# South Wigston Health Centre

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at South Wigston Medical Centre on 22 April 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice requires improvement for providing safe, responsive and well led services. It was providing an effective and caring service.

It also required improvement for providing services for all the population groups

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However there was scope to ensure that learning was disseminated more formally.
- 76.% of patients who responded to the national patient survey said they recommend the surgery to others. 80% described their overall experience as good.
- Risks to patients were not assessed and well managed.
- Some audits had been carried out but we saw no evidence that audits were driving improvement in performance to improve patient outcomes.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had a number of policies and procedures to govern activity, but these were over five years old and had not been reviewed since. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings.
- Some staff that we spoke with on the day of the inspection said that there were not enough staff to maintain the smooth running of the practice, for example, not enough nurses to keep the clinics running in line with patient needs.
- Urgent appointments were usually available on the day they were requested. However patients said that they had to wait a long time to get through by phone

# Summary of findings

and get an appointment. The practice had recognised a lack of patient satisfaction around access to appointments and telephone access to the practice and were taking action to address this.

The areas where the provider must make improvements are:

- Ensure there is a robust system to manage and learn from significant events, near misses and complaints.
- Implement a robust system to ensure that National Patient Safety Alerts and Medical Healthcare Product alerts are disseminated to staff and that action is taken as necessary.
- Identify, assess and manage risks relating to the health, welfare and safety of patients, staff and other people who may be at risk within the practice. For example, risk assessments for, legionella, general office environment, disclosure and barring (DBS) and control of substances hazardous to health (COSHH), infection control and fire safety.
- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include the checking of medical equipment and disclosure and barring checks for newly recruited staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to enable them to deliver the care and work they carry out in the practice.
- Ensure training records are maintained and available.
- Ensure staff have appropriate and up to date policies and guidance to carry out their roles in a safe and effective manner.

In addition the provider should

- Ensure all staff are aware that National Institute for Health and Care Excellence guidelines are available on the practice intranet.
- Ensure there is an up to date business continuity plan which includes risks and mitigating actions.
- Have a robust system in place to track prescription pads.
- Consider gaining patient views in the delivery of service and driving improvements. For example, the appointment system.

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

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

**Are services safe?**

Requires improvement

The practice is rated as requires improvement for providing safe services and improvements must be made. There was insufficient information to enable us to understand and be assured about safety. Not all staff were clear about the process for reporting incidents, near misses and complaints. Although the practice reviewed when things went wrong, investigations were not thorough enough and lessons learned were not communicated and so safety was not improved. Patients were at risk of harm because systems and processes were either not in place or not well implemented in a way to keep them safe.

National patient safety alerts were not reviewed by a GP to ensure appropriate action was taken. Medical equipment was not regularly checked as per the practice policy. Risks to patients were not assessed, reviewed or well managed, such as risk assessments for the general office environment, control of substances hazardous to health (COSHH). The legionella and fire risk assessments carried out by NHS Property services was out of date. The practice did not have a robust system in place to track prescription pads.

**Are services effective?**

Good

The practice is rated as requires as good for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or above average for the locality. Reference to national guidelines were inconsistent. National Institute for Care and Health Excellence guidance was shared with some staff. Patient outcomes were hard to identify as little or no reference was made to audits.

There was no evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. There had been no appraisals for staff for three years and little support for any additional training that may be required. Staff worked with multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice good for some aspects of care. The majority of patients said they were treated with compassion, dignity and respect.

Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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**Are services responsive to people's needs?**

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified.

Appointment systems were not working well so patients did not receive timely care when they needed it. Patients reported considerable difficulty getting through by telephone and appointments were difficult to get. Urgent appointments were available on the same day. It could take up to five weeks to get routine appointments. Patients could get information about how to complain in a format they could understand if they asked for it. It was not readily available and there was no evidence that learning from complaints had been shared with staff.

**Are services well-led?**

Requires improvement

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues. We looked at 17 of these policies. Not all policies and procedures we looked had been regularly reviewed.

Governance meetings were not held. The practice proactively sought feedback from patients and had an active patient reference group (PRG). However they had not gained patients views on the current appointment system. All staff had received inductions but staff had not received regular performance reviews or attended staff meetings and events.

# 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**

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Longer appointments were available for older people when needed, and this was acknowledged positively in feedback we received from patients. The leadership of the practice had started to engage with this patient group to look at further options to improve services for them.

The practice had close links with the district nursing team. The district nurses ran a clinic at the practice every afternoon. All patients over the age of 75 had a named GP. A named GP visited patients who were resident at a local care home every Tuesday but would also visit at other times as needed. The practice had found that it had decreased the number of emergency admissions to hospital. 2% of the patients had a care plan in place for unplanned admissions.

**People with long term conditions**

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. However, not all these patients had a named GP, a personalised care

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plan or structured annual review to check that their health and care needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

**Requires improvement**

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

The practice had a significant number of children on child protection plans. Three of the GP partners focussed on child surveillance. Children who are on child health surveillance were 'flagged' on the electronic patient record system.

Childhood immunisation rates for the vaccinations given to children under two ranged from 87.1% to 100% and for five year olds from 93.9% to 100%. These were comparable to CCG averages.

Patients told us that children and young people were treated in an age-appropriate way and we saw evidence to confirm this. Appointments were available outside of school hours.

The practice ran a drop in family planning clinic twice a week. This had been well received by patients we spoke with on the day of the inspection. A midwife ran antenatal classes twice a week. The practice had close links with the health visitor. They met monthly to discuss family and safeguarding issues. The health visitor was available in the practice every morning for a limited amount of time.

**Working age people (including those recently retired and students)**

**Requires improvement**

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had done some

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adjustments to the services to try and ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice offered extended hours surgeries Monday, Tuesday, Wednesday and Thursday 6.30pm to 7pm and 7.30 to 8am Tuesday and Thursday. We found that this was not widely advertised. A member of staff we spoke with felt that the practice did not cater for working people. Currently there were no late evening appointments.

Patients could book appointments or order repeat prescriptions online. Health promotion material was available through the practice. There was a low uptake for health checks.

**People whose circumstances may make them vulnerable**

**Requires improvement**

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. No health checks had been carried out in 2014 due to capacity issues. 10.5% had been carried out so far this year.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Most staff knew how to recognise signs of abuse in

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vulnerable adults and children. Most staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia. The provider was rated as requiring improvement for safe, responsive and well led. The practice was providing an effective and caring service. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a lead GP for patients who lived with dementia. 70.37% of patients had received an annual review.

Only 39.5% of people experiencing poor mental health had received an annual physical health check. We spoke with the registered manager who told us it was due to a recording error on the electronic patient system. There was a weekly Improving Access to Psychological Therapy clinic.

100% of patients who had depression had received an annual review.

A drug and alcohol worker held a clinic with a GP on a weekly basis. A GP within the practice did two sessions a week at a local prison for patients with substance misuse problems.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE.

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## What people who use the service say

The January 2015 national patient survey had a 41% return rate. It showed that 76.% of patients who responded would recommend the surgery to others. 80% described the overall experience as good. 84% felt the GP treated them with care and concern. This was below the Clinical Commissioning Group average but above the national average. In relation to nurses, 92% of patients felt they were treated with care and concern.

We spoke with nine patients on the day of our visit. Five patients expressed concern regarding the lack of appointments and the difficulty getting through to the surgery by phone. However all nine were very positive about the care and support they received at the practice once they got an appointment.

We reviewed 11 comments cards that had been completed and left in a CQC comments box. The comment cards enabled patients to express their views on the care and treatment received. Seven out of the 11 cards completed had both positive and negative comments on them. They all felt that the quality of care was very good. They felt respected, well looked after and said staff were kind and considerate. Six patients reported that there were issues with getting an appointment and getting through on the phone. We spoke with the management team who were aware that this was an on-going issue.

We met with the chairperson of the patient reference group (PRG). The PRG is a group of patients who highlight patient concerns and needs and work with the practice to drive improvement within the service. The PRG chair told us they were developing work with the practice to address issues patients had raised.

## Areas for improvement

### Action the service MUST take to improve

- Ensure there is a robust system to manage and learn from significant events, near misses and complaints.
- Implement a robust system to ensure that National Patient Safety Alerts and Medical Healthcare Product alerts are disseminated to staff and that action is taken as necessary.
- Identify, assess and manage risks relating to the health, welfare and safety of patients, staff and other people who may be at risk within the practice. For example, risk assessments for, legionella, general office environment, disclosure and barring (DBS) and control of substances hazardous to health (COSHH), infection control and fire safety.
- Implement effective systems for the management of risks to patients and others against inappropriate or unsafe care. This should include the checking of medical equipment and disclosure and barring checks for newly recruited staff.
- Ensure that staff have appropriate support, identified through a formal appraisal system to enable them to deliver the care and work they carry out in the practice.
- Ensure training records are maintained and available.
- Ensure staff have appropriate and up to date policies and guidance to carry out their roles in a safe and effective manner.

### Action the service SHOULD take to improve

- Ensure all staff are aware that National Institute for Health and Care Excellence guidelines are available on the practice intranet.
- Ensure there is an up to date business continuity plan which includes risks and mitigating actions.
- Have a robust system in place to track prescription pads.
- Consider gaining patient views in the delivery of service and driving improvements. For example, the appointment system.

# South Wigston Health Centre

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector and the team included a GP, a GP practice manager and another CQC inspector.

## Background to South Wigston Health Centre

South Wigston Health Centre is a GP practice which provides a range of primary medical services under a GMS contract to around 9,000 patients from a surgery in Wigston, Leicestershire.

South Wigston Health Centre is in an area of high socio-economic deprivation. The practice has a large number of patients with chronic co-morbidity. Co-morbidity is the presence of one or more additional disorders or diseases.

The practice's services are commissioned by East Leicestershire and Rutland Clinical Commissioning Group (ELR CCG). ELR CCG have full responsibility for commissioning healthcare services for residents in Blaby, Lutterworth, Market Harborough, Rutland, Melton Mowbray, Oadby and Wigston and the surrounding areas. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

The service is provided by seven GP's(four female and three male), two part-time practice nurses, three health care assistants, one practice manager, one assistant practice manager, two part-time secretaries,10 reception and administration staff and one audit/Quality Outcomes Framework (QOF) clerk. QOF is a system used to monitor the quality of services in GP practices.

The practice has one location registered with the Care Quality Commission (CQC) which is South Wigston Health Centre, 80 Blaby Road, Leicester. LE18 4SE.

The property in which South Wigston Health Centre occupy a number of rooms is owned by NHS Property Services. It is a single storey building with a small car park used by the health centre.

The practice is open between 8.30am and 12.30pm and 1.30pm to 6pm from Monday to Friday. Appointments are from 8.30am to 12 o'clock and 3pm to 6pm. Extended hours surgeries are offered on Monday, Tuesday, Wednesday and Thursday 6.30pm to 7pm and 7.30 to 8am Tuesday and Thursday.

South Wigston Health Centre have opted out of providing out-of-hours services (OOH) to their own patients. The OOH service is provided to Leicester City, Leicestershire and Rutland by Central Nottinghamshire Clinical Services.

The practice is a GP training practice. (Teaching practices take medical students and GP trainees.

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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

## How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- The working-age population and those recently retired (including students)
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew. We also reviewed information we had requested from the practice prior to our visit, as well as information from the public domain including the practice website and NHS choices.

We carried out an announced visit on 22 April 2015. During our visit we spoke with a range of staff including GPs, the management team, the nursing team as well as reception and administration staff. We also spoke with patients who used the service.

During our visit we spoke with a representative of the patient reference group to gain their views on the service provided by the practice.

We observed how people were interacted with and talked with carers and family members.

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice were unable to demonstrate a safe track record over the long term. The records we looked at which related to significant events, near misses and complaints showed that issues had been considered. However, they had not always been reviewed or investigated in enough depth to ensure that relevant learning and improvement could take place. The practice did not have a risk log and had not carried out assessments to identify risks and improve patient safety.

### Learning and improvement from safety incidents

The practice did not have a clear or robust system for reporting, recording and monitoring significant events. There was no policy in place for dealing with significant events. The practice had kept a log of significant events that had occurred during the last year. There were 13 significant events recorded for 2014/2015.

However the log of significant events did not document a summary of key learning points and actions to be taken. The practice had not documented who the actions were for or a date that the actions had to be completed by. Significant events were not reviewed to detect themes or trends in line with the Significant /Critical Event toolkit produced by the practice. There was no evidence that the practice had shared the findings with relevant staff. Staff members we spoke with were not aware of any significant events that had taken place over the past year. We looked at minutes of meetings and could only find one entry where significant events were discussed. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue and they felt encouraged to do so. We spoke with the management team after the inspection who advised us that they would look at the process they currently had in place for the recording of significant events and ensure that future significant events and accidents were investigated, documented and information shared with staff. Since the inspection the practice have updated and implemented the policy.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. He showed us the system used to manage and monitor incidents. We tracked one incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result.

The practice had a system in place to disseminate national patient safety alerts or Medicines and Healthcare Products Regulatory Agency (MHRA) alerts to all practice staff. MHRA alerts are sent when there are concerns over the quality of a medication or equipment. The safety alert policy identified two key people to receive alerts. We found there was no GP lead responsible for clinical safety alerts. We found that clinical safety alerts were assessed by a non-clinical member of staff who determined if the information required clinical action. This meant that we could not be assured that patients were safe and that safety alerts were being managed in a robust and consistent manner.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. The practice had a significant number of children on child protection plans. Three of the GP partners focused on child surveillance. We saw evidence of active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Requires improvement

# Are services safe?

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly 'flagged' and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed.

The practice had a chaperone policy. A chaperone poster was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). We saw evidence that two members of staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We did not see any evidence that staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).The practice had not undertaken a risk assessment to ascertain if a DBS check was required.

## Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The practice did not have a policy to provide staff with guidance on the management of medicines.

The practice did not have a cold chain policy to ensure that medicines were kept at the required temperatures or describe the action to be taken in the event of a potential failure. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were not handled in accordance with national guidance as the prescription pad log had not been updated since October 2014.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated from 2013 to 2015. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the practice. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD.

The practice had protocols for the nursing team to refer to for guidance when treating patients with long term conditions. On the day of the inspection we found the protocols to be out of date. After the inspection we received evidence to demonstrate that the practice had updated all the protocols used by the nursing team.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

## Cleanliness and infection control

The property in which South Wigston Health Centre occupied a number of rooms was owned by NHS Property Services.

During the inspection we looked at the areas of the health centre used by the practice which included the GP

consulting rooms, treatment rooms, store rooms, patient toilets and waiting areas. The contract for cleaning the health centre was the responsibility of a single external company.

We found that the areas used by the practice were mostly visibly clean and tidy. We did find some high level areas, such as tops of curtain rails, dusty.

We saw there were cleaning schedules kept by the external cleaning company. We spoke with the cleaner who told us that she did not always have enough time to do all the tasks set out on the schedules. The practice did not carry out spot checks of the areas they used within the health centre to ensure it was kept clean and tidy. We spoke with the management team who told us they would put a process in place.

Patients we spoke and comments cards we reviewed told us they always found the practice clean and had no concerns about cleanliness or infection control.

We spoke with the infection control lead. He told us he had recently taken on the role. He had completed an online training module for infection control. We were not assured that this was comprehensive enough to enable him to provide advice on the practice infection control policy and carry out staff training. South Wigston Health Centre had not carried out any infection control audits to identify any improvements or actions for the external company which undertook the cleaning in the practice. National guidance states that audits must be undertaken to ensure that key policies and practices are being implemented appropriately. Minutes of practice meetings we looked at did not show that infection control was discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. The practice infection prevention and control policy had been updated in line with recommendations from the CCG. Staff knew the procedure to follow in the event of an injury.

All cleaning materials and chemicals were stored securely. Control of substances hazardous to health (COSHH) information was available to ensure their safe use. Some information had not been reviewed since 2000. The practice did not have a COSHH risk assessment. We spoke with the registered manager who told us they would contact the external cleaning company and ask them to review and update the COSHH information.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Notices about hand hygiene techniques were displayed on the soap dispensers in staff and patient toilets. Some of the worktops had ingrained marks in them which the cleaner was unable to remove.

South Wigston Health Centre had arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.

Sharps bins were correctly assembled and labelled. We saw a flowchart for needlestick injuries evident in each clinical room for staff to refer to. The practice did not have a needlestick injury policy to provide guidance to staff. There were arrangements in place for the safe disposal of clinical waste and sharps such as needles and blades. We saw evidence that their disposal was arranged by a suitable external company.

We saw the practice had both material and disposable curtains in use in some of the clinical rooms we looked at. These ensured that patients had privacy when being examined. We saw evidence that these had been changed every six months in line with national guidance.

NHS Property Services had a risk assessment for legionella testing dated December 2012. This is a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place. There were no records to confirm that the practice had taken steps to ensure that legionella risk assessments and water checks were carried out in the areas of South Wigston Health Centre used by the practice to reduce the risk of infection to staff and patients. The practice did not have a policy for the management, testing and investigation of legionella. Legionella is a term for particular bacteria which can contaminate water systems in buildings.

### Equipment

Staff we spoke with were satisfied with the equipment available to carry out diagnostic examinations, assessments and treatments. The practice did not maintain

an inventory of equipment that required electrical safety testing, servicing and calibration. This would ensure that when testing and calibration took place and that no equipment was missed.

We found weighing scales that had not been tested since 2013. We spoke with the management team and there were no records to confirm when appliances and equipment such as scales had routinely undergone servicing and calibration to ensure accuracy of readings.

We saw evidence that most electrical equipment had undergone portable appliance testing (PAT) within the last 12 months.

### Staffing and recruitment

The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff.

We saw evidence that staff were not following the policy as six staff files we looked at did not contain evidence, that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service were not available in all files. (These 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).

The registered manager did not have GP files available for us to look at. We found that the General Medical Council (GMC) registration was not checked on a regular basis. We were told by the registered manager that the GMC and Nursing and Midwifery Council (NMC) numbers were given at recruitment. We were told that the practice relied on the Performers list to inform them of any changes to a GP's registration. The Performers List provides reassurance for the public that GPs practising in the NHS are suitably qualified, have up to date training, have appropriate English language skills and have passed other relevant checks.

The practice told us they had never used locum agencies and tended to use the same locums GP's who were known to the practice on a regular basis. They did not have a policy and appropriate procedures in place relating to this. This exposed practice staff and patients to additional risks.

Some staff that we spoke with on the day of the inspection told us that there were not enough staff to maintain the smooth running of the practice, for example, not enough nurses to keep the clinics running to keep patients safe. Prior to February 2015 the practice had three practice nurses. One has since left and the practice are actively trying to recruit into this vacant post. The practice manager could not show us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

### Monitoring safety and responding to risk

The practice was located in a health centre that was shared with other services and was maintained by NHS property services. We saw evidence that maintenance was undertaken as required, for example for gas, electric and fire safety systems. There was a process in place for staff to report any faults or problems and they confirmed that issues were dealt with in a timely manner. However the practice did not undertake their own checks to ensure that maintenance was undertaken in a timely manner.

The practice had not taken steps to ensure that risk assessments had been carried out in the areas of South Wigston Health Centre used by practice. They had not ensured that they were aware of any potential risks to patients, staff and visitors and planned any mitigating actions to reduce the possibility of harm. For example, general office environment, control of substances hazardous to health (COSHH), disclosure and barring (DBS), fire, legionella and medicines carried by GPs when on home visits. The meeting minutes we reviewed did not show that risks were discussed at GP partners' meetings and within team meetings. We spoke with the management team who informed us they would carry out the necessary assessments and commence a risk log. Since the inspection we have received evidence that the practice have commenced a risk log and have a process in place to update and discuss the log on a regular basis.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. However records showed that not all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this

equipment. We reviewed the checklist and found that the emergency equipment and medicines had not been checked in October 2014 or in the period from 30 January 2015 to 17 April 2015. We checked that the pads for the automated external defibrillator were within their expiry date.

The emergency equipment and medicines were not in a secure area of the practice. They were stored in an area accessed by the public and this had not been risk assessed by the practice. We saw that a comprehensive range of emergency medicines was available to cover a range of conditions requiring emergency treatment at a GP surgery. Staff knew of their location.

Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. The practice told us that, following the inspection, they would be risk assessing the storage of the emergency equipment and medicines.

A disaster handling and business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. It had been reviewed in March 2015 and risks identified included loss of main premises, loss of computer and telephone systems and access to the building. However we found that the risks identified had not been rated and mitigating actions recorded to reduce and manage the risk.

The practice had not taken steps to ensure that a fire risk assessment had been carried out in the areas of South Wigston Health Centre used by practice. For example, emergency routes and exits, and the needs of vulnerable people, e.g. the elderly, young children or those with disabilities. They had not ensured that they were aware of any potential risks to patients, staff and visitors and planned any mitigating actions to reduce the possibility of harm. We spoke with the management team who informed us they would carry out the necessary assessments.

NHS Property Services had carried out a fire risk assessment in January 2014 which included actions required to maintain fire safety. The risk assessment was out of date and there was no evidence to demonstrate if the actions that had been identified had been actioned. We were told hat staff had not received fire training.

NHS Property Services checked the fire equipment, for example, fire extinguishers on a regular basis.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. For example, in relation to hypertension, diabetes and COPD. We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. Not all staff we spoke with were aware that NICE guidance was available on the practice intranet.

We saw minutes of clinical meetings. We did not see any evidence where NICE guidance was discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

All patients over the age of 75 had a named GP. We were told that 2% of the patients had a care plan in place for unplanned admissions. A named GP visited patients who were resident at a local care home every Tuesday and visited at other times when needed.. The practice had found that the number of emergency admissions to hospital had decreased since the regular visits to the care home commenced.

### Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

For example, we saw an audit regarding a review of osteoporosis, calcium and vitamin D. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. The GPs had maintained records since this audit which demonstrated how they had evaluated the service and documented the success of any changes. Staff we spoke with told us that audits were not discussed at practice meetings.

The practice showed us a further six audits undertaken in the last 12 months. Only one was a completed clinical audit, for example, minor operations audit. None of the audits had a designated person identified to implement any recommendations or actions. None had a date for the audit to be repeated.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98.8% of the total QOF target in 2014, which was above the CCG average of 97.7% and national average of 93.5%. For example:

- Performance for diabetes related indicators was 96.6% which was better than both the CCG and national average.

Good

# Are services effective?

## (for example, treatment is effective)

- The performance for patients with hypertension was 99.2% which was above both the CCG and national average.
- The performance for patients with COPD was 100% and above both the CCG and national average.
- The dementia diagnosis rate was 80.2% and below both the CCG and national average.

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. In line with this staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. The repeat prescriptions were normally competed within 24 hours. Staff also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. Reception staff we spoke with were not aware of a repeat prescribing policy.

The IT system flagged up relevant medicines alerts when the GP was prescribing high risk medicines. High risk medicines are prescribed under shared care protocols.

The CCG prescribing reports demonstrated that the practice was within normal limits for most medicines prescribed. The practice had a high level of 'special drugs' but the practice found that patients had initially been prescribed these when in secondary care.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. 31% of patients had received at least one review in the last year.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups, for example, people who were homeless, travellers, and those with learning disabilities. The practice had not undertaken any reviews of patients with a learning disability in 2014. Since the beginning of April 10% had had an annual review.

We were shown data that all patients who suffered with depression and 70.37% of patients with dementia had received an annual review.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that not all staff were up to date with attending courses such as annual basic life support. There was an e-learning package in place in the practice however there were no clear guidelines on what was mandatory and how training was being monitored. There was evidence from the local safeguarding administrator that the GPs had undertaken training in safeguarding children to level three within the last three years. All except one GP had completed the safeguarding adults training within the last three years. We were told this would be undertaken in the next few weeks.

All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). We were told the GP's were responsible for keeping their own revalidation up to date.

Staff we spoke with told us they maintained their registration and undertook courses and training relevant to their role.

The practice could not provide robust evidence to demonstrate staff had received the training they needed to fulfil their specific roles. We saw a list of current staff and the e-learning that had been undertaken in the last two years, for example, mental capacity act, safeguarding adults, safeguarding children, complaints and infection control. We were given a further training matrix which was not comprehensive and did not list what basic training was needed for the different staff roles. There was no robust record keeping of this and the practice did not monitor when refresher training or basic training was needed or had been carried out by staff.

Information we received from the practice identified that staff had not had appraisals for at least two years. Staff we spoke with confirmed this and one staff member had not received an appraisal for at least five years and had not had any clinical supervision. However staff acknowledged that when they approached the management team to undertake training they were happy to agree to staff increasing their knowledge and experience. We spoke with the practice manager who told us that he would ensure that appraisals were carried out during 2015. However our interviews with staff they confirmed that the practice was proactive in providing training and funding for relevant courses, such as a diploma in asthma care.

Good

# Are services effective?

## (for example, treatment is effective)

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example, seeing patients with long-term conditions such as asthma, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

We were told by staff that the health care assistants were being asked to undertake roles which they did not feel adequately trained for due to lack of nurses in the practice, for example, removal of sutures on patients who had had major surgical operations. We spoke with the management team who told us the health care assistants had had training in the removal of sutures. The practice were also in the process of recruiting a practice nurse which would alleviate the pressure on the health care assistants.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in reviewing and acting on correspondence, reports and results.

Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively high at 16.8% compared to the national average of 13.6%.

The practice had close links with the district nursing team. The district nurses ran a clinic at the practice every afternoon.

The practice held multidisciplinary team meetings every six weeks to discuss patients with complex needs. For example, (those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register). These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

### Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

### Consent to care and treatment

We found before patients received any care or treatment they were asked for their consent and the practice acted in accordance with their wishes. Staff were able to give examples of how they obtained verbal or implied consent.

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing.

Good

# Are services effective?

## (for example, treatment is effective)

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The GPs we spoke with were knowledgeable about Gillick competency assessments of children and young people.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. We were shown two minor surgery audits but they did not mention that the consent process had been adhered to.

### Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. Practice data showed that only 47 patients in this age group had taken up the offer of the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Records showed that 81.68% of patients with hypertension had a last blood pressure reading measured in the preceding 9 months of 150/90mmHg or less against a national average of 83.3%. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Data reviewed showed that 96.9% of patients with physical and/or mental health conditions had records which identified their smoking status in the preceding 12 months against a national average of 95.29%.

Information we received reported that 80.71% of women who were aged between 26 and 64 had a record that a cervical screening test has been performed in the preceding five years against a national average of 81.89%. A member of staff we spoke with told us patients were recalled via alerts and tasks on the electronic patient system. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children as well as travel vaccines and flu vaccinations in line with current national guidance. Immunisation clinics were held once a week. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for patients over 65 were 74.6%, and at risk groups 51.5%. These were similar to national averages.

Childhood immunisation rates for the vaccinations given to children under two ranged from 87.1% to 100% and for five year olds from 93.9% to 100%. These were comparable to CCG averages.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the January 2015 national patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated by patients as good. However the practice was mostly good for its satisfaction scores on consultations with doctors and nurses. For example:

- 86% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 85% said nurses were good at listening to them compared to the CCG average of 91% and national average of 91%.
- 86% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 92% said nurses gave enough time compared to the CCG average of 93% and national average of 92%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 99% said they had confidence and trust in the last nurse they saw compared with the CCG average of 97% and national average of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards. Seven out of the 11 cards completed had both positive and negative comments on them. They all felt that the quality of care was very good, They felt respected, well looked after and staff were kind and considerate. Six patients identified that the practice had issues with getting an appointment and getting through on the phone.

We spoke with nine patients on the day of our visit. Five patients expressed concern regarding the lack of appointments and the difficulty getting through to the surgery by phone. However all nine were very positive about the care and support they received at the practice once they got an appointment.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that where possible it enabled confidentiality to be maintained. From the January 2015 national GP patient survey 88% of patients who responded said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

### Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients responded to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 92% said nurses were good at explaining tests and treatments compared to the CCG average of 91% and national average of 9076.7%
- 79% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 88% and national average of 85%.
- 89% said nurses were good at involving them in decisions about their care which was slightly above the CCG average of 85% and national average 85%.

Good

# Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

### Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.
- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. The practice had registered 23.4% of patients as carers against a national average of 18.2%.

The practice had a system in place to alert GP's if a family had suffered a bereavement. The practice did not call the patient or have a bereavement leaflet but family members could book an appointment to see a GP at a time convenient to them.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice did not always respond to patients' needs. They had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to try and address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, to address the inequality of additional funding allocated to support key quality indicators was the practice is unique in having the highest deprivation in the CCG area.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, the purchase of a new ECG machine that produced reports electronically which attached to the patient's medical records.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities or a long term condition. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerable patients in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with and e-learning records we looked at confirmed that they had completed equality and diversity training in the last two years.

### Access to the service

The surgery was open from 8am to 12:30pm and from 1:30pm until 6:30pm on Monday to Friday. Appointments were available from 8.30am until 11 am and from 3pm to 6 pm on weekdays.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a local care home on a specific day each week, by a named GP and to those patients who needed one.

The practice had offered 4566 bookable appointments with a GP in the last three months. They had reviewed their Do Not Attend (DNA) rates. 4% were DNA. The nurse/health care assistant appointments offered were 2803. 9% were DNA. The practice continued to put information in the waiting room and text reminders to patients with mobile phones.

Patients we spoke with and comments cards we reviewed indicated that it was not easy to obtain an appointment and there was difficulty getting through on the telephone. Patients dissatisfaction with the system was reflected in the data from the January 2015 national survey.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

For example:

- 68% were satisfied with the practice's opening hours compared to the CCG average of 73.% and national average of 76%.
- 59.% described their experience of making an appointment as good compared to the CCG average of 74% and national average of 74%.
- 48% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 64% and national average of 65.%.
- 52% said they could get through easily to the surgery by phone compared to the CCG average of 70% and national average of 74%.

Two people who we spoke with on the day of inspection described their frustration with the appointment system. They said getting through by telephone sometimes took 30 to 40 minutes. From the 11 completed comments cards there were seven with negative comments with regard to access. Most patients we spoke with and comments cards we reviewed were not satisfied with the appointments system and said it was not easy to get an appointment. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Staff we spoke with told us patients currently had to wait five weeks for a pre-bookable appointment.

We spoke with the management team with regard to telephone access and appointments. We were told that they had made a number of changes to the appointment system. We asked if the practice had consulted with patients to gain any insight into the problems they faced getting through by phone or getting an appointment but they had not.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The practice policy had been reviewed in January 2015 but had out of date information in regard to reporting a complaint to a primary care trust when it should now be a NHS England.

Information about the complaints system was not freely available to patients. There was no complaints poster or information displayed in the practice. A complaints procedure leaflet was available to patients once they identified to a staff member that they wished to make a complaint. We spoke with the management team who advised us they would ensure that information about how to make a complaint was readily available. Since our inspection the practice informed us they had put a complaints poster and information in the waiting area. Patients we spoke with were not aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had a complaints log. The practice had received 35 complaints in the last 12 months. 15 of these were issues with regard to getting an appointment. We looked at two complaints received in the last 12 months and found they had been dealt with appropriately and in a timely manner.

There was no process in place to review complaints annually in order to identify themes or trends. We did not see any evidence that learning from complaints had been disseminated to staff. Staff we spoke with were aware of the practice procedure for complaints. However they did not get information from the management team with regard to complaints received in the practice.

# Are services well-led?

Requires improvement

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

## Our findings

### Vision and strategy

The practice had a vision to provide high quality, safe, professional primary health care general practice services to their patients. To work in partnership with their patients, their families and carers towards a positive experience and understanding, involving them in decision making about their treatment and care.

We found details of the practice values included in the practice's statement of purpose. Further objectives were to continue plans for a new build in an area close to the current premises. They were in the process of employing another GP partner. They also had plans to increase the number of nursing hours for chronic disease management.

We spoke with 14 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and were keen to be involved in developing them.

### Governance arrangements

The governance arrangements in place at the time of our inspection had not ensured risk assessments had been carried out in the areas of South Wigston Health Centre used by practice. They had not ensured that they were aware of any potential risks to patients, staff and visitors and planned any mitigating actions to reduce the possibility of harm for example, general health and safety, business continuity, fire safety, legionella and location of emergency equipment and medicines. Since the inspection the practice have carried out risk assessment, commenced a risk log and added an item to the partner meeting agenda.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 17 of these policies. Not all policies and procedures we looked at had been reviewed regularly. We saw evidence of policies in place but not in all areas of practice activity, for example, cold chain policy, legionella or a comprehensive infection and prevention policy.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead GP for infection control and two GP partners were the leads for safeguarding. We spoke with 14 members of staff and they were all clear about their own roles and responsibilities. Most staff told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. QOF data was not regularly discussed at monthly team meetings therefore action plans were not produced to maintain or improve outcomes.

The practice did not have a clear or robust system for reporting, recording and monitoring significant events. There was no policy in place for dealing with significant events. There was a log of significant events that had occurred during the last year. However the log did not document a summary of key learning points and actions to be taken. The practice had not documented who the actions were for or a date that the actions had to be completed by. Significant events were not reviewed to detect themes or trends which were not in line with the practice. Since the inspection we have been informed by the practice that they have arranged regular practice meetings where complaints and SEAs will be discussed every six weeks with all the staff. A protected learning event will take place in October 2015 and will be used to discuss such events with the whole practice team in order to share learning. Minutes of partners meetings will be available for all staff.

South Wigston Health Centre had not carried out any infection control audits to identify any improvements or actions for the external company who undertake the cleaning in the practice. Minutes of practice meetings we looked at did not show that infection control was discussed. We spoke with the infection control lead. He told us he had recently taken on the role. He had not undertaken any training to enable him to provide advice on

# Are services well-led?

Requires improvement

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

the practice infection control policy and carry out staff training. Since the inspection the lead GP has undertaken blue stream academy training. A member of staff has been identified to support him.

We found that some equipment had not undergone calibration tests since 2013. There were no records to confirm when appliances and equipment such as scales had routinely undergone servicing and calibration to ensure accuracy of readings. Since the inspection the practice have had all equipment calibrated and commenced an appliance and equipment log.

The emergency equipment and medicines were not in a secure area of the practice. Since the inspection the practice have a carried out a risk assessment and moved the equipment and medicines to a secure area of the practice.

The practice did not have an on-going programme of clinical audits to use to monitor quality and systems to identify where action should be taken.

The practice used locum GPs on a regular basis but did not have a policy and appropriate procedures in place relating to this. We spoke to the registered manager who told us they relied on the agency to provide appropriate information but did not check that the information was correct and training was up to date.

The practice did not hold monthly staff meetings where governance issues where performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff electronically on any computer within the practice.

### Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that most were approachable and always take the time to listen to all members of staff. However some staff told us that they were not involved in discussions about how to run the practice and how to develop the practice. Staff went on to say that they would like to have the opportunity to improve the service delivered by the practice.

There were some elements of the practice in which leadership was clear, for example, safeguarding and involvement with external bodies. However there were areas in which leadership was less clear such as the monitoring of risks and monitoring of service provision, for example, lack of robust systems in place for management of risk, maintenance of equipment and staff appraisals.

Staff we spoke with however felt clear about their own roles and responsibilities and who to go to at the practice if they had any questions.

The practice did not hold regular team meetings. Staff we spoke with were not aware of what took place within the practice, for example, significant events, or complaints

Although some staff told us they felt supported and had received training there were no robust systems in place in terms of training and appraisal.

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

The practice encouraged feedback from patients. It had an active patient reference group (PRG) and gathered feedback from patients through the PRG surveys and complaints received.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. This reflected that 66% of patients rated the practice good. The results and actions agreed from these surveys were available on the practice website. We spoke with one member of the PRG and they were very positive about the role they played and told us they felt engaged with the practice. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The practice had not gathered feedback from staff as the practice did not hold regular team meetings. However some staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

# Are services well-led?

Requires improvement

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

### Management lead through learning and improvement

The practice did not have an appraisal policy in place to provide guidance to staff. Staff we spoke with confirmed that they had not had an appraisal for at least two years and in one case over five years therefore staff may not have had the opportunity to update and improve their knowledge and skills. We spoke with the registered manager who told us he planned to implement formal appraisals this year.

Some staff we spoke with said they felt supported by the practice and were happy in their job roles, other said they were asked to undertake tasks that exceeded their knowledge and competence. Most staff felt there could be more regular meetings to enable information to be shared.

The practice was a GP training practice.

We saw limited evidence that information about the service was used in ways to develop and improve the service provided to patients. For example through learning from investigating significant events and complaints.

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<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br><br>We found that the registered person did not have a robust system in place for incidents that affect the health, safety and welfare of people using services must be reported internally and to relevant external authorities/bodies. They must be reviewed and thoroughly investigated by competent staff, and monitored to make sure that action is taken to remedy the situation, prevent further occurrences and make sure that improvements are made as a result. Staff who were involved in incidents should receive information about them and this should be shared with others to promote learning. Incidents include those that have potential for harm.<br><br>We found that the registered person had not done all that was reasonably practicable to mitigate risks. They should follow practice guidance and must adopt control measures to make sure the risk is as low as is reasonably possible, They should review methods and measures and amend them to address changing practice. Providers should use risk assessments about the health, safety and welfare of people who sue their services to make required adjustments. For example, risk assessments for, legionella, legionella water checks, general office environment, disclosure and barring (DBS) and control of substances hazardous to health (COSHH), infection control and fire safety.<br><br>The registered person must comply with relevant Patient Safety Alerts, recalls and rapid response reports issued from the Medicines and Healthcare Products Regulatory Agency (MHRA) and through the Central Alerting System (CAS).<br><br>The registered person did not have a system in place to ensure an appropriate standard of cleanliness and infection control, for example, checks on cleaning standards and infection control audits. |

This section is primarily information for the provider

# Compliance actions

The registered person did not have arrangements to take appropriate action if there is a clinical or medical emergency. For example, a robust disaster handling and business continuity plan with identified risks rated and mitigating actions recorded to reduce and manage the risk. Storage of emergency equipment and medicines.

The registered person must ensure that any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation. For example, no themes or trends identified and learning was not shared with staff.

This was in breach of 12 (2) (b) (f) (h) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>We found that the registered person did not have records relating to the management of regulated activities relevant to the planning and delivery of care and treatment. This included governance arrangements such as policies and procedures. For example, significant events, infection control, cold chain, needlestick injury and legionella. Nurse protocols were also out of date.<br><br>The registered person did not operate effective systems and processes to make sure they assess and monitor their service against Regulations 4 to 20A of Part 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended). The provider must have a process in place to make sure this happens at all times and in response to the changing needs of people who use the service. For example, patient comments and complaints re appointment system and getting through to the practice by telephone.<br><br>This was in breach of Regulation 17 (1) (2) (a) (b) (d) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). |

This section is primarily information for the provider

# Compliance actions

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>Persons employed by the service provider in the provision of a regulated activity must:-<br>receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform,<br>This was in breach of Regulation 18 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014). |

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>The registered person did not have a system in place to demonstrate that potential employees were:-<br>a) be of good character,<br>(b) have the qualifications, competence, skills and experience which are necessary for the work to be performed by them, and<br>(c) be able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the work<br>for which they are employed. For example, appropriate checks, such as registration with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) had been carried out prior to employing staff and after to ensure registration was maintained.<br>This was in breach of Regulation 19 1(a)(b) and 4 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) |