they made use of National Institute for Health and Care Excellence (NICE) guidelines and safety alerts. The practice undertook a small amount of minor surgical procedures, for example removal of lesions. Staff carried these out in line with their registration and NICE guidance.

Staff were appropriately trained and kept up to date to ensure they were competent in carrying out procedures. Clinical audits were carried out and results were used to ensure that staff knowledge was kept up to date with current guidance. We looked at a sample of three clinical audits. One of which related to assessing whether blood tests were carried out for patients on warfarin (a blood thinning medicine). This clinical audit was reviewed on a three monthly basis and an improvement made as a result of this was the introduction of a warfarin register to enable patients to be identified effectively and checks made on the treatment provided. Another clinical audit was carried out on patients with a diagnosis of non-alcoholic fatty liver which involved the checking of regular blood tests to monitor their condition and whether further treatment was needed. For example an ultrasound or biopsy. Yellow flags were added to patient records to indicate what actions were needed and when.

The practice routinely collected information about patients care and effectiveness of treatments. They used the national Quality and Outcomes Framework (QOF) to assess performance and undertook regular clinical audits. We noted that the most recent overall QOF score for the practice was 99.52%, which is higher than the national average. Other areas where performance was comparable or above the national average included uptake of immunisations. We found that regular NHS health checks were offered to identify potential health conditions which gave GPs and nurses opportunity to work proactively with patients about how to manage their health. For example. Health checks for those aged 40-74 years. We also saw that patients outside this age range could have a health check if they wanted.

The practice held a register for patients in need of palliative care and met with other health care professionals three monthly to discuss individual patient care. Meetings were also held monthly with other health professionals such as district nurses and health visitors to discuss the needs and treatment of patients. We were shown an audit of patients with learning disabilities which was carried out by an external agency and was voluntary for the practice to take part in. Results from this audit showed that patients with learning difficulties were offered a comprehensive health check each year and an action plan was in place to monitor their condition.

Effective staffing

Phlebotomy services were being performed by two health care assistants who had training to undertake this.

Nurse led clinics were in place for removal of stiches, ear syringing, baby immunisations, wound dressings, cytology, travel advice and chronic disease management. One nurse said that if needed baby and child immunisations could be booked into routine appointments, rather than on the set clinic days, to minimise distress for the child.

Healthcare assistants employed by the practice carried out blood pressure checks, removal of stiches and ECGs (The electrocardiogram, or ECG, is the most common test used to assess the heart) and had received training to carry out these tests.

Good

Are services effective?

(for example, treatment is effective)

Pregnant women were offered shared ante and post natal care with midwives and the local hospital.

GPs undertook regular training including that provided by the clinical commissioning group (CCG). This kept GPs up to date with how to promote best practice. Nursing staff and GPs spoke with each other and met regularly to discuss individual patient's needs.

There were arrangements in place to support learning and professional development. These included GP NHS appraisals and practice staff appraisals. Staff confirmed that these occurred and included a review of their performance and identification of any training needs they had.

Working with colleagues and other services

There were arrangements in place for engagement with other health and social care providers.

The practice held regular multi-disciplinary team meetings with district nurses and health visitors, which practice nurses and GPs attended. Referrals to secondary services, such as hospitals, were made within current guidelines. The practice used the system of Choose and Book for patients' hospital appointments (Choose and Book is a system which allows patients to select a hospital of their choice and arrange a suitable day and time for their appointment). Information was shared between the practice and out of hours providers. Patient treatment information gathered by the out of hour's service and hospitals was shared with the practice each morning and reviewed by GPs and appropriate action taken if needed.

We found the practice's patient booklet sign posted patients to a community innovations team. The team offered support and guidance, social activities and health and wellbeing advice. Patients were able to self-refer to this service if they chose to. The booklet also contained details of walk in clinics and local hospitals.

Information sharing

The administration team were responsible for coding information received by the practice such as outcomes of hospital appointments and blood tests. This information was coded and scanned onto patient records so that it could be accessed by practice staff when needed. The practice protocol on scanning information included guidance that patients were to be notified of any abnormal blood test results, in order that an appointment could be made with a GP or nurse to monitor the patient's treatment.

Reception staff were able to tell us about protecting patient confidentiality and we noted that all staff had received training on data protection. Patients' records and telephones were situated away from the main reception desk to ensure confidentiality.

Consent to care and treatment

We reviewed data from the national patient survey which showed that the practice was rated at 78%, which is in line with the national patient satisfaction average about being involved in decisions about their care.

Patients said that they felt involved in decisions about their care and treatment. They said they were given time to consider options available and were never rushed.

One nurse explained how they would obtain consent from patients and ensure that the patient understood treatment options prior to proceeding. The nurse gave a specific example regarding young adults who were the appropriate age to consent to care and treatment, but due to having special needs were unable to sign the form. Verbal consent was obtained and recorded. Checks were also made to ensure that the correct person with parental responsibility for young children and babies gave consent for immunisations.

Staff spoken with were able to describe the principles of the Mental Capacity Act 2005 when assessing whether a patient was able to give informed consent, however they had not received specific training on this area.

Health promotion and prevention

Patients were encouraged to take an interest in their health and take action to improve it. We saw a range of health promotion information available at the practice and on its website. This information included preventative health care services. For example, cervical smears and vaccination for influenza (flu) and shingles. The practice said that they had trialled one walk in clinic for children for flu immunisations. Letters had been sent to parents informing them of the date and time the clinic would be open. The practice reported that to date 50% of children who were eligible for a flu vaccine had attended and been vaccinated after one clinic.

Good

Are services effective?

(for example, treatment is effective)

The practice had links with a community health team who collected vaccines from the practice and administered them to patients registered with the practice, who were housebound or lived in care homes.

The patient booklet had information on smoking cessation and contraceptive advice offered by the practice, along with sign posting to relevant websites. The GPs and nurses said that the teenage population in the area did not routinely attend the practice for sexual health advice. They said that this was due to a teenage drop in centre being situated close to the practice and local schools. The centre was promoted on the practice website and we saw it gave information on health and social issues for young patients, such as contraception, drug use and sexual health needs.

The practice offered travel vaccinations which included anti-malarial medicines. Information for patients who intended to travel was included on the practice website.

The practice offered routine childhood immunisations in line with national guidance and flu vaccinations to all eligible patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received two comment cards and spoke with six patients during our inspection. All said that they were treated with dignity and respect.

Consulting and treatment rooms were situated away from the main waiting area and we saw that doors were closed when consultations were occurring. Curtains were provided in all treatment and consulting rooms for privacy.

We reviewed data from the national patient survey which showed that the practice was performing in line with national average in a number of areas. These included patients being treated with care and concern by GPs and nurses and being involved in making decisions about their care.

The layout of the waiting area meant that the reception desk was in the next room. This provided a private area for reception staff to speak with patients. Telephones were answered away from the reception desk behind glass screens. Two comments cards both were positive and patients said they were treated inclusively and had no concerns about the practice or service provided.

Care planning and involvement in decisions about care and treatment

Patients said that they were given enough time to discuss their concerns and were given clear information about treatment options open to them. When a patient required assistance with communication due to their condition specific arrangements were in place to involve them in their care and treatment. For example, patients living in sheltered housing schemes were offered home visits and GPs would take any necessary equipment with them to carry out tests in the patient's home, such as blood tests. Similarly patients with learning disabilities were routinely offered home visits and picture cards were used to assist in explaining what treatment was needed.

Patient/carer support to cope emotionally with care and treatment

Indicators were on patients' records to show whether the patient had a carer or was cared for by another person. The practice held a register of patients who were carers for other people. The patient participation group had held an evening for carers to meet and be provided with information from support services available to them, such as organisations which assisted with financial matters.

The patient participation group said they had arranged a session, for grandparents who looked after their grandchildren, on basic life support in case they had to deal with any situations where a child collapsed or was choking.

All staff were notified of patients' deaths and contact was made with the bereaved family or friends before and after a funeral had taken place. If needed referrals or guidance was given for a bereaved person to contact or see support services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We reviewed data from the national patient survey which showed that the practice was performing better than the national average in a number of areas. These included 87% of patients who responded would recommend the practice to others, 94% who were satisfied with telephone access and 85% who were satisfied with the opening hours of the practice.

The practice was responsive to patients' needs and continually reviewed processes in place to maintain and improve the level of service provided.

The practice had a higher than average percentage of patients with children and carried out two baby immunisation clinics per week in response to this. A nurse said that routine appointments could also be booked for immunisations if needed. The nurse added that they were able to book longer appointments for patients who had complex needs or had complicated dressings changed at the practice. Patients were able to choose whether to be seen by a male or female GP. For young patients there was a teenage drop in centre situated near the practice, however, if these patients had concerns about using the centre they were able to be seen confidentially about matter such as sexual health, at the practice.

The practice had six care homes within its practice area. Patients were able to choose to be registered with the practice and each care home had a named GP to offer continuity of care.

Tackling inequity and promoting equality

The practice had suitable arrangements in place to protect patients' confidentiality. Staff we spoke with were aware of Gillick competence when asked about treating teenage patients. (Gillick competence is a term used in law to determine whether a patient aged under 16 is able to consent to their medical treatment, without the need for parental permission or knowledge).

The practice premises were accessible to patients who were wheelchair users or required walking aids. The reception desk was directly opposite the front door, so reception staff could see quickly if anyone needed assistance with the door.

Baby changing and disabled toilet facilities were available and all consulting rooms were on the ground floor.

There was access to a language line for patients who needed an interpreter and a hearing loop was in place for patients with a hearing impairment.

Access to the service

The practice was open at 8am to 6.30pm Monday to Friday, at the St Luke's Surgery site. Botley Road Surgery site was open on Monday, Tuesday and Thursday at 8.30am to 12.30pm and 3pm to 6pm and 8.30am to 12.30pm on Wednesdays and Fridays. Patients were able to arrange appointments at either surgery and GPs and nurses worked at both sites.

The practice had worked with the patient participation group (PPG) on the appointment system offered by the practice. The PPG had surveyed patients on their preferences and information from this survey was used to review the appointment system. This had resulted in appointments being released for the following two weeks on a Monday afternoon. A mobile telephone application had also been developed which informed patients via their mobile telephones of the next available appointment. This gave information in real time about available appointments in the next two weeks and included the names of the GPs who were available. This information was displayed on the television screen in the waiting area.

Another change implemented as a result of the survey was the increase in the number of face to face and same day consultations. The same day service was run by a GP and two nurses who carried out telephone triage and either asked that the patient attended the surgery to see a GP or nurse, or offered appropriate advice over the telephone. Patients' views on how the appointment system was working were sought after six months of the new processes being put into place in May 2014 and were in the process of being reviewed. Initial analysis showed that improvements had been made.

Home visits were offered for patients who were vulnerable such as older people or those with learning disabilities. The practice also provided care and treatment for temporary residents in their catchment area.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with

Good

Are services responsive to people's needs?

(for example, to feedback?)

recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for managing complaints. Information on how to make a complaint was displayed in the surgery and on the practice website.

We reviewed a selection on complaints the practice had received. These had been investigated and resolved as far as possible to the complainant's satisfaction. We noted that an overarching analysis of complaint themes had not been carried out to ascertain whether more action was needed to address concerns.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice gave a presentation at the start of the inspection and stated that one of their key aims was to reach out to all patient groups to provide appropriate care. The practice was aware of the population they provided a service for, which included a high number of working age patients and young children. This was shared with all staff members and the patient participation group (PPG).

All staff we spoke with were aware of how the GP partners wanted the practice to develop and were able to comment on how this could be achieved.

Governance arrangements

The practice had systems in place to monitor service provision. However, information collected was not always analysed thoroughly to identify trends or themes. The practice kept a record of significant events and complaints received, but did not currently use a software reporting system on their database to collate overarching reports of particular time periods, such as the previous 12 months.

Staff who worked at the practice were aware of their roles and responsibilities. For example, the reception team had five senior receptionists who shared the management responsibilities between them. Reception staff said this worked well and allowed them to take responsibility and develop. GPs who worked in the practice were designated leads for areas such as safeguarding or prescribing practices.

Staff were able to access practice policies and procedures on a shared drive on the computer system. These included safeguarding, infection control and confidentiality.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing higher than the national average, with total QOF points of 99.52, against the national average of 96.44.

Information received by the practice was coded onto the computer system and if a patient required an appointment with a GP, for example, after a hospital admission, this was arranged.

Leadership, openness and transparency

Staff considered that the leadership at the practice was visible and accessible. They said they were able to share information and learning.

GPs attended locality meetings and clinical commissioning group meetings to share information and learning with other practices in the area. Internal meetings included regular practice meetings, 'away days' and meetings with other health care professionals, such as health visitors.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had an active patient participation group (PPG) who met face to face and also virtually via email. A patient survey was in progress at the time of our inspection. The group had worked closely with the GP partners to review the appointments system, by gathering views of patients and informing the partners of what patients felt would work. The current survey was focussed to follow up on actions taken as a result of the changes in the appointment system, for example, whether patients considered telephone appointments were effective and whether a text reminder system would be useful.

The PPG had 132 responses to its survey for 2013/14 and an action plan was developed to address issues. The members of the PPG told us that they worked with the GPs and a GP would always attend their face to face meetings which were held each month. They added that one member was due to attend a CCG meeting in December 2014 to gain more information on what issues there might be in the area.

The PPG had organised a number of events over the previous 12 months to support patients. For example, a chair exercise session was held for patients with limited mobility, to teach them suitable exercises they could carry out at home to maintain their health and wellbeing. Also, a carers social evening had been arranged to support patients with caring responsibilities. Speakers from the local community were invited to inform carers about the service available to support them. A member of the PPG said one of the aims of the group was for patients to be responsible for their own care and the group actively arranged events to promote this. However, the work of the group was not fully visible on the practice website or in the reception area.

Are services well-led?

Good

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

Management lead through learning and improvement

There were systems in place to support learning and promote improvement. For example, whole practice meetings were held weekly, which provided an opportunity for GPs and nurses to discuss clinical cases and to share learning. The practice also attended three monthly CCG education meetings.

The practice had responded positively to patients' concerns about appointment availability and was working proactively to find the best possible solution. The practice manager said that they had not received any formal complaints since the system changed to a telephone triage and more emergency appointments being made available.

Staff said they were able to talk about their training needs during their appraisals and received training appropriate for their role. For example, infection control and basic life support. Nurses said they were able to ask GPs for advice when needed and found the GPs to be approachable and supportive.

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 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must operated effective recruitment procedures to ensure that all necessary checks are made prior to a new member of staff commencing employment. This includes obtaining satisfactory information for locum GPs.** Regulation 21 (a) (I) (ii) (b)