Billericay Medical Practice

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	Good
Are services safe?	Requires improvement
Are services effective?	Good

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 Billericay Medical Practice on 11 July 2016. The overall rating for the practice was good. Safe, caring, responsive and well-led were rated as good and effective was rated requires improvement. The full comprehensive report on the July 2016 inspection can be found by selecting the 'all reports' link for Billericay Medical Practice on our website at www.cqc.org.uk.

This inspection was an announced focused inspection carried out on 26 September 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 11 July 2016. This report covers our findings in relation to those requirements and also additional improvements or risks identified since our last inspection.

Overall, the practice is now rated as good although safe is now rated as requires improvement.

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

- There were arrangements in place to monitor patients taking certain medicines.
- The practice continued to identify patients who had a role as a carer. The practice had now identified 122 patients who also had a role as a carer. This amounted to 1% of the practice population.
- Not all clinicians at the practice were prescribing medicines in accordance with manufacturer and other guidelines.

There were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure care and treatment is provided in a safe way to patients.

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 

This practice is rated as requires improvement for providing safe services.

- Not all clinicians at the practice were prescribing medicines in accordance with manufacturer and other guidelines.

Are services effective?

Good 

This practice is rated as good for providing effective services.

- There were arrangements in place to monitor patients taking certain medicines.

Summary of findings

Areas for improvement

Action the service MUST take to improve

- Ensure care and treatment is provided in a safe way to patients.

Billericay Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC inspector and included a GP specialist adviser.

Background to Billericay Medical Practice

Billericay Medical Practice is located in Billericay, Essex. It shares premises with other healthcare providers. The practice provides GP services to approximately 12,700 patients living in Billericay.

The practice is one of 44 practices commissioned by the Basildon and Brentwood Commissioning Group and it holds a General Medical Services (GMS) contract with NHS. This contract outlines the core responsibilities of the practice in meeting the needs of its patients through the services it provides.

The practice population has a comparable number of children aged five to 18 years compared to the England average, as well as patients aged over 65 years. Economic deprivation levels affecting children and older people are considerable lower than average as are unemployment levels. The life expectancy of male and female patients is higher than the local average by three years. The number of patients on the practice's list that have long standing health conditions is comparable to average, as is the number of patients who are carers.

The practice is governed by a partnership that consists of six GPs, four male and two female.

The partnership is supported by four practice nurses and two healthcare assistants. Billericay Medical Practice is a training practice and as such, there are also two GP registrars working at the practice. A GP registrar is a qualified doctor who is undergoing training to become a GP.

Administrative support consists of a full-time practice manager, a senior administrator and a number of reception and administrative staff.

The practice is open from 8am until 6.30pm on weekdays and is open from 8.15am until 11.30am on a Saturday morning. The practice is also a member of the local hub, which means that it works with other GPs in the locality to provide appointments outside of the usual opening hours. Routine appointments can be booked at the hub between 6.30pm and 8.00pm on a Monday to Friday and between 8am and 8.00pm Saturday and Sunday. Appointments at the hub are available with a GP, Nurse or health care assistant.

Why we carried out this inspection

We inspected this service as a focused follow up inspection to check the provider has made improvements to the legal requirements and regulations associated with the Health and Social Care Act 2008.

How we carried out this inspection

After our last inspection, we asked the provider to submit to us an action plan telling us how they were going to improve services at the practice. We carried out an announced visit on 26 September 2017. During our inspection we:

Detailed findings

- Spoke with a GP partner and administrative staff.
- Reviewed documents and a sample of the treatment records of patients.

We asked the following questions:

- Is it safe?
- Is it effective?

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.

Requires improvement

Are services safe?

Our findings

What we found at our inspection of 11 July 2016

At our previous inspection of 11th July 2016, we found the practice were good at providing safe services. There were effective systems in place to manage MHRA alerts (Medicines and Healthcare Products Regulatory Agency) and significant events. Medicines and vaccines were handled appropriately.

What we found at our inspection of 26 September 2017

Overview of systems and processes

We reviewed the records of patients taking a particular high risk medicine that is used for the treatment of certain cancers, psoriasis and rheumatoid arthritis. We found that there had been three occasions since the beginning of the year whereby patients who were prescribed this medicine were also prescribed a certain antibiotic, and when these two medicines are used together, there is a risk of serious harm to the patient. This is detailed in the manufacturer prescribing information and the British National Formulary.

We raised this with the practice, who took immediate steps to mitigate the risks and learn from these incidents. Following the inspection, we were sent an audit of patients who had been prescribed these medicines and saw that relevant patients' notes were reviewed to ensure that they had received a normal blood test result following the incident.

This was subsequently raised as a significant event, which was highlighted to all clinicians. We saw that there was a considered but timely analysis of what went wrong and the actions taken. This included sharing the serious event with local pharmacies, the CCG and contacting the IT system provider.

Good

Are services effective?

(for example, treatment is effective)

Our findings

What we found at our inspection of 11 July 2016

Although the practice had identified that improvements were required with regards to monitoring patients on certain medicines, effective action was yet to be implemented to ensure patients were safe.

At that inspection, we found that when some high risk medicines were being monitored, the practice relied on other providers to inform them when blood tests identified that there was an abnormality. Although this meant there were some safeguards in place which sought to ensure patients were safe, this was not effective. The practice did not routinely request confirmation of blood test results before generating a repeat prescription.

What we found at our inspection of 26 September 2017

Management, monitoring and improving outcomes for people

At our most recent inspection, we found that the provider had effectively implemented their action plan to meet the requirement notice that was served after our previous inspection. The practice regularly audited patients who were prescribed medicines that required monitoring to ascertain whether a blood test was due. There was an effective recall system whereby patients were identified and reminded to attend for their blood tests prior to a repeat prescription being issued.

The practice was working with the CCG to improve and change the system for monitoring Warfarin, a medicine used to thin the blood. The practice was continuing to prescribe and monitor this medicine until the new system had been implemented. We saw evidence to confirm that relevant patients were updated about the changes.

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:** The registered person did ensure that care and treatment was provided in a safe way. They did not do all that was reasonably possible to mitigate the risks to patients, as some patients had been prescribed medicines when it was not safe to do so. This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.