Wallis Avenue

Quality Report

The Surgery Wallis Avenue
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Date of inspection visit: 6 and 11 May 2015
Date of publication: 27/08/2015

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?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
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 of Wallis Avenue (also known as Wallis Avenue Surgery) on 6 and 11 May 2015. The inspection was carried out over two days as there was insufficient time to establish enough information in one day. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing caring and responsive services. It required improvement for providing safe, effective and well-led services which has led to this rating being applied to all patient population groups; older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed but not always addressed.
- Not all risks to patients were assessed and well managed.
- Patient's needs were assessed and care was planned and delivered in line with current legislation. Staff had received some training appropriate to their roles. However, not all training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. Staff treated patients with kindness and respect, and maintained confidentiality.
- Patients said they experienced few difficulties when making appointments and urgent appointments were available the same day.

Summary of findings

- There was a leadership structure but not all staff felt supported by management. The practice took into account the views of patients and those close to them as well as engaging with staff when planning and delivering services.

However, there were areas of practice where the provider needs to make improvements.

Importantly the provider must;

- Ensure all staff are up to date with relevant training and trained to the appropriate level.
- Review infection control management to ensure all areas of the practice are clean and comply with national infection control guidance.
- Review risk assessment activity to include all risks to patients.
- Review the accuracy and reliability of systems used to measure performance including the completion of clinical audit cycles.
- Revise its governance processes and ensure that all documents used to govern activity are up to date and followed in practice.

The provider should also;

- Review medicines management records.
- Review information about the practice and ensure it is accessible to all patients when the practice is closed.

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 safe. The practice was unable to demonstrate it was fully compliant with national guidance on infection control. Wallis Avenue Surgery had systems to monitor, maintain and improve safety and demonstrated a culture of openness to reporting and learning from patient safety incidents. The practice had policies to safeguard vulnerable adults and children who used services. However, staff were not trained to the appropriate level in safeguarding and the practice was unable to demonstrate that locum GPs employed through an agency were up to date with safeguarding training. They monitored safety and responded to some identified risks. There were systems for medicines management. Sufficient numbers of staff with the skills and experience required to meet patients' needs were employed, although the practice relied heavily on regular locum staff to fill the shortfall in permanent staff. There was enough equipment to enable staff to care for patients. The practice had plans to deal with foreseeable emergencies but not all staff had up to date basic life support training. The practice was unable to demonstrate that locum staff employed through an agency had up to date basic life support training.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services. Staff at the Wallis Avenue Surgery referred to guidance from the National Institute for Health and Care Excellence (NICE) and had systems to monitor, maintain and improve patient care. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice was unable to demonstrate plans to carry out clinical audit cycles to improve the service. The practice Quality and Outcomes Framework (QOF) data was inaccurate and unreliable. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. Staff had received training appropriate to their roles. However, not all staff were up to date with mandatory training such as infection control training. There was evidence of appraisals and personal development plans, or plans to carry these out, for all staff. The practice had not always followed its own policy when carrying out staff disciplinary action. Staff worked with multidisciplinary teams. There was a backlog of paper communications dating back to 2012 that the practice had received that had yet to be scanned into their patient records system.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice equal to others for several aspects of care. Patients were satisfied with the care provided by Wallis Avenue Surgery and were treated with respect. Staff were careful to keep patients' confidential information private and maintained patients' dignity at all times. Patients were supported to make informed choices about the care they wished to receive and felt listened to.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was responsive to patients' individual needs such as language requirements and mobility issues. Access to services for all patients was facilitated in a wide variety of ways, such as routine appointments with staff at Wallis Avenue Surgery and home visits. The practice provided an on-line booking service for appointments and repeat prescriptions. Patients could get information about how to complain in a format they could understand and the practice demonstrated that learning from complaints and action as a result of complaints had taken place.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services. There was a leadership structure with named members of staff in lead roles. However, the lead GP was not always visible in the practice. The practice used a variety of policies and other documents to govern activity. However, the practice was unable to demonstrate that they had a system to help ensure all governance documents were kept up to date. The practice held meetings where governance issues were discussed. However, the practice was unable to demonstrate how results of clinical audits were shared with relevant staff. The practice took into account the views of patients and those close to them as well as engaging staff when planning and delivering services. However, the practice was unable to demonstrate they had an action plan to address any of the suggestions for improvements or changes identified by the 2014 patient survey. Practice systems had failed to identify and reduce risks associated with infection control and the backlog of paper communications received.

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 overall rating applies to everyone using the practice, including this patient population group. Patients over the age of 75 had been allocated a dedicated GP to oversee their individual care and treatment requirements. Patients were able to receive care and treatment in their own home from practice staff as well as district nurses and palliative care staff. There were plans to help avoid older patients being admitted to hospital unnecessarily. Specific health promotion literature was available as well as details of other services for older people. The practice held regular multi-professional staff meetings that included staff who specialised in the care of older people.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The overall rating applies to everyone using the practice, including this patient population group. Service provision for patients with long-term conditions included dedicated clinics with a recall system that alerted patients as to when they were due to re-attend. The practice employed staff trained in the care of patients with long-term conditions. The practice supported patients to manage their own long-term conditions. Specific health promotion literature was available.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The overall rating applies to everyone using the practice, including this patient population group. Services for mothers, babies, children and young people at Wallis Avenue Surgery included access to midwives and health visitor care. Specific health promotion literature was available. The practice held regular multi-professional staff meetings that included staff who specialised in the care of mothers, babies and children.

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 overall rating applies to everyone using the practice, including this patient population group. The practice provided a variety of ways this patient population group could access primary medical

Summary of findings

services. These included appointments from 8.30am to 12noon and 3pm to 6.30pm Monday to Friday. Appointments and repeat prescriptions could be accessed on-line. Specific health promotion literature was available.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people living in vulnerable circumstances. The overall rating applies to everyone using the practice, including this patient population group. The practice offered primary medical service provision for people in vulnerable circumstances in a variety of ways. Patients not registered at the practice could access services and interpreter services were available for patients whose first language was not English. Specific health promotion literature was available. Specific screening services were also available.

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 overall rating applies to everyone using the practice, including this patient population group. This patient population group had access to psychiatrist and community psychiatric nurse services as well as local counselling services. Specific health promotion literature was available. The practice held regular multi-professional staff meetings that included staff who specialised in the care of patients experiencing poor mental health.

Summary of findings

What people who use the service say

During our inspection we spoke with six patients who told us they were satisfied with the care provided by the practice. They considered their dignity and privacy had been respected and that staff were polite, friendly and caring. They told us they felt listened to and supported by staff, had sufficient time during consultations and felt safe. They said the practice was well managed, clean as well as tidy and they experienced few difficulties when making appointments. Patients we spoke with reported they were aware of how they could access out of hours care when they required it as well as the practice's telephone consultation service.

We looked at 22 patient comment cards. Nineteen comments were positive about the service patients experienced at Wallis Avenue. Patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. Three comments were less positive but there were no common themes to these.

We looked at the NHS Choices website where patient survey results and reviews of Wallis Avenue Surgery were available. Results ranged from 'among the worst' for the percentage of patients who would recommend this practice, through 'average' for scores for consultations with doctors and nurses. The GP patient survey score for opening hours was 56% and 40% of patients rated their ability to get through on the telephone as very easy or easy. Forty four percent of patients rated this practice as good or very good.

Areas for improvement

Action the service MUST take to improve

- Ensure all staff are up to date with relevant training and trained to the appropriate level.
- Review infection control management to ensure all areas of the practice are clean and comply with national infection control guidance.
- Review risk assessment activity to include all risks to patients and ensure clinical audit cycles are completed.
- Review the accuracy and reliability of systems used to measure performance including the completion of clinical audit cycles.
- Revise its governance processes and ensure that all documents used to govern activity are up to date and followed in practice.

Action the service SHOULD take to improve

- Review medicines management records.
- Review information about the practice and ensure it is accessible to all patients when the practice is closed.

Wallis Avenue

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a second CQC Inspector.

Background to Wallis Avenue

Wallis Avenue Surgery is situated in Maidstone, Kent and has a registered patient population of approximately 3,500.

The practice staff consist of one GP (female), one acting practice manager, one practice nurse (female), one healthcare assistant (female) as well as administration and reception staff. The practice also employs locum GPs directly and through locum agencies. There is a reception and a waiting area on the ground floor. All patient areas are accessible to patients with mobility issues as well as parents with children and babies.

The practice is not a training or teaching practice (teaching practices take medical students and training practices have GP trainees and F2 doctors).

The practice has a general medical services (GMS) contract with NHS England for delivering primary care services to local communities.

Primary medical services are provided Monday to Thursday between the hours of 8.30am to 12noon and 3pm to 6pm, and Friday 8.30am to 6pm. Extended hours surgeries are offered Monday 6.30pm to 8.15pm. Primary medical services are available to patients registered at Wallis Avenue Surgery via an appointments system. There are a range of clinics for all age groups as well as the availability of specialist nursing treatment and support. There are arrangements with other providers (the 111 service and IC24) to deliver services to patients outside of surgery hours.

We carried out an unannounced, focussed inspection of Wallis Avenue Surgery on 3 November 2015 as we had received concerning information about the practice. We did not inspect against all elements of the domains at that time and, therefore, were not able to give an overall rating. The inspection found that there were areas of practice where the provider needed to make improvements. These were;

- Ensure that they have an appropriate process for assessing and monitoring the needs of patients and planning their care to meet individual needs
- Review the process of administration staff writing out prescriptions for patients without them being seen or assessed by a GP
- Have a process for investigating and learning from complaints
- Ensure they have risk assessed the way patient records are stored to help ensure that confidential information is not accessible to anyone but relevant practice staff
- Risk assess all staff roles that do not have criminal records checks
- Ensure that all staff have relevant health checks and all information relevant to safe recruitment is recorded in staff files
- Ensure that all staff have regular appraisals and access to appropriate training
- Ensure that there are appropriate processes to asses and monitor risks as well as services.

Additionally the inspection found that the provider should improve access to appointments for patients and improve the process for making appointments for being seen on the same day.

Detailed findings

Services are provided from The Surgery, Wallis Avenue, Maidstone, Kent, ME15 9JJ, only.

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 received a comprehensive inspection before and that was why we included them.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as NHS England, the local clinical commissioning group, the Local Medical Committee and the local Healthwatch, to share what they knew. We carried out announced visits on 6 and 11 May 2015. The inspection was carried out over two days as there was insufficient time to establish enough information in one day. During our visit we spoke with a range of staff (two GPs, the acting practice manager, one practice nurse, one healthcare assistant, one administrator and one receptionist) and spoke with six patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risk and improve quality regarding patient safety. For example, reported incidents and accidents, national patient safety alerts as well as comments and complaints received. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, an incident where a patient was prescribed the wrong dosage of a blood thinning medicine had been reported, investigated and the outcome discussed with staff so that they were aware of the practice systems to reduce the risk of this happening again.

We reviewed safety records and incident reports for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system for reporting, recording and monitoring incidents, accidents and significant events. We reviewed records of three significant events that had occurred in the last 12 months and saw this system was followed appropriately. All reported incidents, accidents and significant events were managed by designated staff. Staff told us that feedback from investigations was discussed at significant event meetings and records confirmed this.

The practice produced an annual report of significant incidents that had taken place at Wallis Avenue Surgery. Staff told us that the report described the incident, the action taken as well as the learning implemented and records confirmed this. For example, an urgent fax received by the practice before lunch time had not been shown to a GP in a timely manner. The practice's system of dealing with urgent information received had been revised and all staff informed of the revised system by memorandum to reduce the risk of this happening again.

National patient safety alerts were disseminated electronically as well as in paper form to practice staff.

Reliable safety systems and processes including safeguarding

The practice had systems to safeguard vulnerable adults and children who used services. There was written information for safeguarding vulnerable adults and children as well as other documents readily available to staff that contained information for them to follow in order to recognise potential abuse and report it to the relevant safeguarding bodies. For example, a safeguarding policy for children and young persons. Contact details of relevant safeguarding bodies were available for staff to refer to if they needed to report any allegations of abuse of vulnerable adults or children. The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children. However, they were not trained to the appropriate level (level three). Records showed they were trained only to level two in safeguarding. All staff we spoke with were aware of the dedicated appointed lead in safeguarding as well as the practice's safeguarding policies and other documents. Permanent staff told us they were up to date with training in safeguarding and records confirmed this. However, the practice was unable to demonstrate that locum GPs employed through an agency were up to date with safeguarding training. When we spoke with staff they were able to describe the different types of abuse patients may have experienced as well as how to recognise them and how to report them.

The practice had a whistleblowing policy that contained relevant information for staff to follow that was specific to the service. The policy detailed the procedure staff should follow if they identified any matters of serious concern. The policy contained the names and contact details of external bodies that staff could approach with concerns, such as the General Medical Council. All staff we spoke with were able to describe the actions they would take if they identified any matters of serious concern and most were aware of this policy.

The practice had a monitoring system to help ensure staff maintained their professional registration. For example, professional registration with the General Medical Council or Nursing and Midwifery Council. We looked at the practice records of four clinical members of staff which confirmed they were up to date with their professional registration.

Records demonstrated all relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check) or an assessment of the potential risks involved in using those staff without DBS clearance.

Requires improvement

Are services safe?

The practice had a chaperone policy and information about it was displayed in public areas informing patients that a chaperone would be provided if required. (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). Patients we spoke with told us they were aware this service was available at the practice. Records showed that staff who acted as chaperones had received training to do so or were due to attend such training in the near future.

Medicines management

Wallis Avenue Surgery had documents that guided staff on the management of medicines such as a repeat prescribing policy. Staff told us that they accessed up to date medicines information and clinical reference sources when required via the internet and through published reference sources such as the British National Formulary (BNF). The BNF is a nationally recognised medicines reference book produced by the British Medical Association and Royal Pharmaceutical Society. There was a GP lead in prescribing and the practice received input from the local clinical commissioning group's pharmacy advisor.

Patients were able to obtain repeat prescriptions either in person or by completing paper repeat prescription requests as well as on-line. Patients' medicines reviews were carried out during GP appointments and during dedicated clinic appointments such as asthma clinics.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Medicines and vaccines were stored securely in areas accessible only by practice staff. The practice did not hold any controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The practice kept records of the ordering and receipt of medicines. However, inventories of medicines and vaccines held were not maintained. Staff told us that stock levels and expiry dates of medicines and vaccines held were not routinely audited, although they said that the expiry date of all medicines were checked before staff administered them to patients. Medicines and vaccines that we checked were within their expiry date and fit for use.

Appropriate temperature checks for refrigerators used to store medicines and vaccines had been carried out and records of those checks were made.

The practice nurse administered vaccines using directions that had been produced in line with legal requirements and national guidance. Records showed that staff had received appropriate training to administer vaccines.

Cleanliness and infection control

The premises were generally tidy. Patients we spoke with told us they always found the practice clean and had no concerns regarding cleanliness or infection control at Wallis Avenue. There was carpet on the floor of some clinical rooms where invasive procedures were carried out. The carpet was porous and therefore cleaning may not always be effective. Carpets in one clinical room and some communal areas of the practice were stained and there were no records to demonstrate that the practice had plans to clean them other than vacuuming. Chairs in some clinical rooms were cloth covered and some contained tears in the fabric. Staff told us these were cleaned between patients with hard surface cleaning products. However, as the material was porous and not intact cleaning would not always be effective. An audit carried out on 29 April 2015 had identified some of these infection control issues. However, the practice was unable to demonstrate they had an action plan to address the issues identified by the audit.

Antibacterial gel was available throughout the practice for staff and patients to use. Antibacterial hand wash, paper towels and posters informing staff how to wash their hands were available at all clinical wash-hand basins in the practice. Some clinical wash-hand basins at the practice did not comply with Department of Health guidance. For example, some clinical wash-hand basins contained overflows and plugs. There was, therefore, a risk of cross contamination when staff used them. Staff told us that the practice had plans to replace these clinical wash-hand basins and address other issues, such as tears to cloth covered chairs during future refurbishment. However, there were no records available to confirm these plans and no risk assessment had been carried out or action plans made to reduce the risk of infection.

The practice had infection control policies that contained procedures for staff to refer to in order to help them follow

the Code of Practice for the Prevention and Control of Health Care Associated Infections. The code sets out the standards and criteria to guide NHS organisations in planning and implementing control of infection.

The practice had an identified infection control lead. The practice was unable to demonstrate that all relevant members of staff were up to date with infection control training. We looked at the training records of five clinical members of staff and only two contained records of up to date infection control training.

Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use.

There was a system for safely handling, storing and disposing of clinical waste. This was carried out in a way that reduced the risk of cross contamination. Clinical waste was stored securely in locked, dedicated containers whilst awaiting collection from a registered waste disposal company.

Cleaning schedules were used and there was a supply of approved cleaning products. Records were kept of domestic cleaning carried out in the practice and audits of domestic cleaning were undertaken. Staff told us that they cleaned equipment such as an examination couch, between patients but did not formally record such activity.

The practice had a system that monitored and recorded the hepatitis B status of GPs and nurses at Wallis Avenue Surgery.

The practice had a system for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). There was a risk assessment and action plan that included regular testing to help reduce the risk of infection to staff and patients from legionella. Records confirmed that this testing had been carried out regularly by practice staff.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment (including clinical equipment) was tested, calibrated and maintained regularly and there were equipment maintenance logs and other records that confirmed this.

Staffing and recruitment

The practice had policies and other documents that governed staff recruitment. For example, a recruitment policy. Personnel records contained evidence that appropriate checks had been undertaken prior to employment. For example, proof of identification, references and interview records.

Records demonstrated all relevant staff had Disclosure and Barring Service (DBS) clearance (a criminal records check) or an assessment of the potential risks involved in using those staff without DBS clearance.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Locum GPs were employed directly and via a locum agency to cover vacancies and the GP's planned leave such as annual leave. Part time staff covered each other's leave to help ensure the practice had sufficient staff at all times. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However, the practice relied heavily on the employment of locum GPs to meet the shortfall in permanent medical staff.

Monitoring safety and responding to risk

The practice had a health and safety policy to help keep patients, staff and visitors safe. Health and safety information was displayed for staff to see and the practice had a designated health and safety representative.

There was a record of identified risks and action plans to manage or reduce risk. A fire risk assessment had been undertaken that included actions required in order to maintain fire safety. Permanent staff told us they had received fire safety training and records confirmed this. However, the practice was unable to demonstrate that locum GPs employed directly or through an agency were up to date with fire safety training.

Staff told us there were a variety of systems to keep them, and others, safe whilst at work. They told us they had the ability to activate an alarm via the telephone system to summon help in an emergency or security situation.

Requires improvement

Are services safe?

There was a system governing security of the practice. For example, visitors were required to sign in and out using the designated book in reception. Non-public areas of the practice were secured with coded key pad locks to help ensure only authorised staff were able to gain access.

The wheelchair accessible patient toilet at Wallis Avenue Surgery was equipped with an alarm so that help could be summoned if required and baby changing facilities were available.

Arrangements to deal with emergencies and major incidents

There were documents that guided staff in dealing with medical emergency situations. For example, anaphylactic reactions: treatment of adults and children in the community. However, these were out of date and did not reflect current national guidance.

Records confirmed that all permanent clinical staff were up to date with basic life support training. However, one member of administration staff had not received basic life support training and the practice was unable to demonstrate that locum staff employed through an agency were up to date with basic life support training.

Emergency equipment was available in the practice, including access to emergency medicines, medical oxygen and an automated external defibrillator (AED) (used to attempt to restart a person's heart in an emergency). Staff told us that these were checked regularly and records confirmed this.

There was a business and service continuity plan document that indicated what the practice would do in the event of situations such as a temporary or prolonged power cut and loss of the practice premises due to fire.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly 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 Clinical Excellence (NICE) and from local commissioners. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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 regular intervals to help 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 GP told us they led in specialist clinical areas such as diabetes, heart disease as well as asthma and the practice nurse and healthcare assistant 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. GPs told us this supported all staff to review and discuss best practice guidelines, such as the management of respiratory disorders, and records confirmed this.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to help ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to help ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with clinical staff showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of each patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected, monitored and 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, managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

Staff told us the practice had a system for completing clinical audit cycles. For example, an inadequate smear tests audit for the period 1 April 2014 to 31 March 2015. Records demonstrated analysis of its results. An action plan was not required as only one smear test out of 173 was found to be inadequate. However, the practice was unable to demonstrate plans to repeat the audit to complete a cycle of clinical audit. Staff told us that one other clinical audit, a medicine audit, had been carried out in the last 12 months at Wallis Avenue Surgery. This also failed to demonstrate plans to repeat the audit and complete a cycle of clinical audit.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice. The 2013 / 2014 QOF data for this practice showed it was performing in line with national standards. A probity check was carried out on behalf of NHS England by the Probity Department of the Kent Primary Care Agency on 9 May 2014 to provide assurance that the points achieved at the year-end QOF submission by Wallis Avenue Surgery could be verified by supporting documentation at the practice. It was expected that 100% verification would be achieved for each indicator tested. However, the report showed that none of the 15 indicators tested confirmed 100% achievement. The practice QOF data was therefore inaccurate and unreliable.

The practice's prescribing rates were similar to national figures with the exception of one group of antibacterial prescription items. The practice attributed this exception to the fact they cared for 89 patients in a local nursing home

who required the prescription of these items. Staff followed national guidance for repeat prescribing. They regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as coronary obstructive pulmonary disease (a breathing problem) and that the latest prescribing guidance was being used.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities, dementia and those on the mental health register. Structured annual reviews were undertaken for patients with long-term conditions. For example, diabetes.

Effective staffing

Practice staffing included medical, nursing, managerial and administration staff. We reviewed staff training records and saw that not all staff were up to date with attending mandatory courses such as annual basic life support. Staff underwent induction training on commencement of employment with the practice. The GPs were up to date with their yearly continuing professional development requirements and either had plans to be revalidated or had been revalidated. (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 practice and remain on the performers list with NHS England).

The practice had a staff appraisal system that identified learning needs from which action plans were documented. The practice had processes to identify and respond to poor or variable practice including policies such as the alcohol misuse policy and the sickness absence reporting policy. Records demonstrated that the practice had appropriately managed the poor performance of a member of locum staff recently. However, other records showed that the practice had not followed its own policy when carrying out disciplinary action in relation to another member of staff.

Permanent staff had job descriptions outlining their roles and responsibilities as well as providing evidence that they were trained appropriately to fulfil these duties. For example, the practice nurse was trained in the administration of vaccinations. However, the practice was unable to demonstrate that locum GPs employed directly or via an agency had job descriptions. Those with extended roles, such as nurses carrying out reviews of patients with long-term conditions (for example, asthma), were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with midwives, health visitors and community nursing teams to deliver care to patients. Records confirmed that multi-disciplinary meetings took place in order to discuss and plan patient care that involved staff from other providers.

The practice also worked with district nurses and palliative care services to deliver end of life care to patients.

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. However, there was a backlog of paper communications that the practice had received dating back to 2012 that had yet to be scanned into the system. The practice was unable to demonstrate how this backlog of communication paperwork was being addressed or the timeframe by which it would be scanned into their system. There was no assessment of the risks associated with such a large volume of correspondence awaiting scanning.

Staff told us that all paper documentation awaiting scanning had been seen by relevant clinical staff, acted upon and a note made in the patient's records. We checked six documents that were waiting to be scanned into the system and found notes indicating that clinical staff had seen the correspondence, acted upon it and a note was made in the patient's record for five of them. The remaining document was a blood result that required action by the practice. Staff told us that the correct action had been taken in response to the correspondence received but no note of the action had been recorded in the patient's records.

The practice had a system to refer patients to other services such as hospital services or specialists.

Requires improvement

Are services effective?

(for example, treatment is effective)

Staff told us that there was a system to review and manage blood results on a daily basis. Results that required urgent attention were dealt with by the GP at the practice promptly, and out of hours doctors as well as palliative care staff were involved when necessary.

Information sharing

Relevant information was shared with other providers in a variety of ways to help ensure patients received timely and appropriate care. For example, staff told us the practice met regularly with other services, such as hospice staff, to discuss patients' needs.

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the local GP out of hours provider to help enable patient data to be shared in a secure and timely manner. There was a system for sharing appropriate information for patients with complex needs with the ambulance and out of hours services.

Consent to care and treatment

The practice had a consent protocol and procedural documents that governed the process of patient consent and guided staff. The policy described the various ways patients were able to give their consent to examination, care and treatment as well as how that consent should be recorded.

Staff told us that they obtained either verbal or written consent from patients before carrying out examinations, tests, treatments, arranging investigations or referrals and delivering care. They said that parental consent given on behalf of children was documented in the child's medical records. Most staff had received formal training on the Mental Capacity Act 2005. Staff we spoke with were able to describe how they would manage the situation if a patient did not have capacity to give consent for any treatment they required. Staff also told us that patients could withdraw their consent at any time and that their decisions were respected by the practice.

Health promotion and prevention

All new patients registering with the practice were offered a health check. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture amongst clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic smoking cessation advice to smokers.

Specific health promotion literature was available for all patient population groups such as shingles vaccination information for older patients, respiratory organisation information for patients with long-term breathing problems, information about whooping cough immunisation for pregnant women and baby immunisation guidance for parents, alcohol and drugs recovery services details, details about how to recognise signs and symptoms of tuberculosis as well as treatment (this information was also available in other languages) and contact details of a dementia charity for patients who were worried about their memory.

The practice provided dedicated clinics for patients with certain conditions such as diabetes and asthma. Staff told us these clinics helped enable the practice to monitor the on-going condition and requirements of these groups of patients. They said the clinics also provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration. Patients who used this service told us that the practice had a recall system to alert them when they were due to re-attend these clinics.

Patients told us they were able to discuss any lifestyle issues with staff at the practice. For example, issues around eating a healthy diet or taking regular exercise. They said they were offered support with making changes to their lifestyle. For example, referral to a smoking cessation service.

The practice offered a full range of immunisations for children, travel vaccines and influenza vaccinations in line with current national guidance. Child immunisation rates were slightly higher than the national average at Wallis Avenue. Influenza vaccination rates for patients aged 65 years and over was slightly below national averages. For patients aged 6 months to 65 years in the defined influenza clinical risk groups indicators were slightly above national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We looked at the NHS Choices website where patient survey results and reviews of Wallis Avenue were available. Results ranged from 'among the worst' for the percentage of patients who would recommend this practice, through 'average' for scores for consultations with doctors and nurses. The GP patient survey score for opening hours was 56% and 40% of patients rated their ability to get through on the telephone as very easy or easy. Forty four percent of patients rated this practice as good or very good.

We looked at 22 patient comment cards. Nineteen comments were positive about the service patients experienced at Wallis Avenue. Patients indicated that they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said that staff treated patients with dignity and respect. Patients had sufficient time during consultations with staff and felt listened to as well as safe. Three comments were less positive but there were no common themes to these.

We spoke with six patients, all of whom told us they were satisfied with the care provided by the practice and that their dignity and privacy had been respected. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained whilst they undressed / dressed and 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.

The practice had documents that guided staff in order to keep patients' private information confidential. For example, the confidentiality policy and the information governance policy.

Incoming telephone calls answered by reception staff and private conversations between patients and reception staff that took place at the reception desk could be overheard by others. However, when discussing patients' treatments staff were careful to keep confidential information private. Staff told us that a private room was available near the reception desk should a patient wish a more private area in which to discuss any issues.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The acting practice manager told us they would investigate these and any learning identified would be shared with staff.

Patients' records were in electronic and paper form. Records that contained confidential information were held in a secure way so that only authorised staff could access them.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively 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, the proportion of respondents to the GP patient survey who stated that the last time the saw or spoke with a nurse, the nurse was good or very good at involving them in decisions about their care was marginally below the national average.

Patients told us health issues were discussed with them and they felt involved in decision making about the care and treatment they chose to receive. Patients told us they felt listened to and supported by staff and had sufficient time during consultations in order to make an informed decision about the choice of treatment they wished to receive.

Patient/carer support to cope emotionally with care and treatment

Timely support and information was provided to patients and their carers to help them cope emotionally with their care, treatment or condition. Literature was available in the practice such as information about a support group for carers.

The patient survey information we reviewed showed patients were less positive about the emotional support provided by the practice and rated less than average in this area. For example, the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke with a GP, the GP was good or very good at treating them with care and concern, was below the national average. The proportion of respondents to the GP patient

Good

Are services caring?

survey who stated that the last time they saw or spoke with a nurse, the nurse was good or very good at treating them with care and concern, was also below the national average.

The patients we spoke with on the day of our inspection and the comment cards we received were not consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

The practice supported patients to manage their own health, care and wellbeing and to maximise their independence. Specialised clinics provided the practice with the opportunity to support patients to actively manage their own conditions and prevent or reduce the risk of complications or deterioration.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GP partner, as the only permanent GP at the practice, had been allocated as the dedicated GP to oversee patients' care and treatment requirements. This included patients over the age of 75 years as well as patients with long-term conditions and poor mental health. Staff told us that patients over the age of 75 years were informed of this by letter. The practice held regular multi-disciplinary staff meetings that included staff from other services. For example, social services staff and those trained in the care of patients with dementia. Records confirmed this.

The practice employed staff with specific training in the care of all patient population groups. For example, one GP had extensive training in contraception management, nurses were trained in the care of patients with long-term conditions such as asthma, cervical screening, ear irrigation and immunisation / vaccination of all age groups. Other staff were trained in the care of patients with acute kidney injury, smoking cessation, Doppler studies (investigations of poor blood circulation) as well as wound care and were trained to give diet and nutrition advice. Records showed that the staff were competent to carry out electrocardiograms (electronic monitoring of the heart) and NHS Health Checks. Records showed the practice identified patients at high risk of admission to hospital and implemented care plans to reduce the risk and where possible avoid unplanned admissions to hospital.

Patients were able to receive care and treatment in their own home from practice staff as well as community based staff such as district nurses and palliative care staff. Staff external to the practice provided midwifery services to patients at Wallis Avenue Surgery.

Patients told us they were referred to other services when their condition required it. For example, one patient told us they were referred to the local hospital for treatment that the practice was not able to provide.

Tackling inequity and promoting equality

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 patient areas were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there was an access enabled toilet and baby changing facilities. There was a waiting area with space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us Wallis Avenue Surgery did not have any policies or guidance documents governing equality and diversity. However, they said that services were delivered in a way that took into account the needs of different patients on the grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation.

The practice maintained registers of patients with learning disabilities, dementia and those on the mental health register that assisted staff to identify them to help ensure their access to relevant services. All patients on the register with learning disabilities had received a physical health check within the last 12 months.

Staff told us that they did not have any patients who were homeless 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 vulnerability in individual patient records.

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 and dementia.

The practice had access to on-line and telephone translation services.

Access to the service

Primary medical services were available Monday to Friday between the hours of 8.30am to 12noon and 3pm to 6.30pm via an appointments system. Staff told us that patients could book appointments on-line, by telephoning the practice or by attending the reception desk in the practice. The practice did not provide a telephone consultation service but did carry out home visits if patients were housebound or too ill to visit Wallis Avenue Surgery. There was a range of clinics for all age groups and conditions as well as the availability of specialist nursing treatment and support. There were arrangements with another provider (the 111 service and IC24) to deliver services to patients when the practice was closed.

Continuity of care was provided to patients by one permanent GP, one permanent practice nurse and one

Good

Are services responsive to people's needs?

(for example, to feedback?)

permanent healthcare assistant conducting appointments. The practice employed regular locum GPs to cover appointment shortfalls, annual leave and staff sickness to help maintain continuity of care to patients. Patients we spoke with said they experienced few difficulties when making appointments and were happy with the continuity of care provided by Wallis Avenue Surgery.

The practice opening hours as well as details of how patients could access services outside of these times were available for patients to take away from the practice in written form. For example, in a practice leaflet. Although they were available on the practice's website they were not displayed on the front of the building. Patients who did not have access to the internet or who did not have a copy of the practice leaflet may not therefore be aware of the practice opening hours or how to access services when the practice was closed.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Timescales for dealing with complaints were clearly stated and details of the staff responsible for investigating complaints were given. Information for patients was available in the practice that gave details of the practice's complaints procedure and included the names and contact details of relevant complaints bodies that patients could contact if they were unhappy with the practice's response. Patients we spoke with were aware of the complaints procedure but said they had not had cause to raise complaints about the practice.

The practice had received 21 complaints in the last 12 months. Records demonstrated that complaints were investigated, complainants received a response to their complaint, the practice learned from the complaints it received and implemented changes when appropriate. We looked at three complaint records which demonstrated they were acknowledged and responded to within the timeframe stipulated in the practice's complaints policy.

Staff told us that complaints were discussed at staff meetings. Records confirmed this and demonstrated that learning from complaints and action as a result of complaints had taken place.

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

Wallis Avenue Surgery had a mission statement that set out its vision and strategy to meet patients' healthcare needs. Most staff were aware of the practice's mission statement and it was displayed in the waiting area.

Governance arrangements

There were documents that set out Wallis Avenue Surgery's governance strategy and guided staff. For example, an information governance policy. The GP was the clinical governance lead and clinical governance issues were discussed at staff meetings. For example, prescribing practices. There were a variety of policy, protocol, procedural and other documents that the practice used to govern activity. For example, the chaperone policy, the consent protocol, the complaints procedure as well as the business and service continuity plan. We looked at 21 such documents and saw that three were not dated so it was not clear when they were written or when they came into use. One of the documents had a review date of March 2015. This policy was therefore overdue for review. None of the remaining documents contained a planned review date. Two documents were dated 2001 and contained out of date guidance on the treatment of anaphylaxis (a severe life threatening allergic reaction). The practice was unable to demonstrate that they had a system to help ensure all governance documents were kept up to date.

There was a leadership structure with named members of staff in lead roles. For example, the GP had lead responsibilities such as safeguarding vulnerable adults and children. All staff we spoke with were clear about their own roles and responsibilities. Some staff we spoke with said they did not feel valued by the practice or able to contribute to the systems that delivered patient care.

Although the practice operated a clinical audit system that improved the service and followed up to date best practice guidance it was unable to demonstrate plans to repeat audits to complete cycles of clinical audit. Some clinical staff we spoke with were not aware if the practice carried out any clinical audits and the practice was unable to demonstrate how results of clinical audits were shared with relevant staff.

The practice identified, recorded and managed some risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. For example, a fire risk assessment. However, the practice had failed to identify risks associated with the backlog of paper communications it had received that had yet to be scanned into the patient records system. The practice had also failed to identify, record and manage some infection control risks in line with national guidance.

The practice demonstrated human resources practices such as comprehensive staff induction training. Staff told us that they received yearly appraisals and GPs said they carried out relevant appraisal activity that now included revalidation with their professional body at required intervals and records confirmed this. There was evidence in staff files of the identification of training needs and continuing professional development.

Leadership, openness and transparency

The lead GP was not always visible in the practice and staff told us that they were not always approachable and did not always take time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. However, some staff told us that suggestions for improvements put forward by staff were not acted upon.

Staff told us they felt well supported by colleagues at the practice. However, some staff said they did not always feel well supported by management. They said they were provided with opportunities to maintain skills as well as develop new ones in response to their own and patients' needs. However, they also said they were sometimes asked to carry out roles they had not been trained to do. When they pointed this out to practice management they were directed to obtain the training from other staff within the practice prior to carrying out the care.

The practice was working with the Local Medical Committee (LMC) and the local clinical commissioning group to improve aspects of leadership at the practice. For example, the LMC had arranged support for the acting practice manager from a practice manager from another local practice following this recommendation by NHS England.

Practice seeks and acts on feedback from its patients, the public and staff

Are services well-led?

Requires improvement

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

The practice took into account the views of patients and those close to them via feedback from the patient participation group (PPG), patient surveys, as well as comments and complaints received when planning and delivering services.

Minutes of the PPG meetings demonstrated regular discussions where comments and suggestions were put forward by members. Staff told us that comments and suggestions put forward at these meetings were considered by the practice and improvements made where practicable. In response to patients' feedback the practice had displayed the role and responsibilities of the PPG on the PPG notice board in the waiting room.

The practice carried out a patient survey in 2014 that canvassed opinion from all patient population groups. Results had been collated and identified positive aspects of the practice that patients would not want to be changed. For example, existing levels of privacy, quality of the nursing staff and the friendliness of staff whilst remaining professional during consultations. However, the practice was unable to demonstrate they had an action plan to address any of the suggestions for improvements or changes identified by the survey. For example, the lack of ability to book an appointment more than two weeks in advance.

The practice monitored comments and complaints left in reviews on the NHS Choices website. Fourteen reviews had been left on this website. Ten were positive and four were negative. Of the negative comments two related to difficulties in obtaining appointments and two related to poor staff attitude. The practice had responded to all of these reviews.

There were a variety of meetings held in order to engage staff and involve them in the running of the practice. For example, clinical meetings, multidisciplinary meetings and staff meetings. Some staff we spoke with told us they did not always feel valued by the practice management and although it was possible to make suggestions for improvements to the systems that delivered patient care none had been implemented. However, minutes of staff meetings demonstrated that staff suggestions were supported. For example, one member of staff suggested attending a prescribing course to enhance patient care and the practice supported this.

Management lead through learning and improvement

The practice valued learning. There was a culture of openness to reporting and learning from patient safety incidents. All staff were supported to update and develop their knowledge and skills. All staff we spoke with told us they had an annual performance review and personal development plan.

The practice had a system to investigate and reflect on incidents, accidents and significant events. All reported incidents, accidents and significant events were managed by designated staff. Staff told us that feedback from investigations was discussed at staff meetings and records confirmed this.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users. The registered person was not: ensuring that persons providing care or treatment to service users had the qualifications, competence, skills and experience to do so safely; assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are health care associated. Regulation 12(1)(2)(c)(h).

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems or processes were not established or operated effectively to ensure compliance with the requirements in this Part (of the Health and Social Care Act 2008 (Regulated Activities) Regulations 20014). The systems or processes did not enable the registered person, in particular, to: assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the experience of service users in receiving those services); assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity; maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to

This section is primarily information for the provider

Requirement notices

the service user and of decisions taken in relation to the care and treatment provided; evaluate and improve their performance in respect of the processing of the information referred to in sub-paragraphs (a) to (e).

Regulation 17(1)(2)(a)(b)(c)(f).