Bury Knowle Health Centre

Quality Report

Bury Knowle Health Centre,
207 London Road,
Headington,
Oxford,
OX3 9JA.
Tel: 01865 761651
Website: www.buryknowle.org

Date of inspection visit: 14 July 2014
Date of publication: 28/10/2014

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.

Contents

Summary of findings

Overall summary

Bury Knowle Health Centre has a patient population of approximately 14,000. It is located on two sites in East Oxford.

We spoke with 24 patients during the inspection and received feedback from five patients on comment cards sent to the practice before the inspection. Patients were complimentary about the care and support they received from the practice. They praised the attitude of staff. There were concerns raised about the appointment booking system.

The practice provided safe care to patients. The practice was well maintained, clean and hygienic. Some risks associated with management of the premises were not assessed or managed properly. The practice was not appropriately monitoring all staff records or all the training required by staff.

Patient care was effective. National guidance and research was followed by staff and managed through a system of clinical governance. Long term conditions and the screening of specific conditions in patients over 45 years old took place as part of the practice's health promotion. New patient health checks did not take place unless the practice was made aware of specific concerns. Patients with long term conditions and mental health problems had access to services which were promoted or delivered by the practice.

The practice enabled patients to see or speak with GPs and nurses through its telephone consultation system. Patients voiced some concerns with this system. They told us they found it difficult to receive calls for a GP phone consultation because the calls were either not at a set time or not at a time which allowed them to answer. This was particularly difficult for patients who worked or who had commitments which meant they could not take a telephone call at any time. There was some positive feedback regarding short phone waiting times. The practice was responsive to the needs of some patients groups who may be in vulnerable circumstances, such as patients with drug and alcohol addictions.

Patients told us the practice was caring. They said staff were courteous, respectful and spent the time they needed with patients to provide the care they needed.

Physical access to the practice was good. Patients complimented the layout of the premises saying it provided a friendly and accessible environment, although some raised concerns about privacy at the reception desk.

There was an open culture which encouraged learning and communication between all the staff working at the practice. There were regular meetings to discuss patient care and information related to the management of the practice.

We found that the practice was not meeting two regulations required to ensure that standards of quality and safety were maintained. This was in relation to assessing and monitoring the quality of service provision and supporting workers. We have asked the practice to send us a report, setting out the action they will take to meet these safety standards. We will check to make sure that action is taken.

During our inspection we looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups we reviewed were:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem

We found the practice was responsive to the needs of older patients, vulnerable groups, patients with mental health problems and mothers with young children. Patients who worked told us they found it difficult to use the phone consultation system to book appointments. The practice ensured the clinical outcomes for all of these population groups were good.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The practice had a good track record on safety. Incidents which could potentially have impacted on patient safety were reported by staff, investigated and learning shared with relevant staff. Changes were made to the practice where learning was identified from complaints, incidents or other reviews of patient care. Staff were alerted to issues regarding individual patient's safety, such as circumstances which might impact on their wellbeing. The building was well maintained, clean and hygienic. Cleaning checks and infection control audits were undertaken. The practice did not undertake all the risk assessments in order to ensure the practice functioned safely. Some medical equipment and medications were past their date of expiry. The practice was not meeting the regulation related to monitoring standards of safety and quality or identifying, assessing and managing risks.

Are services effective?

The practice provided effective care to patients. Clinical guidance and up to date clinical research was followed by staff and there was a system of clinical governance to ensure patient care reflected national guidance. The practice assessed clinical outcomes for patients and it performed well against national indicators of quality. Staff received support and professional development to support them in providing good quality care. However, not all training requirements were identified and monitored effectively. Health checks were available for some patients but not for all new patients. The practice worked with external services to ensure they were aware of the needs of their patients who were in vulnerable positions or had significant health problems.

Are services caring?

The practice was caring. Patients told us they were treated with respect and courtesy when they came to the practice. They were complimentary about the staff. Patients' privacy and confidentiality was maintained by staff. However, some patients were concerned about the lack of privacy at the reception desk. Patients were involved in decisions about their care and treatment. There was no policy and no training for most staff on how to follow the principles of the Mental Capacity Act 2005 when caring for patients who may lack capacity to consent to their care.

Are services responsive to people's needs?

The practice was responsive to patients' needs. The practice considered and responded to the needs of patients in vulnerable

Summary of findings

positions such as those children who were at risk of abuse or patients with drug and alcohol addictions. Physical access to the surgery was good for patients with limited mobility, such as older, frail or disabled patients. Patients told us they often found it difficult to use the appointments system. Patients who worked found the phone consultation system particularly awkward. Patient feedback was responded to and acted on. There was a patient participation group (PPG) which met regularly with staff from the practice.

Are services well-led?

The practice was well-led. However, we found concerns regarding monitoring and management of risk. There was an open culture where staff and patients felt they were listened to and their feedback was acted on. Learning from events, audits and complaints was shared amongst staff through meetings. There was good communication within the practice. However, systems to monitor and manage the practice and identify risks to patients and others were not always robust.

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
The practice ensured older patients were cared for effectively. The practice responded to older patients when they needed care at home and their care was discussed with external clinicians. The practice was accessible for patients with restricted mobility.

People with long-term conditions
Patients with long term medical conditions were prompted to come for check-ups at the practice in line with national guidance. Patients were supported to care for themselves and live independent lives.

Mothers, babies, children and young people
The practice provided accessible care for pregnant women, mothers and children which reflected national guidance. The premises at Bury Knowle Health Centre provided baby changing facilities.

The working-age population and those recently retired
Patients who worked told us the phone consultation system was difficult for them to use because they could not always take a phone call from the practice while they were working. Extended hours appointments were available for patients who found it difficult to attend appointments during normal working hours. There were options for patients to book appointments either over the phone or on-line.

People in vulnerable circumstances who may have poor access to primary care
The practice made provisions to ensure some patients in vulnerable circumstances could access care and treatment. However, the appointment system may have been difficult for some patients with cognitive impairments or learning disabilities to use.

People experiencing poor mental health
Services for patients with mental health problems were advertised in the practice and the website and could be accessed at the Bury Knowle Health Centre.

Summary of findings

What people who use the service say

We spoke with 24 patients during the inspection and received feedback on comment cards we sent to the practice before the inspection. We also looked at the patient survey undertaken by the practice in March 2014 and the national GP survey from 2014.

Patients we spoke with were complimentary about the service they received. They praised staff for the time they spent with them during consultations. Feedback from patient surveys indicated patients were pleased with the care they received. Patients said the repeat prescription service worked well. The national GP survey from 2014 found that 87 per cent of patients thought the last GP they saw or spoke to was good at treating them with care and concern. There was very positive feedback from the survey regarding nurses demeanour when seeing patients from the national GP survey. Eighty five per cent of patients from this practice who responded to the national GP survey said the last GP they saw or spoke with was good at involving them in decisions about their care. Patients we spoke with told us they felt well informed & involved in decision making about their care and treatment. The GP national survey from 2014 found 12 per cent of patients could not get an appointment when they tried. This is a higher proportion than the national average. Eleven per cent of patients said they needed to call back closer to the time that they required their appointment. Twenty eight per cent of patients reported that they found it difficult to get through on the practice's telephony system on the practice's March 2014 survey. Patients told us it could be difficult to get an appointment or telephone consultation using the practice's appointment system.

Areas for improvement

Action the service MUST take to improve

- Monitoring of medication and medical equipment must be undertaken to ensure equipment is safe and effective.
- Risks related to premises such as legionella contamination and fire must be identified, assessed and managed to ensure the safety of patients and others.
- Checks required on staff to ensure they are eligible to practice must be undertaken.
- Training required by staff to ensure they are appropriately skilled and aware of their responsibilities should be provided and monitored effectively, including training in the Mental Capacity Act 2005, the Gillick Principles and hygiene and infection control.

Action the service SHOULD take to improve

- Patients did not always understand the telephone consultation system or that there was an alternative to using it. Information on the options available to patients in how to book appointments should be improved.

Bury Knowle Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist adviser. The team included a second CQC inspector and an expert by experience. Experts by experience are people who use services or care for people who use services. They assist us in gaining the perceptions of patients during our inspections.

Background to Bury Knowle Health Centre

Bury Knowle Health Centre is located in the east of Oxford. It has a patient population of approximately 14,000 patients. The practice operates from two sites, Bury Knowle Health Centre and Barton Surgery. The practice has eight GPs and eight nursing staff. The practice also coordinates care provided by other professionals such as health visitors, community midwives and community nurses. The patient population is above the national average for people of working age and there is low unemployment in the area. The patient population has a higher than national average prevalence for patients who suffer from depression.

Bury Knowle Health Centre 207 London Road, Headington, Oxford, OX3 9JA.

Barton Surgery, Neighbourhood Centre, Underhill Circus, Headington, Oxford, OX3 9LS

Outside of the practice opening hours patients could access an out of hours service provided by an alternative provider. This service was advertised on the practice website so patients could find contact information if required.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting we checked information about the practice before the site visit. This included information from the Clinical Commissioning Group (CCG), Oxfordshire Healthwatch, NHS England and Public Health England. We visited the Bury Knowle Health Centre in Headington, Oxford on 14 July 2014. During the inspection we spoke with GPs, nurses, the practice manager, reception staff, patients and representatives of the patient participation group (PPG). We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises. We did not visit Barton Surgery as part of this inspection.

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

- Is it safe?
- Is it effective?

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem

Are services safe?

Our findings

Safe Track Record

The practice had a good track record on safety. We found any incidents which potentially impacted on patient safety were recorded, investigated and responded to by the practice to reduce the risk of them reoccurring. For example, there was a change to the chaperone policy following concerns raised about a locum GP who worked at the practice. A chaperone is a member of staff who is present during certain consultations to protect patients and staff from inappropriate contact or allegations of abuse.

Staff told us the patient record system flagged patients in vulnerable circumstances or those who had multiple diagnoses of disease. This enabled receptionists and GPs and nurses to identify patients who could be at risk of harm, such as children on the child protection register (a list of children at greater risk of abuse due to their circumstances) or patients with dementia or learning disabilities. A practice manager told us reception staff were alerted with specific information on patients which could indicate the patient required a face to face appointment instead of a phone consultation. Nurses and GPs told us they would consider the information flagged on patient records when seeing patients.

Learning and improvement from safety incidents

The practice recorded incidents, complaints and reviews of care where there were potential issues regarding safety in a log of significant events. Individual significant events were reviewed at staff meetings and investigations were undertaken where required. Meetings were held to discuss the outcomes and any learning from significant event reviews and the meetings included any staff that the learning was relevant to. We saw minutes from meetings where significant events were discussed. A GP showed us a presentation for staff at a clinical team meeting from May 2014, where learning from a significant event was shared with staff. The practice improved the safety of its service by responding to incidents and concerns quickly and ensuring any lessons from events were shared with relevant staff.

Reliable safety systems and processes including safeguarding

The practice had policies for safeguarding children and vulnerable adults. The policies included contact information for the local safeguarding team and a referral form for the practice to report any suspicions of abuse. Staff told us they would report any concerns about safeguarding to a GP or the safeguarding lead at the practice. Nurses told us about instances where they had reported concerns to a GP about patients within the last year. They said GPs had reported their concerns to the local safeguarding team and informed the nurses who made referrals of the action taken to ensure the patients were safe. Staff told us they received training in safeguarding vulnerable adults and children but were not certain when they had received training. The practice did not monitor how often staff received safeguarding training. Staff told us that safeguarding was discussed at meetings to raise awareness about potential indicators of abuse. Although staff were provided with awareness about protecting patients from abuse, the practice was not ensuring that staff received safeguarding training in line with the requirements of their roles.

Staff discussed children on the at-risk register and vulnerable adults at quarterly meetings when they had concerns about their safety and welfare. We saw from minutes that the meetings raised staff awareness about the risks posed to each patient they discussed.

The practice had a chaperone service which was advertised to patients. This enabled patients and staff to request chaperones for intimate examinations which could compromise patients or staff. A practice manager told us staff were trained to provide the service so they understood the role of a chaperone.

Monitoring Safety & Responding to Risk

Some monitoring and assessing of risks took place. For example, we saw a risk assessment for control of substances hazardous to health (COSHH) was available for the storage of chemicals in the cleaning cupboard. However, there were no risk assessments for fire or the risk of legionella for the practice. There were no checks on the emergency lighting which would be required in the event of a fire. A practice manager had booked a legionella risk assessment by the end of the inspection. They also told us they would contact the fire and rescue service to gain advice and support to regarding fire safety and risk assessment. Following the inspection the practice sent us a fire risk assessment which undertaken by practice staff.

Are services safe?

The practice had monitoring systems to ensure medical equipment and medication was safe. However, not all of the monitoring systems were effective. We found some medicines and medical equipment were past their expiry date.

Medicines Management

We saw logs for checking emergency medication were within their expiry dates. We saw all medicines on a medical emergency trolley were within their expiry date. However, we saw a GP's bag for off site visits contained a medicine which expired at the end of June 2014. There was stock of the same medication within its expiry date also stored in the GP's bag. A nurse removed the drug when we showed them it had expired. We checked medications stored in treatment room cupboards and found they were in date. We found hypodermic needles on the emergency trolley and stored in a cupboard which were past their date of expiry. The nurse explained the needles we found in the cupboard were no longer used. However the needles stored on the trolley could have been used in an emergency. There was evidence that the system for monitoring medication and medical supplies was not fully effective.

We checked fridges used to store immunisations were kept at a constant temperature to ensure the medication stored in them were effective. Logs of temperature checks were kept on the fridges. A nurse told us the fridges were alarmed to ensure staff would be aware if the fridges were not within the correct temperature range. The nurse said that new stocks of immunisations were placed at the back of the fridge shelves to ensure the oldest stock was used first. All of the immunisations were within their date of expiry and the immunisations were separated into labelled boxes to reduce the risk of them being incorrectly selected or used.

Cleanliness & Infection Control

The practice had a hygiene and infection control policy and we saw infection control audits from July 2013 and July 2014. The audits identified areas where minor improvement was required in the practice. A practice manager showed us where improvements had been made as a result of the audit from 2013. We found treatment and consultation rooms were clean and hygienic. Treatment rooms had washable flooring and work surfaces. A nurse told us one of the practice management team did regular checks in the practice to ensure appropriate standards of cleanliness were maintained. They said there was regular communication with the cleaners to report any issues with cleaning. We saw cleaning equipment was colour coded to ensure it was used in designated areas of the practice such as clinical rooms and toilets and it was not stored where it could come into contact with other cleaning equipment. This reduced the risk of cross infection. Clinical waste was stored and disposed of in line with guidance from the Department of Health.

Hand washing guidance was available above sinks. Nursing staff told us they received hygiene and infection control training but they said there was no annual update provided to staff. We looked at a training planner and saw there was no hygiene and infection control training listed.

Staff who were at risk of coming into contact with blood were asked to have their hepatitis B status checked and receive an inoculation if necessary.

Staffing & Recruitment

The practice had a recruitment policy which ensured a consistent process was followed when staff were employed. We saw information was requested on new staff including references where staff had worked in health or social care and full employment histories. Staff had criminal record checks undertaken using the Disclosure and Barring Service (DBS). Checks were undertaken on staff to ensure they were safe to work with patients. However, photographic identification and proof of qualifications was not always available when we requested proof from staff records. This information is required in line with the regulations of the Health and Social Care Act 2008. New staff were inducted and provided with induction plans to ensure they were aware of issues relating to safety in the practice.

Dealing with Emergencies

There was a business continuity and emergency plan for the practice. This was easily accessible for staff should they need to review protocols in the event of an emergency which could prevent the normal running of the service.

Emergency medical equipment was available. We saw it was working and well maintained. Emergency medicines stored on an emergency trolley were within expiry dates. Staff told us they received annual basic life support training. We saw a training log which indicated this training took place for all staff.

Are services safe?

Equipment

Electrical appliances were tested annually to ensure they were safe. Fire extinguishers were maintained and checked by an external company every year. We saw servicing records for medical equipment were up to date. Disposable medical supplies were used and we found two of the three instruments we checked were past their date of expiry. One expired in January 2014. The instruments were stored in a clinical treatment room ready for use. The expiry dates indicate how long the equipment can be kept for before there is a risk of infection due to the time it has been stored. There was insufficient monitoring of medical supplies. We reported this to the practice partners and managers so action could be taken to remove out of date medical equipment.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

The practice had a lead for clinical governance who was responsible for ensuring any changes to clinical guidance such as National Institute for Health and Care Excellence (NICE) guidelines were reflected in patient care. Staff told us any changes to guidance would be communicated to them and changes made to any care protocols when updates to guidance were made. A nurse told us any clinicians who attended external training where they learnt new or different approaches to care, would be asked to share this with the clinical team. Any changes to care protocols or approaches to treating specific conditions were made through the practice's system of clinical governance.

The practice used the Quality and Outcomes Framework (**QOF**) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. Bury Knowle Health Centre achieved a score of 99.3 per cent on its QOF score in 2012/13 compared to a national average of 96.1 per cent. This indicated the practice was effectively managing a range of medical conditions.

Management, monitoring and improving outcomes for people

The QOF allows exceptions to be made on quality reporting. For example, when a practice has tried to provide the care or treatment to patients who do not attend for appointments when repeatedly reminded to do so. Some of the practice's exception reporting on their 2012/13 QOF was significantly higher than the national average, meaning they had higher numbers of patients who they did not count in their yearly reporting of quality performance. We asked the practice why exception reporting was high in a number of clinical outcomes (these outcomes are can be measured by medical checks required by patients with long term conditions or recording of health and lifestyle information for example). GPs were able to demonstrate they had undertaken reasonable attempts to contact patients in order to request them to attend the practice or provide required information which related to the QOF indicators.

The practice was significantly below the national average in QOF results for recording smoking status and providing support to help patients to stop smoking. We asked clinicians whether they knew the reasons for these results and what the practice was doing to address this. A GP told us the practice had a very high turnover of patients due to a large student population. This made it difficult for them to keep an up to date record of patients' smoking status. Nurses told us they had been calling some patients to ascertain whether they were smoking when there was no up to date information in their medical records. However, the practice had not undertaken any monitoring of whether smoking status was being recorded during appointments, for example routine check-ups, when there was no up to date information for a patient. The practice did not have plans which included all the opportunities to update their patients' records of smoking status.

We looked at the practice's clinical audits. They included reference to national guidance and research and learning outcomes. Staff told us clinical audits were discussed at clinical team meetings to share learning outcomes. Some audits were repeated such as a drug addiction therapy audit from 2013 repeated in 2014. The second audit referred to the previous findings to compare where improvements were still required to improvement the effectiveness and safety of the service provided. This enabled the practice to review its performance against very specific areas of care provision and determine whether it was effectively improving through its system of clinical audit.

A GP partner told us referrals were peer reviewed by GPs. This was in order to assess whether referrals were appropriate and whether there were alternative ways to provide the right care for patients, such as seeing a different GP within the practice with a particular expertise. The GP told us this system provided monitoring of referrals and learning outcomes for staff.

Effective Staffing, equipment and facilities

The practice employed a clinical team with a range of expertise and specialisms. For example the nursing team had expertise in diabetes, contraception and respiratory diseases. Nurses told us they could attend external training in specific clinical areas to improve their expertise and this was identified through appraisals. All the staff we spoke with were complimentary about the appraisal process. They told us their appraisals included feedback from

Are services effective?

(for example, treatment is effective)

colleagues and any patient feedback available to assess their performance. Staff said the practice was supportive and assisted their professional development. For example, a nurse was due to attend training on contraception as a result of their appraisal. We saw from a training planner that staff were required to undertake core training periodically. However, we looked at two training tools and found they were inconsistent with each other. Some staff were not aware of when they had last undertaken some of their core training such as safeguarding vulnerable adults. We saw from meeting planners that safeguarding children and vulnerable adults had been discussed by staff at meetings. Only one staff member was recorded as having hygiene and infection control training and none had received awareness of the Mental Capacity Act 2005 training on the training log. Staff said they did receive informal training from the lead nurse on hygiene and infection control such as hand hygiene awareness. There was a risk staff training was not being monitored effectively.

Working with other services

The practice held regular multi-disciplinary team meetings with external health and social care professionals. We saw from meeting minutes that staff discussed patient care and any issues which might affect patients' safety and welfare. Palliative care nurses, social workers and district nurses attended different multi-disciplinary meetings.

The service invited external professionals to clinical team meetings to provide training and share their expertise. Staff told us that they recently had liver specialist come to a clinical team meeting and they said they found this useful.

Health Promotion & Prevention

There was information on various health conditions and self-care available in the reception area of the practice. The practice website informed patients that if they were aged between 40 and 75 they will be asked to attend the practice for the screening of medical conditions every five years. There was information on what the health checks included and health information such as risks associated with being overweight or smoking.

Staff told us new patients were screened automatically by the patient record system to identify if they had any long term conditions, were on medication or had significant conditions in the past. This would then prompt a GP to review their records and offer new patients a check-up if required. New patients were not automatically offered a health check by the practice and their records were not routinely reviewed by a GP. Although the system for checking new patients screened their medical history, there was a potential risk that without a physical health check the practice could miss important information on new patients. For example, if a medical history was incomplete or did not have some information relevant to health or welfare concerns that GPs needed to be aware of. A GP partner told us the practice did not offer routine check-ups to new patients because there was a high turnover in the patient population due to the practice's close proximity to a university.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with said the staff at the service were caring, friendly and helpful. They told us clinicians spent the time they needed with patients to listen properly during consultations and they did not feel rushed. The national GP survey from 2014 found that 87 per cent of patients thought the last GP they saw or spoke to was good at treating them with care and concern. There was very positive feedback from the survey regarding nurses demeanour when seeing patients from the national GP survey.

The practice was purpose built with consultation and treatment rooms away from an open reception area. Patients told us they liked the friendly and open nature of the reception area but some were concerned that personal information was requested when they were at the reception desk and patients queued directly behind each other. We saw some patients queued directly behind the patient at the reception desk despite a sign requesting patients to keep their distance from the desk. The practice operated a telephone consultation service for appointments which required some information to be requested of patients when they telephoned the practice. Administration staff took these calls away from the reception desk to reduce the risk of confidentiality being breached. Some patients told us they did not like the phone consultation system as they were asked for personal information when they were at work or in public places. They said they could not always guarantee finding a private place to receive a call from a GP because they were not sure when the practice would call them.

Involvement in decisions and consent

Eighty five per cent of patients from this service who responded to the national GP survey said the last GP they saw or spoke to was good at involving them in decisions about their care. Patients we spoke with told us they felt well informed and involved in decision making about their care and treatment. Every patient we spoke with was complimentary about how staff engaged with them.

We saw the practice had information on the Mental Capacity Act (MCA) 2005 in their safeguarding policy. One GP told us they had attended external training on the MCA in 2013 and had shared their knowledge with other staff. However, nursing staff we spoke with told us they had not been given any training or guidance on the MCA since working in the practice. Staff confirmed there was no formal training in the MCA. There was no reference to the Gillick principles of acquiring consent from patients under the age of 16 in policies and no training provided to staff. A GP partner told us this was an area the practice had considered for future training requirements.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice provided visits for patients who lived in care or nursing homes. Any requests for a visit were triaged and assessed by a GP. They were responded to the same day as the request if this was within normal working hours.

There was a phone translation service available for clinicians to use during appointments. However, we spoke with a relative of one patient who attended appointments with their relative to translate for them during consultations. They had never been informed of the translation service.

The patient participation group (PPG) had approximately 20 members. Two of the members met with us during the inspection. They told us the PPG met quarterly and the meetings were usually attended by a practice manager and a GP partner. Two members of the patient participation group (PPG) told us the practice responded to some of their feedback. For example, repairs had been made to chairs in the waiting area as a result of their feedback. The PPG members told us the practice was trying to set up a virtual PPG to enable more patients to participate through emails and online. We saw this was advertised on the practice website. A notice in reception advertised the PPG and information on meetings, the annual PPG review and previous meeting minutes were available. The PPG members told us the group was predominantly older patients and they had found it difficult to recruit young members to the PPG. We saw the minutes from the April 2014 meeting included discussion about the March 2014 patient survey and the action plan resulting from patient feedback.

Access to the service

A practice manager explained how the practice operated a telephone consultation service. Patients would be asked for some information by reception when they phoned for an appointment and would be called back by a GP to determine whether they needed an appointment and which clinician they should see. The practice website advertised that appointments could be booked the same day if a patient needed an appointment. It stated a GP would call a patient back for a phone consultation to determine if they needed a face to face appointment or a different service within three hours of their call. Patients told us this could be frustrating due to the timings of the call back from a GP. Many patients said the phone consultations usually resulted in an appointment being issued so were not sure why they needed to go through the phone consultation.

Receptionists would be prompted with a flag for any patients deemed to have a high need. This could be patients with personality disorders, learning disability, or patients who attend with carers. Receptionists would use this information to assist the patient. Reception staff would not have access to confidential information through this system, only what was relevant to assist the patient. For example patients with a learning disability or dementia may have a note on their records for receptions to book a face to face appointment. There was an online facility for booking appointments.

Sixty one per cent of patients reported that the appointment system was good or very good on the practice's survey from March 2014, to which 156 patients responded. The GP national survey from 2014 found 12 per cent of patients could not get an appointment when they needed. This was a higher proportion than the national average. Eleven per cent of patients said they needed to call back closer to the time that they required their appointment. Twenty eight per cent of patients reported that they found it difficult to get through on the practice's telephone system on the practice's March 2014 survey. The practice partners and management team were aware of the concerns and had altered the telephone system. Patients we spoke with on the day of our visit reported that the telephone system was easy to use and they could speak to a receptionist quickly. Patient feedback also prompted practice to keep four appointments for direct booking for each GP. This enabled patients to book an appointment without needing to speak with a clinician first. All of the patients we spoke with on the day of our inspection who had booked an appointment told us they had to first wait for a call back from a GP. Patients told us waiting for a call back from a GP was very difficult if they worked or had commitments. They said the time the practice stated they would be called back varied, meaning it was difficult to plan taking a call from the practice. Two GP partners told us they were currently testing changes to the phone consultation system. They told us they were aware there needed to be improved communication with patients about the phone consultation system and how it operated.

Are services responsive to people's needs?

(for example, to feedback?)

Appointments could be booked directly online. Patients we spoke with had used this service and found it was a good way to book appointments. The practice opened from 7.30am two days a week and 8.30am every other weekday until 6pm. The practice stayed open until 7pm on a Wednesday and opened for three hours on a Saturday morning. This enabled patients who found it difficult to attend the practice during normal working hours to get an appointment.

GPs had their own patient lists and the practice had a policy and protocol to book patients an appointment with their own GP whenever possible. The GPs told us this was to provide continuity of care for patients. The practice was also meeting clinical guidance which recommends that patients over 75 have a named GP to maintain consistent care. A practice manager told us if a patient wanted to see a GP more urgently they could request to see a different GP.

The reception and waiting area at Bury Knowle Health Centre was accessible for wheelchair users and those who had limited mobility and all of the premises were situated on the ground floor. There was a disabled toilet available near the waiting area. Corridors, treatment rooms and consultation rooms were accessible for wheelchair users. Patients with mobility problems told us staff were helpful when assisting them to access the practice.

Meeting people's needs

Services were provided at Bury Knowle Health Centre for patients with specific conditions or patients in circumstances which may affect their access to health services. For example, patients with drug and alcohol addictions could access support and care as part of a local shared care scheme. A harm minimisation programme and a recovery programme was available through two specialist shared care nurses under the guidance of GPs. The practice was accessible for patients who prefer to access such a service in a community setting rather than at a hospital or another location out of their local area.

Concerns & Complaints

The practice had a complaint policy displayed in the reception area. Some of the patients we spoke with were aware of where it was displayed and told us they would feel confident in raising a complaint if they needed to. We looked at a complaints log and saw the practice coded complaints into clinical and other complaints in order to review complaints periodically. A GP told us there was a review process for complaints which included discussion of any learning from complaints at staff meetings. We saw all complaints were responded to and patients were made aware of the outcome of their complaints.

Are services well-led?

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

Our findings

Leadership & Culture

Staff told us they felt there was an open culture at the practice. Staff were clear on their responsibilities and roles within the staff teams. There were delegated responsibilities within the management team and among the partners which meant staff knew who to report to with concerns or feedback. Staff and members of the patient participation group (PPG) told us they felt the partners were approachable and engaged in the day to day running of the practice.

Governance Arrangements

The practice held regular clinical and administration staff meetings. GPs and nurses held their own meetings when they needed to share specific guidance related to their roles. Nurses said they felt fully involved in the clinical team meetings that were held and in decisions about the running of the practice. Away days were held once a year for all staff to attend. Staff told us they felt valued by the partners and management staff.

Systems to monitor and improve quality & improvement (leadership)

The practice operated effective clinical monitoring systems such as the Quality and Outcomes Framework (QOF) and clinical audits. There were systems to monitor the standards of cleaning, equipment, staff training, and eligibility to perform as a clinician and medical supplies and medication. Not all these systems were fully effective. We found out of date medical supplies stored in a treatment room which was being used. Insurance required for clinicians to perform their roles had not been checked for many staff to ensure it was up to date and that practitioners were eligible to provide care to patients. A practice manager was able to undertake these checks and sent us evidence that the insurance was in place for all clinicians working at the practice following our inspection. The training log used to monitor staff training was not accurately completed and did not reflect the training undertaken by staff. The practice's hygiene and infection control audit had not identified that not all guidance related to infection control was being followed. There was a risk that the practice was not assessing its standards of quality and safety effectively.

Patient Experience & Involvement

The practice undertook its own survey annually. We looked at the most recent from March 2014. The practice had amended the appointment system as a result of patient feedback in June 2014. However, patients we spoke with were not aware of the changes to the appointment system. When we reported this to the practice partners and management they told us they were aware that communication with patients could be improved and they were working to rectify this. Complaints were investigated and responded to by the practice.

Practice seeks and acts on feedback from users, public and staff

The practice had processes for investigating and responding to complaints which included any significant event reviews where the practice deemed necessary. Patients were consulted via the practice's survey; the most recent was undertaken in March 2014. Feedback from this survey led to changes in the appointment system. The practice staff were aware that the changes to this system had not been communicated to patients effectively.

The patient participation group (PPG) had approximately 20 members. Two of the members met with us during the inspection. They told us the PPG met quarterly and the meetings were usually attended by a practice manager and a GP partner. Two members of the patient participation group (PPG) told us the practice responded to some of their feedback.

Management lead through learning & improvement

The practice was pro-active in identifying and delivering some individual professional development to improve staff expertise. Staff were able to identify training which assisted them to provide specialised care to patients through their appraisals. However, we found training monitoring tools were inconsistent and did not identify all the training requirements of staff. Some staff were not aware of when they had last undertaken some of their core training such as safeguarding vulnerable adults. Only one staff member was recorded as having hygiene and infection control training and none had received awareness of the Mental Capacity Act 2005 training on the training log. There was no clear monitoring tool to identify staff training requirements and the frequency staff should receive training. There was a risk staff training was not being monitored effectively.

Are services well-led?

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

Identification & Management of Risk

Some risks were not effectively assessed or managed by the practice. There were no risk assessments on fire safety or legionella. There was a risk to the safety of patients and others. Risks related to the welfare and safety of patients which were identified by the practice were well managed and communicated among staff.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice had a lower than average number of patients over 65 years old. All patients including those over 75 years of age had a designated GP to ensure they had continuity in their care. Flu vaccinations were offered to patients over 65 years of age to reduce the risk of serious illness which can be caused by flu in older patients. The uptake of the flu vaccine among the practice's patients over 65 years old was lower than the national average. The premises at Bury Knowle Health Centre were accessible for patients with mobility problems and all facilities were located on the ground floor. The practice offered same day telephone consultations to patients which can be a benefit to older patients who find it difficult to attend the practice. The practice provided visits for patients who lived in care or nursing homes. Any requests for a visit were triaged and assessed by a GP. They were responded to the same day as the same day as the request if it was within normal working hours. The practice worked with the local palliative care team in planning patients' end of life care. The patient record system alerted receptionists and staff if patients relied on the support of a carer in order to attend the practice.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice had a lower than national average prevalence of patients with long term medical conditions. Patients with long term conditions told us they were reminded to come for periodic check-ups. The Quality and Outcomes Framework (QOF) results for 2013/14 indicated the practice was caring well for patients with long term medical conditions. Patients were able to test their blood pressure independently using equipment located near the waiting area. Staff were able to attend several days external training a year and led within certain areas of clinical expertise to ensure the practice had the skill mix it needed to care for patients with long term medical conditions. Patients with multiple diagnoses of disease were alerted to staff via the patient record system to ensure they could respond appropriately to patients' needs. GPs peer reviewed referrals to secondary care services, including patients with long term conditions. Patients were offered appointments with their own GP. This increased the likelihood of continuity in patient care for those with long term conditions.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice website advertised baby healthcare clinics on Mondays and Thursdays in the Bury Knowle Health Centre and at the Barton Surgery (a branch location of the Bury Knowle practice). Bury Knowle Health Centre was easily accessible for parents with buggies or prams. There was a baby changing facility near the reception area. Local school nurses attended clinical meetings to discuss any concerns regarding children's health or welfare. The practice worked with midwives who provided clinics at the practice. The practice worked with the midwives to ensure national best practice from National Institute for Health and Care Excellence (NICE) guidelines were followed when delivering care to mothers and babies. Staff did not have any training in the Gillick principles of obtaining consent from patients under 16 years of age. Children on the at risk register were flagged to staff on the patient records system so staff were aware of children who needed quick access to care. These cases were discussed and reviewed at regular multi-disciplinary team meetings. Phone consultations were offered to patients which could be a convenient means for parents to discuss children's health problems without visiting the surgery.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice has a higher number of patients who were of working age than the national average and there was low unemployment in the area.

Patients between 40 and 75 were asked to attend the practice to screen them for any medical conditions every five years. There was information on the practice website which described what the checks would include and the risks for patients who were overweight or smoked, for example.

The practice opened from 7.30am two days a week and 8.30am every other weekday until 6pm. The practice stayed open until 7pm on a Wednesday and opened for three hours on a Saturday morning. This enabled patients who found it difficult to attend during normal opening hours due to work commitments to get an appointment when they needed one. Patients booked appointments either online or through a telephone consultation system. Patients who worked during normal working hours told us this system was difficult for them to use because they were not certain when they would receive a call back at a specific time from the practice. Some patients told us they had jobs where it was difficult for them to take a call when they were working or would not be able to discuss confidential information. This service did provide flexibility for patients who needed to speak to a GP or nurse, but did not have to attend the practice. The service meant they would not have to leave work to attend the practice.

Blood testing was available within the practice which meant patients would not have to attend local hospitals for blood tests.

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

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice website had a translation tool which enabled anyone accessing the site to translate it into many different languages. There was a phone translation service available for clinicians to use during appointments. This would assist patients who could not speak English to access important information and the practice independently.

Treatment for patients with drug and alcohol problems was provided at the practice in partnership with other service providers. Treatment under a harm minimisation or a recovery programme was available through two specialist shared care nurses under the guidance of GPs. The practice worked with external services to ensure they were aware of the needs of their patients who were in vulnerable circumstances. Patients who were vulnerable due to their circumstances or ill-health were flagged to reception staff via a note on the patient records system. For example, that they may need to be prioritised for an appointment. Reception staff would not have access to confidential information through this system, only what was relevant to assist the patient. Staff were notified of concerns regarding patients' circumstances where this was relevant to ensure they were aware of information of concern for patients who were vulnerable.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice advertised a talking therapy service provided by another NHS provider in Oxfordshire for patients with mental health conditions. The patient population a higher than national average prevalence for patients who suffer from depression. Staff did not have an appropriate awareness of the Mental Capacity Act 2005 to ensure they would know when it was appropriate to assess patients' capacity to consent to care and treatment or ensure they acted in patients' best interests where they did not have capacity. A practice manager told us how mental health patients had their treatment and medication reviewed by the practice. They said patients were offered regular reviews of their health and medication. They were prompted to do so by the practice sending two letters if the first was not responded to and then a GP called patients to ask them to attend the practice. Patients with depression were asked to attend the practice for reviews between two to eight weeks after diagnosis. They were then reviewed at medication reviews and based on patients own preference for the frequency of their reviews of care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers **The service was not protecting service users or others against the risk of unsafe care or treatment because there was insufficient monitoring and identification, assessment and management of risk. Regulation 10(1)(a)(b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	**The service did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on regulated activities were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by receiving appropriate training. Regulation 23(1)(a)**