Dr Wignell and Partners

Quality Report

Windrush Surgery
21 West Bar
Banbury
Oxfordshire
OX16 9SA
Tel: 01295 251491
Website: www.windrushsurgery.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Our previous comprehensive inspection at Dr Wignell and Partners (Windrush Surgery) on 03 October 2016 found breaches of regulations relating to the safe, effective and well-led delivery of services. The overall rating for the practice was requires improvement. Specifically, we found the practice to require improvement for provision of safe, effective and well led services. It was good for providing caring and responsive services. Consequently we rated all population groups as requires improvement. The full comprehensive report on the October 2016 inspection can be found by selecting the 'all reports' link for Dr Wignell and Partners on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 10 May 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 3 October 2016. This report covers our findings in relation to those requirements and improvements made since our last inspection.

We found the practice had made improvements since our last inspection. At our inspection on the 10 May 2017 we found the practice was meeting the regulations that had previously been breached. We have amended the rating for this practice to reflect these changes. The practice is now rated good for the provision of safe, effective, caring, responsive and well led services. Overall the practice is now rated as good. Consequently we have rated all population groups as good.

Our key findings were as follows:

- The practice had taken steps to improve governance framework and leadership structure.
- The practice had taken steps to improve the risks associated with the premises.
- There was an effective system in place for reporting and recording significant events and complaints. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Learning outcomes were identified and lessons learned were communicated effectively.
- Data showed the practice had demonstrated improvements in patient's outcomes.
- All staff who acted as a chaperone had received a Disclosure and Barring Service (DBS) checks to keep patients safe and safeguarded from abuse.
- Staff we spoke with on the day of inspection was aware about a whistleblowing policy.

Summary of findings

- Staff we spoke with informed us the management was approachable and always took time to listen to all members of staff.
- We found staff annual appraisals had not always completed in a timely manner. However, dates were planned to complete all appraisals by the end of June 2017.

In addition the provider should:

- Review and monitor the system in place to ensure all staff have received annual appraisals in a timely manner.
- Arrange repairs to fix the flooring in both treatment rooms.
- Improve the outcomes for patients with dementia.

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 as there are areas where it must make improvements.

- When we inspected the practice in October 2016 we found concerns relevant to management of legionella, monitoring of fire safety and gas safety, hepatitis B immunisation records, and Disclosure and Barring Scheme (DBS) checks were not carried out for non-clinical staff undertaking chaperoning duties. Lessons were not always identified and shared as a result of significant events and complaints. We saw that flooring in one treatment room was not impervious (it was not sealed where it met the walls) meaning dirt could accumulate.
- At the inspection on 10 May 2017, we found the practice had made some improvements since our last inspection in October 2016, but some work was still in the progress and dates were planned for the completion. For example:
- A fire risk assessment had been carried out and new fire safety doors installed in the premises. However, the practice was in the process of installing an electronic fire detection and alarm system, which was not activated on the day of inspection.
- The practice had not taken any steps to fix the flooring in one treatment room which was not impervious (it was not sealed where it met the walls) meaning dirt could accumulate. This issue was identified in the previous inspection report. We observed that the flooring in second treatment room required similar repair. This posed a risk of spread of infections in treatment rooms used for taking blood and injections.
- Disclosure and Barring Scheme (DBS) checks were undertaken for all staff undertaking chaperoning duties. All staff who acted as chaperones were trained for the role.
- The practice had reviewed the process for investigating and implementing change following incidents, significant events and complaints to ensure actions are completed.
- Records of hepatitis B immunisation were available for all clinical staff.

Are services effective?

Good

The practice is rated as good for providing effective services as there are areas where it must make improvements.

Summary of findings

- When we inspected the practice in October 2016, we found concerns relevant to medicine reviews, exception reporting and staff training. Health checks and care plans were not always completed for patients on the learning disabilities register. Some appraisals were overdue.
- At the inspection on 10 May 2017, we found the practice had made some improvements since our last inspection in October 2016, but some work was still in the progress and dates were planned for the completion. For example:
- We noted that annual staff appraisals were not always completed on time. However, dates were planned to complete all appraisals by end of June 2017.
- We checked staff training records and noted that some role specific training was not organised in a timely manner including basic life support and immunisation training. However, we saw evidence that a basic life support training session was booked on 17 May 2017 (a week after the inspection).
- The practice had reviewed and improved the systems in place to effectively monitor medicine reviews for patients with long term conditions, and care plans and health checks were completed for patients with learning disabilities.
- However, the practice was required to improve the outcomes for patients with dementia. For example, 68% (23 out of 34 patients) structured annual reviews had been undertaken for patients with dementia.
- We noted the practice had demonstrated improvements in reducing exception reporting for Quality and Outcomes Framework (QOF) year 2016-17. However, recent national data was not available to validate this information.

Are services well-led?

Good

The practice is rated as good for providing well-led services as there are areas where it must make improvements.

- When we inspected the practice in October 2016, we observed that the practice had limited governance framework and governance monitoring of specific areas required improvement, such as, staff training, appraisals, monitoring of patient care and the management of the premises were not adequate and Disclosure and Barring Scheme (DBS) checks to ensure risks were managed appropriately. Learning outcomes were not always identified from incidents and complaints.
- At the inspection on 10 May 2017, we found the practice had made improvements since our last inspection in October 2016, but some work was still in the progress and dates were planned for the completion.

Summary of findings

- The practice had taken steps to improve governance framework and leadership structure.
- Learning outcomes were identified from incidents and complaints, and lessons learned were always communicated widely enough to ensure risks were managed appropriately.
- The practice had demonstrated improvements in monitoring of patient outcomes.
- Staff we spoke with on the day of inspection were aware of the whistleblowing policy. Staff informed us they felt supported in their role, and that the management team was approachable and always took time to listen to all members of staff.

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 provider had resolved all the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People with long term conditions
The provider had resolved the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Families, children and young people
The provider had resolved the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Working age people (including those recently retired and students)
The provider had resolved the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

People whose circumstances may make them vulnerable
The provider had resolved the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

- It offered annual health checks and care plans for patients with learning disabilities. Care plans were completed for 22 patients out of 27 patients on the learning disability register.

Good

Summary of findings

People experiencing poor mental health (including people with dementia)

The provider had resolved the concerns for safe, effective and well-led identified at our inspection on 3 October 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Good

Dr Wignell and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor.

Background to Dr Wignell and Partners

Dr Wignell and Partners (also known locally as Windrush Surgery) is situated in Banbury, Oxfordshire. Dr Wignell and Partners provide services from the following two locations. We visited the premises on West Bar as part of this inspection but not the Bretch Hill location.

Windrush Surgery

21 West Bar

Banbury

Oxfordshire

OX16 9SA

12 Bradley Arcade

Bretch Hill

Banbury

Oxfordshire

OX16 0LS

The main premises of Dr Wignell and partners is a converted house. The treatment and consultation rooms are located on the ground floor and have been adapted to be accessible for patients. The practice serves 7,700 patients from the surrounding area. The practice demographics closely match the national average in terms of age but there are higher numbers of five to nine year olds and 65-70 year olds according to national data. There are slightly higher levels of deprivation compared to the local clinical commissioning group (CCG) area, but in terms of national data the practice has less than average deprivation amongst its population.

The practice has encountered resource problems in 2016 for which it has sought the help of the local CCG. The partners have been working towards improving resource monitoring of the practice whilst reviewing their governance structures.

- There are 2.7 whole time equivalent (WTE) GPs and 4.8 WTE nurses who are supported by healthcare assistants and phlebotomists.
- Dr Wignell and Partners is open between 8.00am and 6.30pm Monday to Friday. There are extended hours appointments available on Monday and Wednesday mornings from 7am.
- Out of hours GP services were available when the practice was closed by phoning 111 and this was advertised on the practice website.
- This practice provided placements for GPs in training although it was not officially a training practice.

Why we carried out this inspection

We carried out a previous comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection took place on 3 October 2016 and we published a report setting out our judgements. These judgements identified two breaches of regulations. We asked the provider to send a report of the changes they would make to comply with the regulations they were not meeting at that time.

Detailed findings

We carried out a follow up focussed inspection on 10 May 2017 to follow up and assess whether the necessary changes had been made, following our inspection in October 2016. We focused on the aspects of the service where we found the provider had breached regulations during our previous inspection. We followed up to make sure the necessary changes had been made. We found the practice had made some improvements since our last inspection. However, further improvements are required and we have not amended the rating for this practice.

This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, (Regulated Activities) Regulations 2014, to look at the overall quality of the service, review the breaches identified and review the ratings provided under the Care Act 2014.

How we carried out this inspection

Prior to the inspection we contacted the Oxfordshire Clinical Commissioning Group, NHS England area team and the local Healthwatch to seek their feedback about the service provided by Dr Wignell and Partners. We also spent time reviewing information that we hold about this practice including the data provided by the practice in advance of the inspection.

The inspection team carried out an announced focused visit on 10 May 2017.

During our visit we undertook observations of the environment and spoke with a range of clinical and non-clinical staff.

This report should be read in conjunction with the full inspection report of CQC visit on 3 October 2016.

Good

Are services safe?

Our findings

When we inspected the practice in October 2016 we found risks to patients and staff were not always assessed and managed, specifically those relating to management of legionella, monitoring of fire safety and gas safety, hepatitis B immunisation records and Disclosure and Barring Scheme (DBS) checks or risk assessment for non-clinical staff undertaking chaperoning duties. Lessons were not always identified and shared to make sure action was taken to improve safety in the practice as a result of significant events and complaints. We saw that flooring in one treatment room was not impervious (it was not sealed where it met the walls) meaning dirt could accumulate. Some improvements had been made, but not all of the concerns reported had been addressed and at the May 2017 inspection we found:

Overview of safety systems and processes

The practice had an effective system in place for reporting and recording significant events and complaints. We reviewed records of five significant events and two complaints that had occurred during the last four months. There was evidence that the practice had learned from significant events and complaints. Outcomes were communicated to staff to support improvement. For example, we saw an analysis of a significant event regarding emergency telephone line protocol. We noted all staff were reminded that emergency telephone ringer should never be turned off and the practice had introduced random checks to ensure this.

We found a notice was displayed in the premises, advising 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 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).

Records of hepatitis B immunisation were available for all clinical staff.

Monitoring risks to patients

During the inspection in March 2017 we noted the practice had taken steps to improve the risk associated with the premises to keep patients safe. For example,

- A fire safety risk assessment had been carried out by an external contractor in October 2016. On the day of the inspection, we saw evidence that the practice was in the process of installing an electronic fire detection and alarm system. The practice informed us the fire detection and alarm system would be activated within few days after the inspection because they were experiencing delays due to non-availability of some parts. The practice informed us that fire exit door lock mechanism would be replaced by the end of May 2017.
- We noted that the practice had installed new fire safety doors in the premises to ensure fire safety. Fire extinguishers were checked regularly and the last fire drill was carried out in December 2016. The practice had nominated and trained staff as fire marshals.
- Legionella (a bacterium which can contaminate water systems in buildings) risk assessment had been carried out by an external contractor on 5 October 2016. We saw the practice was carrying out regular water temperature checks and records were maintained. We saw evidence that the practice had sent a water sample for laboratory analysis a week before the inspection.
- A gas safety check had been carried out on 4 October 2016.
- The practice had developed an action plan to complete the ongoing maintenance and improvement building work by the end of June 2017. The practice had carried out restructuring of the reception area and new reception desk would be installed by the end of June 2017. The practice was in the process of building an additional treatment room on the ground floor.
- However, we noted the practice had not taken any steps to fix the flooring in one treatment room which was not impervious (it was not sealed where it met the walls) meaning dirt could accumulate. We observed that the flooring in second treatment room required similar repair. This posed a risk in treatment rooms used for taking blood and injections.
- We noted the infection control lead had not been booked for advanced training to ensure they kept up to date with current infection control practice. The practice informed us the lead had booked their own training but this was cancelled.

Good

Are services effective?

(for example, treatment is effective)

Our findings

When we inspected the practice in October 2016 we found the practice had not undertaken medicine reviews routinely for patients with long term conditions. Some exception reporting in mental health and diabetes indicators showed higher instances than local averages for patients who did not receive care in line with national data. Health checks and care plans were not always completed for patients on the learning disabilities register. Some staff had not completed training relevant to their role including basic life support, immunisation, chaperoning and Gillick competency. The infection control lead had not received advanced training. Some appraisals were overdue. Some improvements had been made, but not all of the concerns reported had been addressed and at the May 2017 inspection we found:

Management, monitoring and improving outcomes for people

The practice had addressed the concerns raised during previous inspection and GPs explained the improvements they had made in the system for reviewing patient medicines. The practice informed us that repeat medicines reviews were not always being recorded and coded properly before to enable effective monitoring of the system. We observed that electronic prescribing prompts were in place and acted on to improve patient's outcomes.

- We saw the practice had shown improvement and repeat medicines reviews had increased from 64% to 71% of patients on less than four repeat medicines.
- We saw repeat medicines reviews had increased from 80% to 90% of patients on four or more repeat medicines.

We noted that the clinical staff had taken the lead role in carrying out medicine reviews for patients with long term conditions.

- We found that on average 80% structured annual reviews had been undertaken for patients with long term conditions including diabetes, asthma, chronic obstructive pulmonary disease and chronic heart disease.
- Medicine reviews for patients with dementia were 68% (23 out of 34 patients).

We noted that the practice followed the national QOF protocol for inviting patients three times for the review of their long term conditions and all potential exceptions from the recall programme were reviewed by a GP. During this inspection in May 2017 we found the practice had demonstrated improvement in reducing exception reporting in the QOF year for 2016-17. For example,

- In 2015-16, exception reporting for diabetes related indictors was 15%. This was higher than the CCG average (13%) and national average (11%). During QOF year in 2016-17, the practice exception reporting for diabetes related indictors was 8%. This was a 7% reduction from the previous year's data.
- In 2015-16, exception reporting for mental health related indictors was 14%. This was higher than the CCG average (11%) and national average (11%). During QOF year in 2016-17, the practice exception reporting for mental health related indictors was 2%. This was a 12% reduction from the previous year's data.

The practice had carried out health checks and care plans for 22 out of 27 patients on the learning disability register, which demonstrated improvement from 15% to 82% compared to previous inspection in October 2016.

Effective staffing

The practice had demonstrated limited improvements in this area and they were required to make further improvements. We found;

- We found that the practice had not completed annual staff appraisals within the last 12 months. For example, we saw six administration staff, two health care assistants, two practice nurses and an emergency care practitioner had not received an appraisal in the last 12 months.
- The practice had appointed a new practice manager in November 2016 after previous CQC inspection visit. The practice manager informed us they had made the decision to delay the appraisals because the practice manager wanted to complete a relevant training course in order to carry out a comprehensive appraisal process, which would be more effective. We saw evidence that the practice manager had recently attended an appraisal training course in February 2017. We saw new practice manager had completed three appraisals and noted that the future dates were planned to undertake all appraisals by the end of June 2017.

Good

Are services effective?

(for example, treatment is effective)

- We noted staff had access to and made use of e-learning training modules and in-house training.
- We observed that all staff who acted as chaperones were trained for the role.
- We noted that two practice nurses and two health care assistants had not updated immunisation training relevant to their specific role and could not demonstrate how they stayed up to date with changes to the immunisation programmes. However, the practice informed us that training had been booked in September 2017. The practice was not able to find an immunisation training record for a clinical nurse practitioner and an emergency care practitioner.
- During previous inspection in October 2016 we found gaps in basic life support training records for eight members of reception staff. During this inspection we noted they still had not completed basic life support training. However, we saw evidence that a training session was booked on 17 May 2017 (a week after the inspection).
- We noted some staff had completed online Gillick competency training. However, staff we spoke with on the day of inspection had demonstrated good understanding. The practice informed us they had organised an internal training session.

Are services well-led?

Good

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

Our findings

When we inspected the practice in October 2016, we observed that the practice had limited governance framework which did not support the delivery of good quality care. We found governance monitoring of specific areas required improvement. For example, staff training, appraisals, monitoring of patient care and the management of the premises were not adequate. Learning outcomes were not always identified from incidents and complaints. The practice had not always undertaken Disclosure and Barring Scheme (DBS) checks or risk assessment of all non-clinical staff undertaking chaperoning duties. Some improvements had been made, but not all of the concerns reported had been addressed and at the May 2017 inspection we found:

Governance arrangements

The practice had prioritised number of concerns identified during the previous inspection and demonstrated improvements. However, some improvement work was still in the progress and dates were planned to complete these tasks.

- The practice had appointed a new practice manager and developed a clear governance and leadership structure.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. However, not all staff had received annual appraisals to enable them to carry out the duties they were employed to do. We saw evidence that dates were planned to complete all appraisals by the end of June 2017.
- Training sessions were not booked in a timely manner and monitored effectively to ensure that staff had the skills, knowledge and experience to deliver effective care and treatment. However, the new practice manager was in the process of establishing new monitoring system.
- The practice did not have effective monitoring system to ensure good record keeping. For example: On the day of inspection the practice was not able to find basic clinical infection control training certificate for the infection control lead and recent infection control audit was not accessible. The practice was not able to find an immunisation training record for a clinical nurse practitioner and an emergency care practitioner.
- The practice had taken steps to improve the risks associated with the premises. For example, fire and legionella risk assessments had been undertaken and gas safety check had been carried out.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, effective monitoring of Disclosure and Barring Service (DBS) checks for all non-clinical staff undertaking chaperoning duties and lessons learned from significant events and complaints were always communicated widely enough to ensure risks were managed appropriately.
- The practice had demonstrated improvements in patient outcomes.
- The practice had developed a new whistleblowing policy and it was available on a shared drive. Staff we spoke with on the day of inspection were aware of whistleblowing policy.
- Clinical and non-clinical staff we spoke with informed us they felt supported in their role and the management was approachable and always took time to listen to all members of staff.