Botley 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.

Ratings

Are services safe?	Good
Are services well-led?	Requires improvement

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Our previous inspection in September 2015 found breaches of regulations relating to the safe and well-led delivery of services. The practice was rated good for providing effective and responsive services. The population groups were rated as requires improvement for the patients registered at the practice.

We carried out an announced focussed follow up inspection at Botley Medical Centre on 12 May 2016 to check the practice was meeting regulations. For this reason we have only rated the location for the key questions to which these relate. This report should be read in conjunction with the full inspection report of 23 September 2015.

During this inspection on 12 May 2016, we found the practice had made some improvements since our last inspection, but further improvements were required. The practice is rated as safe for providing safe services and requires improvement for the being well-led.

Our key findings across all the areas we inspected were as follows:

- The practice had improved engagement and communication across different staff group through the introduction of weekly all-team meetings with break-out times for separate teams, and all staff could add to the agenda. The practice had arranged its first team away day for June 2016.
- The practice now ensured that patient consent for treatment such as minor surgery was appropriately asked for and clearly documented on all patient records.
- The practice had reviewed and followed its chaperone policy to ensure that only DBS checked, risk assessed and trained members of clinical staff and the practice manager undertook chaperone duties.
- All staff had completed Mental Capacity Act 2005 training. The practice had purchased new training software and advised all staff to undertake appropriate training relevant to their role.

The areas where the provider must make improvements are:

Summary of findings

- Ensure to review and monitor building safety issues, carry out relevant health and safety assessments, and ensure installation safety certificates are renewed before their expiry date.
- Ensure that any concerns regarding medicine fridge temperatures are dealt with immediately according to cold chain 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?

Good

The practice is rated as good for providing safe services.

- The practice had made some improvements in relation to the concerns found at the last inspection.
- The practice had reviewed and followed its chaperone policy to ensure that only DBS checked, risk assessed and trained members of clinical staff and the practice manager undertook chaperone duties.
- All staff had completed Mental Capacity Act 2005 training.
- The practice was recording medicine fridge temperatures. However, on the day of inspection, we noted that a previous temperature reading was recorded above the maximum recommended, but no action taken. The lead nurse, who had joined the practice in the week of inspection, took appropriate action to address the risk.
- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

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- There was a governance framework which supported the delivery of the strategy and good quality care. However, monitoring of specific areas required improvement, such as monitoring of fridge temperature and health and safety risk assessment of the premises.
- The practice had a vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.
- The practice had improved engagement and communication across different staff group through the introduction of weekly all-team meetings with break-out times for separate teams, and all staff could add to the agenda. The practice had arranged its first team away day for June 2016.
- The practice now ensured that patient consent for treatment such as minor surgery was appropriately asked for and clearly documented on all patient records.
- The practice had purchased new training software to ensure that all staff received appropriate training and that it was clearly documented.
- However, concerns remained in terms of leadership and governance owing to issues found on the day of inspection regarding fridge temperature monitoring and a building safety matter.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice was performing in line with local and national averages. 261 survey forms were distributed and 119 were returned. This represented 1% of the practice's patient list.

- 84% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 77% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 76% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice's most recent Friends & Family Test results found that 82% of respondents would recommend the practice to family and friends.

Areas for improvement

Action the service MUST take to improve

- Ensure to review and monitor building safety issues, carry out relevant health and safety assessments, and ensure installation safety certificates are renewed before their expiry date.
- Ensure that any concerns regarding medicine fridge temperatures are dealt with immediately according to cold chain policy.

Botley Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector**.** The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to Botley Medical Centre

Botley Medical Centre is situated in Oxford, to the west of the city centre. It serves more than 9,200 patients in a mainly suburban area, and also provides medical services to the Harcourt Hill campus of Oxford Brookes University. The area has little deprivation among its population, and a lower ethnic diversity than some other parts of Oxford.

The practice is located in a purpose built building dating from the early 1990s. There are three GP partners, one salaried GP and two long term locum GPs at the practice. Two GPs are male and four female. The team includes a practice manager, deputy practice manager, practice nurses, a phlebotomist, a health care assistant, administration and reception staff and a medical secretary. Services are provided via a General Medical Services (GMS) contract (GMS contracts are negotiated nationally between GP representatives and the NHS).

The practice offers enhanced services including childhood vaccinations and immunisations, extended hours access, timely diagnosis and support for patients with dementia, flu, pneumococcal, shingles and rotavirus immunisations, learning disabilities identification and support, minor surgery, patient participation, population risk profiling and management, and work to reduce unplanned hospital admissions.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours surgeries are offered on Mondays from 7am to 8am for GP and from 7.30am to 8am for nurse appointments, and from 6.30pm to 7.30pm for GP appointments, on Tuesdays from 7.30am to 8am for nurse appointments, and on Thursdays from 7am to 8am for GP appointments. Appointments can be booked up to six weeks in advance, and urgent appointments are also available on the day.

Services are provided from following location:

Botley Medical Centre, Elms Road, Botley, Oxford OX2 9JS.

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for services to be provided when the practice is closed and these are displayed at the practice, in the practice information leaflet and on the patient website. Out of hours services are provided during protected learning time by Primary Medical Limited out of hours service or after 6:30pm, weekends and bank holidays by calling NHS 111.

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. The 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.

Detailed findings

The practice was previously inspected on 23 September 2015 and was rated as requires improvement for the safe and well-led domains. It was rated as good for the provision of effective, caring and responsive services. Following the September 2015 inspection, the practice was found to be in breach of one regulation of the Health and Care Social Act 2008. A Requirement notice was sent for the regulation relating to ineffective communication systems. The report for this inspection can be found at http://www.cqc.org.uk/sites/default/files/new_reports/AAAD9854.pdf

Specifically, we had found that the provider did not have an effective communications and engagement system within the practice to involve all the different staff teams or to ensure that service users and stakeholders were made aware of the results of reviews and actions regarding the quality and safety of the service.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 12 May 2016. During our visit we:

- Spoke with a range of staff, including three GPs, one nurse, one healthcare assistant, the practice manager, and non-clinical staff. We also spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.

As the practice had found to be good in the domains of effective, caring and responsive, for the purposes of this inspection, we asked the following two questions:

- Is it safe?
- Is it well-led?

  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.

Good

Are services safe?

Our findings

When we inspected the practice in September 2015 we observed that some safety concerns were not consistently monitored in a way to keep patients safe. For example, it was found on the day of inspection that the practice had received only one completed disclosure and barring check (DBS) for its nursing staff and staff undertaking chaperoning duties, although the practice had applied for them. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.) This meant that chaperones were undertaking their duties without a DBS check or a risk assessment in place.

In addition, staff training records did not include relevant training for the Mental Capacity Act 2005 (MCA 2005), which ensures that patients' ability to consent to treatment is appropriately assessed and recorded. While most clinical staff demonstrated an understanding of the act, consent to care and treatment regarding minor operations was found to be not always sought or recorded in accordance with legislations or guidelines.

The practice submitted an action plan that outlined the improvements they were planning to make, which ensured the requirements relating to the regulations were being met. At this inspection, we found some improvements had been made but further improvements were required.

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a possible security breach regarding the clinical computer system was discussed in a full team meeting, providing all staff with the opportunity to be involved in decision making about how to address any future similar concerns.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities
- However, we found that one GP had not completed safeguarding children level three training within the relevant time frame. This was rectified within a week following the inspection. All other GPs and members of nursing staff had completed safeguarding children training relevant to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection

control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice was recording medicine fridge temperatures. However, on the day of inspection, we noted that a previous temperature reading was recorded above the maximum recommended but the practice had not taken appropriate action.
- The lead nurse, who had joined the practice in the week of inspection, took appropriate action to address the risk, along with reviewing the cold chain policy and training for nursing staff who monitored the fridges.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives
- The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services well-led?

Requires improvement

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

Our findings

When we inspected the practice in September 2015 we observed some issues that indicated that the practice did not meet the rating for good in the well led domain. For example, it was found that there was a lack of engagement and communication with staff across the various teams in the practice, and training records were not always accurately maintained or appropriately reflect the training needs of all practice staff.

In addition, concerns addressed above in the safe domain, regarding missing Disclosure and Barring Service checks, staff training for the Mental Capacity Act 2005 and patient consent to treatment, indicated issues regarding some elements of leadership and governance of the practice.

In response to these findings, the practice submitted an action plan that outlined the improvements they were planning to make to ensure that the requirements relating to the regulations were being met. At the inspection in May 2016, we found improvements had been made but further improvements were required, in relation to governance and specifically the safety concerns regarding fridge temperature monitoring and building safety issues

Vision and strategy

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

- The practice had a mission statement which was displayed in the waiting areas. It had been reviewed in one of the practice's first full team meetings.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good care. This outlined the structures and procedures in place, however, improvements were required.

- Concerns remained in terms of governance issues found on the day of inspection. Specifically, regarding the monitoring systems which did not pick up the failures in fridge temperature recording and building safety matters. We found the gas safety certificate was expired in January 2016 and electrical installation certificate was expired in 2015. The practice was unable to provide a copy of the last health and safety risk assessment of the premises.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- The practice had addressed the previous concern regarding training records by purchasing a new software package which enabled it to manage staff training more effectively.
- Patient consent to treatment was now recorded on electronic templates and documented on all patient records.

Leadership and culture

On the day of inspection the partners in the practice told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

Are services well-led?

Requires improvement

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

There was a clear leadership structure in place and staff felt supported by management.

- At the previous inspection, we had found concerns regarding the practice's engagement and communication with its various staffing teams. Since the original inspection, it had started holding weekly full-team meetings, with breakaway subgroups for clinical and non-clinical staff, and was due to hold its first team away day in June 2016. Staff told us that these changes had helped them to feel more involved and engaged in how the practice was run. They felt more able to give feedback, to raise concerns or issues with colleagues and management, and to put forward suggestions to improve how the practice was run.
- In addition, the practice was working to improve the team atmosphere by holding more team social events, celebrating staff birthdays and undertaking charity fundraising.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice was setting up a walking group for patients with osteoarthritis (a common form of joint disease) at the request of, and with the help of the PPG.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice was involved with a human factors research project, which was looking at ways to improve patients' experiences in GP practices, and was awaiting a report which would lead to further staff training. Clinical staff had also attended consultation skills training to further support this work.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered provider did not have suitable systems in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). Systems did not assess, monitor or mitigate risks related to health, safety and welfare of service users in terms of: • The safety of the building where the regulated activities were undertaken. A health and safety risk assessment was not available and service checks were out of date. • Responding to issues related to medicine fridge temperatures. The systems were not in place to allow the registered person to assess monitor and mitigate risks relating to the health, safety and welfare of services users and others who may be at risk which arise from carrying out the regulated activity within the building. This was in breach of regulation 17 (1) and (2)(b)(d)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.