The Wycliffe Medical Practice

Quality Report

Lutterworth Medical Centre
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Website: www.wycliffemedicalpractice.nhs.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We had carried out a focused inspection of the practice on 3 November 2016. At that inspection we found that the practice did not have an effective system in place to ensure that the investigations into significant events were detailed and actions were identified and implemented. We rated the practice as 'Requires Improvement' in the safe key question.

As a result we issued the practice with a Requirement Notice for a breach of regulation 12(1) (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can read the last report from November 2016 by selecting the 'all reports' link for The Wycliffe Medical Practice on our website at www.cqc.co.uk

At this inspection on 2 June 2017 we found that the practice had made significant improvements and as a result the practice is now rated 'Good' in the safe key question. All other ratings remain unchanged.

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?

The practice had an effective system in place to ensure that the investigations into significant events were detailed and actions were identified and implemented.

Good

The Wycliffe Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC inspector.

Background to The Wycliffe Medical Practice

The Wycliffe Medical Practice is located within Lutterworth Medical Centre which also houses another GP practice, a community pharmacy and ambulance services.

The Wycliffe Medical Practice has 10,462 patients and provided treatment and care under a General Medical Services contract commissioned by East Leicestershire and Rutland Clinical Commissioning Group (CCG).

The service is provided by five GP partners (three female and two male), two salaried GPs(female) , one practice manager, one advanced nurse practitioner, four practice nurses and three health care assistants. They are supported by a range of receptionists, managers and administration staff.

The surgery is open between 8am and 6.30pm Monday to Friday. GP appointments are available from 8.30am am to 10.50am and 3pm to 5pm. The practice also has a nurse led minor illness clinic Monday to Friday each running from 8.30am.Telephone consultations and home visits are also available on the day.The practice offered extended hours on Wednesday mornings from 7am to 8am.

The practice had opted out of the requirement to provide GP services when the surgery was closed. Out-of-hours GP service were provided by Derbyshire Health United who were contactable through NHS 111.

Why we carried out this inspection

We undertook a desk top inspection of The Wycliffe Medical Practice on 2 June 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the practice after our focused inspection on 3 November 2016 had been made. We inspected against one of the five questions we asked about the service:

- Is the service Safe ?

This is because the service was not meeting some legal requirements.

At the inspection on 2 June 2017 we found that the practice had made significant improvements.

How we carried out this inspection

We asked the practice to provide us with written evidence of the improvements they had made.

Good

Are services safe?

Our findings

At our previous inspection on 3 November 2016 we found that the practice did not have an effective system in place to ensure that the investigations into significant events were detailed and actions were identified and implemented. We found that most had been reviewed in a timely manner but the system required some improvement. Significant events varied in terms of documentation, investigations, actions and learning. We were able to review minutes of meetings where these were discussed but they were not detailed or easy to follow. Lessons were shared to make sure actions were taken to improve safety to patients but these needed to be evidenced more clearly.

At this desk top inspection on 2 June 2017 we reviewed information that we had requested from the practice in respect of significant events.

We saw that the practice had implemented a comprehensive recording and tracking system that enabled all significant events to be fully recorded and investigated. Learning had been identified and cascaded and those events that required subsequent action and review had been identified.

The practice rated each significant event and categorised it as either a high risk or low risk event. Low risk events were predominantly administration issues and had no effect on patient outcomes. These low risk events had been subject to good evidence collection and analysis and the appropriate measures had been taken to help prevent recurrence.

We looked at the records that related to 33 high risk significant events and saw that all were well recorded and explained. There had been good evidence collection and evaluation. Where appropriate learning had been identified and it was clear how that had been cascaded to staff. For example we saw that individual issues had been discussed at staff members annual appraisals and how a significant event had prompted an educational presentation with regard to the prescribing of hormone replacement therapy medicines.

Each significant event had been discussed at GP, nurse and administration meetings and records of those meetings showed this to be the case.

Those significant events requiring follow-up actions were clearly indicated and reviews had taken place.

All significant events had been categorised to help identify any themes and trends.