Dr Burke and Partners

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 effective?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as good overall. (Previous inspection February 2017 – Good)

The key questions are rated as:

Are services effective? – Good

We carried out an announced comprehensive inspection at Dr Burke and Partners on 17 May 2016. The practice was rated as requires improvement for providing effective services. The overall rating for the practice was good. The full comprehensive report on the May 2016 inspection can be found by selecting the 'all reports' link for Dr Burke and Partners on our website at www.cqc.org.uk.

We carried out a desk-based review on 20 February 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 17 May 2016. The practice remained as requires improvement for effective services.

This inspection was a further desk-based review carried out on 8 November 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous comprehensive inspection on 17 May 2016 and the desk-based review on 20 February 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

Overall the practice is now rated as good.

Our key findings were as follows;

- Patients that do not attend their bowel or breast screening were followed up by the practice. Recall letters were being sent to patients highlighting the importance of attending these clinics and also providing patients with links to further information. The practice told us GPs and nurses were also actively advising patients during consultations.
- The practice had reviewed their diabetes care for patients. The GP and nurse leads have undertaken further enhanced skills in a Year of Care plan for diabetic patients. Data for 2016/17 showed that the practice has made progress and had improved all diabetes indicators, although they were still achieving below local and national averages.
- The practice had reviewed care planning systems for patients with a diagnosed mental health condition. Practice nurses had completed further training to carry out health checks for patients with mental health conditions to support the GPs. They had improved on completed care plans from 84.7% in 2015/16 to 98.7% in 2016/17.
- The practice had appointed a Clinical Pharmacist. This had enabled the repeat prescription process to be streamlined and the practice provided us with their latest figures for medicine reviews which show improvements in the number of reviews being completed within 12 months.
- The practice had introduced a comprehensive risk assessment form and system at the university practice site which enabled them to carry out an initial assessment of the patient and prioritise the urgency of

Summary of findings

the patient's health needs accordingly. Patients were also informed of waiting times and given a choice to come back for their appointment depending on the urgency.

At our previous inspection on 20 February 2017, we rated the practice as requires improvement for providing effective services as patient uptake of the national screening programme, mental health care plans and diabetes care were all below local and national averages. At this inspection we found that the data showed improvements in many areas and that improved systems and processes were in place. Consequently, the practice has been rated as good for providing effective services.

However, the areas where the provider should continue making improvements are;

- Continue to actively encourage patients to attend for health screening through the national screening programs and improve uptake rates.
- Continue to review and improve on diabetes care indicators for patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Dr Burke and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

This desk-based review was carried out by a CQC inspector.

Background to Dr Burke and Partners

Dr Burke and Partners serves over 19,000 patients from the city of Oxford with approximately 11,000 of these students from Oxford Brookes University. All services are provided from two sites;

- St Bartholomews Medical Centre, Manzil Way, Oxford, Oxfordshire, OX4 1XB.
- Oxford Brookes University Medical Centre, 3rd Floor, The Colonnade, Gipsy Lane, Headington, OX3 0BP.

Dr Burke and Partners has two purpose built locations with good accessibility to all its consultation rooms at the main site. The practice has a very transient population with many students only residing in Oxford for part of the year and usually registering for the period of their studies before moving away. The area around the practice also has a high number of new migrants and this has contributed to a steady turnover in patient population. This poses difficulties in managing long term conditions, managing child immunisations and other services. The population is much younger than the national average with a large proportion of patients between 19 and 25 years old. There are local communities which are affected by social deprivation. There is a broad mix of ethnic backgrounds among the patient population.

There are three GP partners at the practice, one female and two male. There are four practice nurses and two health care assistants. A number of administrative staff, a deputy practice manager and a practice manager support the clinical team. The practice is open between 8.10am and 6pm Monday to Friday. There are extended hours appointments on Saturdays from 8.40am to 1pm. Out of hours GP services are available when the practice was closed by phoning NHS 111 and this is advertised on the practice website.

Good

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 20 February 2017, we rated the practice as requires improvement for providing effective services as there were regulation breaches in relation to a lack of initial assessment of patients at the university site and poor data achievement for diabetes care. In addition, we found concerns with a low number of patients with mental health care plans, below average health screening rates and medication reviews were inconsistent.

We issued a requirement notice in respect of the regulation breaches and the practice sent us an action plan outlining how they would meet the standard. We found arrangements had sufficiently improved when we undertook a follow up inspection of the service on 8 November 2017. The practice is therefore now rated as good for being effective.

Effective needs assessment

The practice provided daily nurse-led Minor Illness Walk-In Clinics at their University site where patients were assessed on the day without requiring an appointment. To ensure that they were prioritised according to their health needs, patients were asked to complete a patient risk assessment form on arrival which assisted the practice to carry out an initial assessment. The form then determined whether the patient needed to be prioritised and highlighted to the clinical staff. The practice told us that the system had improved the service and patients who presented with urgent medical conditions were identified and seen immediately by the nurses. Furthermore, patients were made aware of the waiting times and given a choice to come back for their appointment if appropriate.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

The practice's designated Diabetes Lead GP had completed her diabetes training and the lead nurse had started training. The practice informed us that both were working closely together to deliver a comprehensive care to their diabetic patients. The GPs actively encouraged patients to attend retinopathy screening appointments (this is diabetic eye screening, which is a key part of diabetes care. People with diabetes are at risk of damage from diabetic retinopathy, a condition that can lead to sight loss) and a health care assistant carried out foot checks on patients. We reviewed the latest available QOF data (2016/17) and found;

- Overall diabetes related indicators was 85.7% which was below the clinical commissioning group (CCG) average of 94% and national average of 91%. However, this showed an increase from 62% in 2015/16.
- 90% of diabetic patients had achieved a target blood pressure of 150/90 or less in the preceding 12 months compared to the CCG average of 92% and national average of 92%. However, this showed an increase from 80% in 2015/16.
- 84% of diabetic patients had achieved a target blood glucose reading of 75mmol or less in the preceding 12 months compared to the CCG average of 90% and national average of 88%. However, this showed an increase from 72% in 2015/16.
- 70% of diabetic patients had achieved a target blood glucose reading of 64mmol or less in the preceding 12 months compared to the CCG average of 80% and national average of 79%. However, this showed an increase from 61% in 2015/16.

The practice had implemented a year of care plan for their diabetic patients, which is a programme designed to help patients take responsibility for their health care and improve outcomes. The lead GP and lead Nurse had attended appropriate training and provided detailed feedback and training to all clinical and relevant administration staff at the practice. The practice told us this has improved outcomes for patients with diabetes by increasing supported self-care.

The practice had reviewed their care plans for patients with a diagnosed mental health condition and improved their recall systems. Patients who did not respond to first invites are followed up with a further letter and phonecall. Practice nurses were trained to carry out physical checks for patients to help support the GPs and a pharmacist undertook medication reviews. We reviewed the data from 2016/17 and found;

- The practice had made improvements in care planning for patients with long term mental health conditions. In

Good

Are services effective?

(for example, treatment is effective)

2015/16, 117 of 178 patients with long term mental health conditions had a care plan (66%). We reviewed the latest available QOF data for 2016/17 and found they had achieved 98.7%. This demonstrated an increase of 32.7% from the previous twelve months.

The practice had appointed a Clinical Pharmacist. They told us this had made an improvement to their medication reviews and enabled them to streamline the repeat prescription process and evaluate processes at a much faster rate. The practice provided us with their latest figures for medicine reviews;

- 72% of all patients with any repeat medicine prescription had a review of their medicine in the preceding 12 months. This demonstrated an increase of 40% from the previous twelve months.
- 94% of patients on four or more repeat medicine prescriptions had a review of their medicines in the preceding 12 months. This demonstrated an increase of 35% from the previous twelve months.

Supporting patients to live healthier lives

Patients who failed to attend for bowel or breast screening appointments were followed up by the practice and letters and information was sent out to highlight the importance of attending these clinics. GPs and nurses actively gave advice to patients in their consultations. The practice provided data showing that since 1 April 2017, 249 letters had been sent to patients who did not attend their Bowel Screening appointment and 216 letters to patients who failed to attend their Breast Screening appointment.

Data published in our previous report from 2015/16 showed:

- 70% of female patients aged between 50 and 70 had been screened for breast cancer in the preceding 36 months compared to the CCG average of 76% and national average of 73%.
- 47% of patients aged 60 to 69 had been screened for bowel cancer in the preceding 30 months compared to the CCG average of 60% and national average of 58%.

This is the most recent published data available and the practice were unable to provide evidence of increased uptake. However, the practice had undertaken an assessment and put systems in place to mitigate the risk and improve uptake.