Benfleet Surgery

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.

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a short notice announced follow up inspection of Benfleet Surgery reviewing areas of concern on 11 November 2015. This was because of concerns highlighted during their initial inspection on 16 September 2015, where we found the practice was inadequate in respect of safe, effective and well led, good for caring and requires improvement for responsive.

As a consequence of concerns highlighted in the first inspection the practice was issued a notice under section 31 of the Health and Social Care Act 2008 placing

Summary of findings

conditions on their registration relating to conducting surgical activities and their management of infection prevention control. A report was also requested from the provider under regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in response to their governance activities.

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

- There was emergency medical equipment such as a defibrillator and oxygen accessible to staff. But staff had not received emergency first aid training and none was scheduled.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. For example appropriate recruitment checks on staff had not been undertaken prior to their employment. There was no risk assessment in place for administrative staff at risk of contracting blood borne disease from contact with body samples.
- Staff were reporting incidents, near misses and concerns, these were investigated, learning identified and communicated with staff.
- Staff had not received appropriate safeguarding training in children and vulnerable adults.
- The practice had reviewed their infection prevention control audit.
- There was insufficient assurance to demonstrate patients received effective care and treatment. For example, the practice had an absence of systems in place to assess the quality of clinical care being provided to their patients.
- We found the practice had addressed complaints, responding in a timely and appropriate manner. Lessons learnt from complaints had been shared with staff.
- The practice had a leadership structure, but formal governance arrangements were in their infancy.

The areas where the provider must make improvements are:

- Ensure recruitment processes include necessary employment checks for all staff.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff receive training, supervision and support to undertake their roles.

The areas where the provider should make improvements are:

- Schedule clinical audits.

On the basis of the ratings given to this service at the previous inspection conducted in September 2015, the provider was placed into special measures. This will be for a period of six months. We will inspect the provider again in six months to consider whether sufficient improvements have been made. If we find that the provider is still providing inadequate care we will take steps to cancel its registration with CQC.

The practice has been served a notice placing conditions on their registration, which they must comply with. The conditions relate to the management and training of staff in relation to infection control and the suspension of surgical procedures.

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?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements must be made. Improvements had been made to the reporting, investigation and review of incidents, near misses and concerns. The arrangements remained insufficient to keep children and adults safe. Staff had incomplete personnel files without employment contracts and staff had not received training in safeguarding children and vulnerable adults.

Significant improvements had been made by the practice to improve the safety of patients following the Commission's inspection in September 2015. The practice was undergoing extensive refurbishment and had installed a fire alarm system, purchased fire fighting equipment, signage and staff had been trained on its use including evacuation procedures. Emergency medical equipment was in place and appropriately maintained including a defibrillator and oxygen. However, staff had not received emergency life support training and none had been scheduled. Infection prevention control risks had been identified, mitigated and reviewed appropriately.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services, as there are areas where improvements should be made. The practice was revising and increasing their coding of patient data and patient care plans in preparation for the hours of hours service transferring to a new provider in January 2016. The practice was reviewing how they monitored patient needs. Reviews were reactive, triggered from QOF data or prescriptions and failed to sufficiently ensure associated medical needs were being captured. The practice intended to introduce a programme of clinical audits but this had not been progressed. There was evidence of more formalised practice meetings being held and learning being shared. The practice had no evidence to demonstrate all staff had the skills and knowledge to undertake their roles.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services, as there are areas where improvements should be made. The practice had not reviewed their hospital admission data and intended to wait until the end of the QOF year believing this did not represent their complete data return. The practice had given notice to the CCG that they would no longer provide out of

Summary of findings

hours care from January 2016 and were reviewing patient care plans to ensure they were sufficiently detailed to provide continuity of care in the transferral of services. We found the practice had addressed complaints responding in a timely and appropriate manner. Lessons learnt from the complaint had been shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for providing well led services, as there are areas where improvements must be made. The practice had a documented vision and strategy. This outlined an increase to the size of their practice. Staff we spoke with were clear about their responsibilities. They enjoyed working at the practice and felt supported by the practice management. The practice was in the process of formalising their structures and systems through the introduction of policies and procedures. Staff had not been trained in all relevant policies and these required time to be embedded. Practice management meetings were held monthly and comprehensive records were maintained demonstrating greater accountabilities and transparency in decision making. The practice was using national patient feedback data and local benchmarking to inform their services. They had engaged with patients over the refurbishment of the premises and invited them to comment on their preferred colours for walls and flooring. Staff had not received appraisals, but these were scheduled to be completed by 31 March 2016.

Summary of findings

What people who use the service say

The National GP Patient Survey results published on July 2015 showed the practice was performing above local and national averages. There were 106 responses which represents 32.8% response rate, 2.86% of their practice population views.

- 97% find it easy to get through to this surgery by phone compared with a CCG average of 70% and a national average of 73%.
- 98% find the receptionists at this surgery helpful compared with a CCG average of 87% and a national average of 87%.
- 90% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 68% and a national average of 60%.
- 97% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 87% and a national average of 85%.
- 100% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 97% describe their experience of making an appointment as good compared with a CCG average of 74% and a national average of 73%.
- 89% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 74% and a national average of 65%.
- 91% feel they don't normally have to wait too long to be seen compared with a CCG average of 67% and a national average of 58%.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment processes include necessary employment checks for all staff.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.
- Ensure staff receive training, supervision and support to undertake their roles.

Action the service SHOULD take to improve

- Schedule clinical audits.

Benfleet Surgery

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 adviser and a practice manager specialist adviser.

Background to Benfleet Surgery

Benfleet Surgery is situated in a residential area of Benfleet and has approximately 3700 patients.

The clinical team consists of a full time single male GP and a female GP who are supported by a practice nurse and administrative team. The practice holds a General Medical Services contract with NHS England who commissions their services.

Their patients are over represented amongst the younger age bands with greater than average national representation amongst five year olds and under 18 years. The practice patient profile suggests income deprivation levels are low for both children and older people. Their patients are in full time work or education and they have lower numbers of patients with long term conditions and health related problems in daily life. Life expectancy for their patients is also better than the national average.

The practice is open between 8am and 7pm Monday to Friday. Appointments are available from 9am to 1pm every morning and 4pm to 6.30pm daily, with the exception of Friday afternoon when the practice is closed. Appointments could be booked in advance, although daily appointments and urgent appointments were also available for people that needed them.

The practice currently provides their own out of hour's service however they have given notice to the CCG that they will stop providing this service from January 2016.

The practice was inspected on 16 September 2015. The inspection found that the practice was inadequate in respect of safe, effective and well led, good for caring and requires improvement for responsive. The inspection highlighted concerns.

Following the initial inspection of the practice the practice was issued a notice under section 31 of the Health and Social Care Act 2008 placing conditions on their registration relating to conducting surgical activities and their management of infection prevention control. A report was also requested from the provider under regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in response to their governance activities.

Why we carried out this inspection

We conducted this inspection to confirm the actions taken by the practice following our inspection on 16 September 2015 and the notice served under section 31 of the Health and Social Care Act 2008.

The practice were also issued a letter under regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The practice had provided a detailed response how they would address the concerns. During the inspection we assessed their progress against these.

Detailed findings

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 during a comprehensive inspection:

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

However, this inspection was conducted at short notice to follow up on concerns relating to four domains, safe, effective, responsive and well led where the practice had been rated as inadequate or requiring improvement. The practice had been rated as good for caring following their initial inspection.

Before visiting, we reviewed a range of information that we hold about the practice. We carried out a short notice announced visit on Wednesday 11 November 2015. During our visit we spoke with a range of staff including the GP, practice manager and a receptionist.

Inadequate

Are services safe?

Our findings

Safe track record and learning

We found there was a system in place for reporting and recording significant events. The practice had recognised this as an area requiring improvement and had more recently improved their recognition of such incidents. We found the reception staff noted potential complaints or significant incidents in a general communication book. The notes were reviewed daily and significant incidents were escalated for discussion at monthly management meetings. The lead GP told us they were introducing regular Friday meetings whereby they would discuss significant incidents. We reviewed an incident reported in September 2015. The incident had been appropriately investigated, communicated to staff and learning identified and shared.

Overview of safety systems and processes

The practice had recently, since our September 2015 inspection, introduced a number of policies and processes. We found;

- Arrangements were not sufficiently robust to ensure adults and children were safeguarded from the potential of abuse. The patient record system had the capacity to highlight those children or adults who may be vulnerable. However, the practice was coding only those children on the child protection register, not those potentially at risk. Vulnerable children and adults identified were however reviewed during the practice management meetings. Reception staff told us they were unaware of which children or adults were potentially vulnerable and/or at risk but would report any concerns to the GP.
- We reviewed the practice safeguarding children policy dated July 2015. The policy identified the lead GP as the safeguarding lead. We reviewed five staff files and found one member of staff had undertaken safeguarding children training. There was no evidence of clinical or non-clinical staff undertaking training in safeguarding adults. The GP told us they had attended relevant training and would contribute to case conferences where necessary. Online training was proposed for administrative staff that had been issued log in passwords to access the learning systems.
- A notice was displayed at the reception desk and on the GP consultation door advising patients that staff may act as chaperones, if required. Staff told us they had been spoken with by the GP about undertaking the role of a chaperone. The member of staff we spoke with had undertaken specialist training with their previous employer. Staff knew where they needed to stand and what was required of them. They had disclosure and barring checks (DBS) but these were registered for a separate location and it was not known if these were transferable. (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).
- There were procedures in place for monitoring and managing risks to patients and staff safety. The practice conducted a fire risk assessment on 25 July 2015 identifying a number of action points. These had been addressed and a mains connected fire alarm had been installed, along with emergency lighting and equipment being available. Staff had received verbal instruction on the fire equipment, evacuation procedures and where to assemble in an emergency. Access to the first floor was not permitted at the time of the inspection due to extensive refurbishment being undertaken. Notices were displayed throughout the practice apologising to patients for the inconvenience. We found the practice had a designated accident report book located by the first aid kit and this was known to staff.
- We reviewed the practice infection prevention control policy dated 6 October 2015. It identified the practice infection control team consisting of three GPs. The practice had a separate cleaning plan defining areas to be cleaned daily, weekly and monthly, that mirrored the policy.
- Training for non clinical and clinical staff was in progress and records were kept for all practice staff on Infection prevention control education programmes. Staff had been issued with their learning access codes but had not completed the training; they knew it was a priority. Staff confirmed they had signed to confirm they had received basic awareness in infection prevention control covering how to use personal protective equipment, handling bodily fluid samples, effective handwashing and needle stick injuries, but there was no record maintained of what in particular the training covered. Staff had access to spillage kits and were trained in their use.
- We reviewed the practice Hepatitis B policy dated October 2015. It stated all staff in regular contact with

patient, bloods; blood products and tissues contaminated with blood are at risk of infection. We found records of the clinical team receiving appropriate vaccinations to mitigate the risks of contracting a blood borne infection. However, no risk assessment had been conducted for frontline operational staff to be offered the vaccination despite potentially coming into contact with samples.

- We reviewed the infection control biological substance incident protocol produced in July 2015 and found it had been revised in October 2015. The practice had re-audited their infection control inspection checklist in November 2015. The key areas highlighted for action had not been appointed deadlines but review dates. Many of the risks identified under the action plan were being addressed as part of the refurbishment of the practice such as the treatment room floor and ceiling covering and equipment requirements.
- We spoke with the practice manager who was aware of the legal requirements to have agreements in place regarding the employment of staff, this included terms and conditions, pensions and job descriptions. The practice intend to issue all staff the required legal documents by 11 December 2015. The practice told us they had revised staff files since the last inspection in September 2015. We checked five staff personnel files including the practice nurse and found three staff members had disclosure and barring service (DBS) checks and the others staff members had submitted applications for DBS checks. There was no evidence of staff training or qualifications on the staff files reviewed. A professional registration check had been conducted for the practice nurse confirming they were appropriately registered with the NMC.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs over two practices. The clinical and management team worked across two sites, their other practice was located in Shoeburyness, Essex. The practice told us that foreseeable changes could be managed within their current clinical provision.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

The practice had a defibrillator and oxygen was available and accessible to staff. However, the staff had not undertaken basic life support training and none had been scheduled. The oxygen was not stored appropriately with clear signage on the door of the room. This was brought to the attention of the practice, who agreed to display appropriate signs.

We reviewed the practices emergency medicines and found they were in date, accessible and appropriate.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Clinical use of templates was not consistently employed making it difficult to assess that the National Institute for Health and Care Excellence (NICE) best practice guidelines were being consistently applied.

The practice did not have established systems in place to ensure guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

We found the practice did not consistently monitor patient outcomes and did not use the data to inform improvements to services. The practice participated in the Quality and Outcomes Framework (QOF). This 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 e.g diabetes and implementing preventative measures. The results are published annually. The practice reported significant improvement in their QOF points since their last inspection through addressing the coding of data.

The practice emergency cancer admission per 100 patients on their disease register were higher than the national average at 24.14 as opposed to 7.4 and the practice told us they had interrogated the data to identify why it was high. However, they believed it was misrepresentative having been distorted by the influx in patient numbers or a coding issue with the hospital recording routine attendances incorrectly. They believed the next years QOF data would more accurately reflect their clinical performance. The practice acknowledged the need to undertake quality assurance on their data and utilise the capacities of their patient record systems.

We asked them how they assessed and met the clinical needs of their patient population. They told us that they reviewed all new patients for existing conditions and long term medication. They confirmed that they did not search their patient clinical data to identify unmet needs. The practice told us how they monitored some patient outcomes through repeat prescriptions and QOF alerts, a reactive system inviting patients to attend for reviews. This process failed to capture associated medical reviews such as thyroid tests.

We found no full clinical cycle audits had been conducted or scheduled.

Effective staffing

We found no evidence to demonstrate that all staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had not used their induction programme for newly appointed clinical and non-clinical members of staff, covering topics as safeguarding, fire safety, health and safety and confidentiality. The practice told us that they planned to introduce these by 11 December 2015.
- The learning needs of staff were not identified through any system, such as appraisals, meetings or reviews of practice development needs. The GPs had access to various training forums through the CCG and peer support. The practice had purchased access to online training for their staff and they were in the process of enrolling. However, they had not completed appropriate training to undertake their roles, such as in information governance and patient confidentiality. The reception staff, practice nurse and practice manager had not received an appraisal or formal supervision within the last 12 months.

Coordinating patient care and information sharing

The practice had stopped conducting surgical procedures, intending to resume once the refurbishment of the practice was complete.

The practice had notified the Clinical Commissioning Group that they would stop providing out of hours care to their patients, from January 2016. They accepted that in doing so, there was a need to ensure patient care plans were sufficiently detailed to inform the continuity of patient care between services. The practice was addressing this, ensuring the coding of patient data, scheduling reviews and recording more information on the patient record system that was previously just known to the GP.

The practice had not reviewed their out of hour's referral data or emergency admissions following their last

Inadequate

Are services effective?

(for example, treatment is effective)

inspection where they were shown to exceed the CCG and national averages. The lead GP told us they believed the data had been distorted and he would consider revisiting the data at the end of this QOF year 2015-2016 to assess unmet patient needs.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Access to the service

The practice had given notice to NHS England regarding providing their patients out of hour's provision. However, the practice was concerned that their patient satisfaction levels would decline when they ceased to provide this service.

We asked the practice about their high emergency cancer admissions. The practice had an 24.14 average per 100 patients on their disease register higher than the national average at 7.4. The lead GP questioned the validity of emergency admission data. The GP reviewed all patient information received relating to both hospital and emergency admissions. They confirmed that they had not conducted any analysis of their patient's attendances to reduce practice prevalence. There was no documented system to ensure referrals to secondary care were actioned on time. All information was known and acted on by the lead GP. We asked about patient care plans and were told they were trying to improve these as currently they were applied inconsistently.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures had recently, since our September 2015 inspection, been aligned with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. For example, a patient information leaflet revised in July 2015. This included information on the independent complaints and advocacy service.

The staff told us complaints were infrequent. Concerns raised with them were always addressed immediately and where possible resolved. One complaint had been recorded since our inspection in September 2015. We found the practice had addressed the concern and responded in a timely and appropriate manner. Lessons learnt from the complaint had been shared with staff.

Are services well-led?

Inadequate

(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 clear vision to deliver accessible and good quality care to their patients. The practice cared for their patients and valued their feedback. However, they accepted that they needed to improve in a number of areas highlighted within their earlier inspection conducted in September 2015. They were committed to making the changes to reach compliance and had commissioned external professionals to advise and renovate the practice to meet current requirements.

Governance arrangements

The practice were establishing a governance framework which supported the delivery of the good quality care. They were introducing structures and procedures in place that required time to embed. We found that:

- Staff were aware of their own roles and responsibilities. The lead GP and practice manager regularly spoke with staff reviewing service delivery but did not formally oversee them to ensure staff fulfilled all aspects of their responsibilities.
- There was no understanding of the overall clinical performance of the practice. They were reactionary, identifying patient medication review dates or those who may benefit from attending health screenings through QOF.
- There was no programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- The practice had appointed health and safety leads and relevant information was displayed for patients and staff.

Leadership, openness and transparency

The GP was well informed regarding proposals and developments within Castle Point and Rochford Clinical Commissioning Group. The partners in the practice were experienced and committed to their patient population. They prioritised accessible and compassionate care and were visible in the practice.

The practice had conducted two management meetings since their last inspection in September 2015. We reviewed the minutes and found them to be comprehensive, examining clinical, financial and managerial issues. Actions were identified appointed owners and given completion or review dates.

The practice spoke highly of their staff and their low staff turnover. The practice acknowledged the need to formalise working arrangements with staff. They accepted they needed to improve their employment practices and this included staff contributing towards the NHS pension scheme, if they so wished.

The practice had discussed succession planning but this had not been formalised. The practice manager had been recently appointed to formalise the management of the practice but the lead GP remained pivotal with much of the knowledge on the patients and practice known only to them.

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

We found the practice used the NHS Friends and Family Test, National GP Patient Survey 2015 data and NHS Patient Choices to capture patient feedback. The practice had no patient participation group but had invited patients to comment on the refurbishment of the premises, specifically the interior colours to be used for flooring and walls.

The practice had recently introduced a staff diary encouraging staff to capture events and verbal feedback from patients. We reviewed the diary and the practice management meetings for the past two months October and November and found entries had been discussed and where appropriate responded to and action taken.

The practice had not gathered formal feedback from staff. Staff had not received appraisals or had one to one meetings with the management to discuss issues. However, staff told us they enjoyed working at the practice and felt supported by the management.