Dr Emil Shehadeh

Quality Report

Quebec Road
Tilbury
Essex
RM18 7RB
Tel: 01375 842396
Website: www.shehadehsurgery.wordpress.com

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Emil Shehadeh on 14 October 2015. This inspection was in follow up to our previous comprehensive inspection at the practice on 2 December 2014 where breaches of legal requirements were found. The overall rating of the practice following the 2014 inspection was inadequate and the practice was placed into special measures for a period of six months. After the December 2014 inspection, the practice wrote to us to say what they would do to meet legal requirements in relation to safe, effective and well-led services.

At our inspection on 14 October 2015 we found that the practice had improved. The two requirement notices we issued following our previous inspection related to the safe and effective delivery of care and both had been met. The ratings for the practice have been updated to reflect our recent findings. The practice is rated as requires improvement overall, and specifically requires improvement for providing safe and well led services, and good for providing effective, caring and responsive services.

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.

Our key findings were as follows:

- Arrangements to safeguard children and vulnerable adults by the detection of suspected non-accidental injury were robust and well managed.
- Patients told us that they felt well cared for and were treated with dignity and respect.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Summary of findings

- Patients told us that it was easy to contact the practice and they could get an appointment when they needed one.
- Risks relating to infection prevention and control also ensuring staff had received the necessary training required better management.

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

Importantly, the provider must:

- Ensure that the risks to patients, staff and visitors from healthcare associated infections are minimised by establishing, and if required taking action on, the immunity of staff to vaccine preventable illnesses.
- Ensure that accurate and required records are kept of staff members' suitability for employment and have oversight of the training they have undertaken.

In addition the provider should:

- Consider the implementation of guidance issued by Public Health England on the storage of vaccines. In particular, consideration of a second method of checking fridge temperature that is independent of mains power. Also, to minimise the risk of mains power to the fridge being turned off unintentionally.
- Review the practice infection prevention and control policy and appoint responsibility and governance to a suitably trained and skilled person to carry out the role.
- Expand practice held emergency medicines to include treatments for a sudden drop in a patient's responsiveness level due to hypoglycaemia (low blood sugar) or prolonged seizures (fitting).
- Evaluate the methods of gathering feedback from patients, to ensure they reflect a wider representation of patients registered at the practice.

I confirm that this practice has improved sufficiently to be rated requires improvement overall. This practice will be removed from special measures.

Further progress must be made; therefore we will re-inspect the practice in 2016 to ensure the requirements of further improvements detailed in this report have been met.

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 services as there are areas where it should make improvements.

Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, infection control audit findings required further action to ensure the risks to patients, staff and visitors from healthcare associated were mitigated. Staff had a robust oversight of safeguarding children and vulnerable adults. Practice staff had been trained to deal with emergency events and equipment to help in an emergency was regularly checked and suitable for use.

Are services effective?

Good 

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good 

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with, or higher than, others for several aspects of care. 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 know about the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good 

The practice is rated as good for providing responsive services. It reviewed the needs of its local population. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same

Summary of findings

day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

Governance for clinical risks such as medicines, changes in patient care and treatment and acting on information about patient care had been well managed. However, the governance for processes designed to keep patients, staff and visitors safe was mixed. Risk management in infection prevention and control had improved in recent months, although needed further improvement.

The practice had previously undertaken satisfaction surveys on patients' views about services. Although, actions taken in the previous year had been based on patient opinion gathered in 2013, this could not be relied on to be the current views of patients registered at the practice.

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 provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in dementia and avoiding unplanned hospital admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP.

People with long term conditions

Requires improvement

The provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

All clinical staff took lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nationally reported data from 2013/14 showed that outcomes for patients with long-term conditions were in line with others. For example, 88.3% of patients with diabetes had received a recent blood test that indicated their longer term blood glucose control was below the highest accepted level. This was similar to the clinical commissioning group (CCG) average of 84% and national average of 87.1%.

Families, children and young people

Requires improvement

The provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

There was a formal system in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were in line or higher than the local and national averages for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as good for effective, caring and responsive services overall and this includes for this population group. The provider was rated as requires improvement for safety and for well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

Ninety per cent of patients with dementia who were on the related practice register had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We spoke with nine patients and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received one completed card, this gave positive feedback about the caring and compassionate nature of staff. All of the patients we spoke with told us they were treated with care dignity, respect and understanding.

We reviewed the results from the latest national GP patient survey published in July 2015. The results from interaction between GPs, nurses and patients were positive:

- 85.7% described their overall experience of the GP practice as good. This was similar to the clinical commissioning group (CCG) average of 80.4% and national average of 84.8%.
- 79.2% said the GP was good at treating them with care or concern. This was similar to the CCG average of 79.3% and national average of 85.1%.
- 95.6% said that the nurse was good at giving them enough time. This was higher than the CCG average of 90.7% and national average of 91.9%.

The survey results in relation to access to the practice were also positive:

- 85.6% of patients found it easy to contact the practice by telephone. This was higher than the CCG average of 75% and national average of 73.3%.
- 95.3% of patients said the last appointment they made was convenient. This was higher than the CCG average of 89.8% and national average of 91.8%.
- 69.4% of patients felt they did not have to wait too long to be seen. This was higher than the CCG average of 56.9% and national average of 57.7%.
- 77.1% of patients were satisfied with the practice's opening hours. This was higher than the CCG average of 71.7% and national average of 74.9%.

We spoke with two members of the patient reference group (PRG) about how the practice and PRG interact. (PRGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). Both members told us that they were happy with the services provided at the practice and they felt involved with planning services.

Areas for improvement

Action the service MUST take to improve

- Ensure that the risks to patients, staff and visitors from healthcare associated infections are minimised by establishing, and if required taking action on, the immunity of staff to vaccine preventable illnesses.
- Ensure that accurate and required records are kept of staff members' suitability for employment and have oversight of the training they have undertaken.

Action the service SHOULD take to improve

- Consider the implementation of guidance issued by Public Health England on the storage of vaccines. In particular, consideration of a second method of checking fridge temperature that is independent of mains power. Also, to minimise the risk of mains power to the fridge being turned off unintentionally.
- Review the practice infection prevention and control policy and appoint responsibility and governance to a suitably trained and skilled person to carry out the role.
- Expand practice held emergency medicines to include treatments for a sudden drop in a patient's responsiveness level due to hypoglycaemia (low blood sugar) or prolonged seizures (fitting).

Evaluate the methods of gathering feedback from patients, to ensure they reflect a wider representation of patients registered at the practice

Dr Emil Shehadeh

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

Background to Dr Emil Shehadeh

Dr Emil Shehadeh is a GP registered with the Care Quality Commission (CQC) as an individual provider.

The provider has two locations registered with CQC. One in Grays (The Shehadeh Medical Centre), the other in Tilbury (Dr Emil Shehadeh). The provider holds a Personal Medical Services contract with NHS England which covers both locations. Around 10,000 patients are registered between the two locations. Our inspection looked solely at the practice in Tilbury (Dr Emil Shehadeh).

Approximately 4,900 patients are currently registered at the Tilbury location, although patients can access services at either site. The practice is open from 8am to 6:30pm on Monday, Tuesday, Wednesday and Friday and from 8am to 7:30pm on a Thursday.

Published demographic data covers both locations. The practice has a higher number of younger than older patients. The number of patients under the age of 18 makes up 18% of total patients. This is higher than the national average of 14.8%. Patients over the age of 65 account for 10.4% of total patients; this is lower than the national average of 16.7%. The practice area has a higher level of deprivation when compared with the national average. For example, the rate of income deprivation affecting children is 29% higher than the national average. All of these factors can increase the demand on GP practices.

Four GPs (two male, two female) assisted by locum GPs when required provide clinical care over both sites. The nursing team comprises of two advanced nurse practitioners, a practice nurse and healthcare assistant. Administrative staff employed directly at Tilbury include a practice manager and five receptionists.

The practice does not provide out-of-hours services to registered patients. These services are provided by South Essex Emergency Doctors Service (SEEDS) and are accessed by telephoning NHS 111.

Why we carried out this inspection

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 inspection was in follow up to our previous inspection at the practice on 2 December 2014, in which the practice was rated as inadequate overall. The practice was placed into special measures for a period of six months. Two breaches of the Health and Social Care Act 2008 were identified. The breaches related to the regulations for

person-centred care and good governance. Two requirement notices were issued; the practice submitted an action plan to CQC on the measures they would take in response to our findings.

How we carried out this inspection

Before our inspection with asked NHS England and the clinical commissioning group (CCG) to share any information or concerns they had. We did not receive any information relevant for the inspection. We also reviewed intelligence including nationally published data from sources including Public Health England and the national GP Patient Survey.

During our inspection we spoke with the lead GP, two advanced nurse practitioners, a practice nurse, practice manager and two members of administrative staff. Following the inspection we also spoke with two members of the patient reference group (PRG) by telephone as they were not available in person on the day. We also observed how staff interacted with patients and visitors and reviewed records that demonstrated the care provided at, and performance of, the practice.

The views of patients were considered by direct conversation with nine patients. We invited comments from patients by providing Care Quality Commission (CQC) comment cards in the practice waiting area for two weeks before our inspection. We received one completed card.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had a system for recording, investigating and discussing safety incidents, concerns and near misses. Occurrences were classified as significant events and recorded on incident forms and submitted to the practice manager or lead GP.

We reviewed significant event records and minutes of practice meetings where these were discussed. Lessons learned were shared to ensure action was taken to improve safety. For example, a discharge letter from a hospital had not had all the changes made to a patient's treatment as suggested. An investigation had not established if the occurrence was caused by clinical or administrative staff. A new process was implemented to clearly define actions for all staff groups to minimise the risk of reoccurrence. The patient had not come to any harm and the practice issued them with an apology.

Learning and improvement from safety incidents

Staff knew the process for reporting significant events and could recall recent incidents. The lead GP oversaw the process of analysis including investigation. Following investigation, all events were discussed at monthly practice meetings. All significant events had been reviewed at appropriate intervals to ensure that any actions taken had been successful in reducing the risk of reoccurrence.

Since 2014 the practice had recorded seven significant events which included both clinical and operational occurrences.

When things went wrong, the practice team worked together to learn from the incident and would issue an apology to those affected and inform them of any action taken as a result.

Reliable safety systems and processes including safeguarding

The practice had policies in place for safeguarding children and vulnerable adults for staff to refer to. Contact details for local safeguarding referral teams were displayed at numerous points within the practice and staff knew their location. All staff had received appropriate safeguarding training. For example, the GPs had received training to level three as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014). Staff understood their responsibility to protect patients from avoidable harm. The practice nursing team also had level three training.

Children who had been identified as being at increased risk of harm had their records flagged on the practice computer system. This gave the treating clinician oversight of the concerns and record links also extended to include other family members. Including family members allowed staff to view relationships that may not be immediately obvious. For example, children with different surnames. All patient attendances at A&E walk in centres or out-of-hours services were reviewed by an advanced nurse practitioner (ANP). We also saw examples of when the team had followed up patients with high numbers of A&E attendances with injuries that could have been non-accidental.

Chaperones were available when needed, all staff had received training, been vetted and knew their responsibilities when performing chaperone duties. 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. The availability of chaperones was displayed in the practice waiting room.

Medicines management

The practice identified patients who took medicines that may cause side effects and required regular follow up including blood tests. We reviewed the care records of some patients who took medicines to treat severe poor mental health, rheumatoid arthritis and diabetes. Computer alerts had been set to prompt clinicians to arrange follow up blood tests. All of the records we reviewed showed that patients had received treatment in line with nationally recognised guidance.

Medicines kept on site were stored safely and in line with manufacturers and nationally recognised guidance. For example, vaccines were stored safely and securely, at the correct temperature and were in date. A system of daily checks took place to ensure that vaccines were fit for use. We did see the fridge may be mistakenly turned off as it was wired to mains power with a switchable socket and there was no sign to state that the power should not be switched off. The system of assuring temperature in use relied on the use of a single integral fridge thermometer. Guidance on the storage of vaccines published by Public Health England in 2014 recommends that fridges should ideally have two

thermometers, one being independent of mains power. The guidance also suggests that fridges are hard wired into switch less sockets to avoid them being turned off unintentionally.

The practice nursing team consisted of two independent prescribers working as advanced nurse practitioners. Other practice nurses administered vaccines using patient group directions that had been produced in line with legal requirements and national guidance. The healthcare assistant administered a single vaccine when required; this was done in line with patient specific directions given by a GP.

Blank prescription forms were kept securely at all times and were handled in accordance with national guidance.

Cleanliness and infection control

The practice was visibly clean and tidy. Comments from patients we received expressed they found the practice to be clean.

The practice had commissioned an infection control audit in July 2015. We saw that the findings of the audit recommended a number of measures to improve infection prevention and control measures. A number of measures including resitting sharps disposal bins and expanding cleaning schedules had already been completed. However, an important recommendation still needed to be addressed:

- The immunity of staff involved in direct patient care to vaccine preventable illnesses such as Hepatitis B, Varicella (chicken pox) and BCG (TB) was not known. Whilst it was possible staff may have been up to date with immunisations, the overall risk was uncertain as there was not a consistent way of checking. These illnesses could cause harm to patients with lowered immunity. For example, those who are pregnant and patients diagnosed with diabetes.

The practice had an infection prevention and control policy in place. The policy stated that records of staff members Hepatitis B status would be kept and maintained. The records had not been kept and the policy also did not take account of other illnesses as detailed in The 'Green Book' Immunisation against infectious diseases guidance published by Public Health England in 2014.

Staff had received training in infection control, this was confirmed in records supplied to us by the practice after the inspection.

The practice had acted on findings of a recent Legionella risk assessment by arranging for remedial work to be carried out and flushing infrequently used water lines. The checks were carried out by the practice manager and documented. Legionella is a bacterium which can contaminate water systems in buildings.

Equipment

Equipment was annually tested for electrical safety and where appropriate was calibrated to ensure its clinical effectiveness. For example, blood pressure monitoring devices and weighing scales had been checked to ensure they were accurate and fit for use. Staff told us there was enough equipment available for them to carry out their role safely and effectively.

Staffing and recruitment

The practice had a policy and protocol for staff to follow when recruiting staff. All staff had received enhanced checks through the Disclosure and Barring Service (DBS). 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. We reviewed four staff files to establish if the practice followed legislative requirements relating to the suitability of employees. The most recent member of non–clinical staff had been recruited in line with guidance. Although there were risks with the practice system of ensuring existing clinical staff met the requirements of their role. For example, records of three members of clinical staff did not have a copy of their professional registration checked and recorded. We checked and all staff held professional registration, although the practice had not had robust oversight of this.

Appraisals had taken place although the records had not been placed within staff files. We were able to obtain copies, although this required telephone calls and emails by the management team. Further examples included lack of management awareness of the individual members of staff who had undertaken training such as basic life support and safeguarding. All of the staff we checked had received appropriate training; however the overall system to manage the oversight of staff training was not robust.

Requires improvement

Are services safe?

Staff told us there was always enough staff to provide a safe service to patients.

Monitoring safety and responding to risk

The practice management team were responsible for managing risks associated with providing services. There was a health and safety policy, risk assessments had been carried out and training had been provided to prepare staff to deal with emergencies such as fire, sudden illness and accidents.

Arrangements to deal with emergencies and major incidents

All staff had received recent annual update training in annual basic life support and the practice had equipment and emergency medicines available for staff to use if required. Emergency equipment included an automated external automated defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).

Emergency medicines were available within the practice to treat emergencies that may be faced in general practice. For example, allergic reactions, worsening asthma and septicaemia (blood poisoning). There were no practice held medicines to treat a sudden drop in a patient' responsive level due to hypoglycaemia (low blood sugar) or prolonged seizures (fitting). We spoke with the lead GP about this; they told us they planned to include medicines to treat these conditions in the practice held emergency medicines.

A business continuity plan detailed the practice response to emergencies such as loss of power, computers or premises. The document contained information such as contact numbers for contractors and alternative premises arrangements for staff to refer to in the event of an unplanned occurrence that affected services.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used current evidence based guidance and standards to inform their assessments, and the delivery of care and treatment. We saw examples of care and treatment provided in line with National Institute for Health and Care Excellence (NICE) guidance. We saw examples of NICE guidelines that had been summarised, then shared with staff for use within the practice.

We looked at the latest available data from both the NHS Business Authority (NHSBA) and the clinical commissioning group (CCG) on the practice levels for prescribing anti-inflammatory, antibiotic and hypnotic medicines. We saw that the practice levels of prescribing of these medicines were similar or better (lower) than the expected ranges when compared to CCG and national averages.

The practice offered a number of directed and local enhanced services. Enhanced services are the provision of services beyond the contractual requirement of the practice. Examples of enhanced services included childhood vaccination, minor surgery and avoiding unplanned admissions.

Practice supplied data showed that 93.4% of patients who took regular medicines, had received a medicines review within the previous 12 months.

The lead GP coordinated the care needs of patients identified at higher risk of unplanned admission to hospital. Patients in this group had individual care plans that were reviewed regularly to determine and meet their social and care needs. Bi-monthly meetings with other professionals including a community matron and community nurses involved in the care of patients were held at the practice.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). QOF is a system intended to improve the quality of general practice and reward good practice. The practice monitored outcomes for patients using QOF. In 2013/14 the practice achieved 97.9% of the total number of QOF points available; this was higher than the national average of 94.2%. Clinical outcome data from QOF showed;

- The practice clinical exception rate of 3.4% was lower than the CCG average of 6.3% and national average of 7.9%. Clinical exception rates relate to the number of patients who did not attend a review. A lower clinical exception rate indicated that more patients had attended a review or received treatment than the local and national averages.
- Outcomes in the indicators related to patients diagnosed with diabetes were higher than local and national averages. For example, 88.3% of patients with diabetes had received a recent blood test that indicated their longer term blood glucose control was below the highest accepted level. This was similar to the CCG average of 84% and national average of 87.1%.
- Performance outcomes in the indicators related to patients diagnosed with dementia were higher than local and national averages. For example, 90.2% of patients diagnosed with dementia had been reviewed in the last year compared with the CCG average of 79.1% and national average 83.8%.
- Patients who experienced severe poor mental health were supported by the use of comprehensive care plans. Performance outcomes showed that 87.4% of patients in this group had a comprehensive care plan in place. This was higher than the CCG average of 83.1% and national average and national average of 85.9%. The practice did not have any reported clinical exceptions in this group.

Data from the CCG showed that the practice had identified more than the expected average number of patients with dementia, atrial fibrillation (irregular heart rhythm), diabetes and chronic obstructive pulmonary disease (COPD). Identifying and managing patients with long-term conditions can lead to better outcomes by more effective treatment of their condition.

We looked at the latest published data from both the CCG and Public Health England on the practice's performance for referral of patients to hospital in urgent or emergency circumstances;

- The rate of patients attending accident and emergency departments between January and March 2014 was 8% lower than the national average.
- Emergency unplanned admission rates for patients diagnosed with long-term conditions between January and March 2014 were 38% below the national average.

Good

Are services effective?

(for example, treatment is effective)

- The number of patients with symptoms that could be suggestive of cancer that had been referred to specialists under a nationally recognised two week referral pathway was in line with local and national averages.

We reviewed three clinical audits that had been carried out within the last two years. All audits had completed at least two cycles, to examine the changes made following the initial audit. One audit examined that 50% of patients with a greater risk of developing cardio-vascular disease had been prescribed the most appropriate medicine to reduce the risk. The first cycle of the audit revealed that 5% of patients had received the medicine recommended. The guidance was shared within the practice and discussed at a clinical meeting. The audit had been repeated within five weeks and revealed an increased performance to 10% of total patients. The practice was due to repeat the audit to ensure that performance had further improved. Other audits included the accuracy of read coding the diagnosis of rheumatoid arthritis on records and that a medicine used to treat elevated blood cholesterol had been prescribed in line with national guidance.

Effective staffing

The staff at the practice were experienced and showed they had the skills and knowledge to deliver effective care and treatment.

- A GP had extended training in dermatology and was a GP trainer.
- The practice employed two experienced nurse practitioners; both were independent prescribers and led in safeguarding and areas of QOF management.
- Staff had been supported to develop in line with their personal development plans to enhance their skills. For example, the practice healthcare assistant administered flu vaccines under patient specific directions.
- Two salaried GPs had been recruited, following being trained themselves at the practice.

Staff received regular appraisals and told us they felt supported to undertake additional training if appropriate for their development or job role.

Coordinating patient care and information sharing

The practice had an established system for recording and sharing the information needed to deliver care and treatment. Staff were aware of their responsibilities for ensuring that information was shared promptly and appropriately and they followed up any information when required.

Communication letters and test results from hospitals, out-of-hours and other services were followed up on the day they were received. We saw the practice was up to date on the management of communications and test results.

An advanced nurse practitioner showed us the shared computer system used for communicating with external colleagues such as community nurses. Tasks could be electronically allocated from one individual to another.

The practice interacted on a regular basis with other professionals to help coordinate patients care and treatment.

- Staff organised and attended monthly multi-disciplinary team meetings to discuss patients approaching the end of their life with other professionals that were also involved in their care. This included palliative care nurses and community nurses.
- The care needs of patients who were approaching the end of their life were reviewed with other professionals at monthly palliative care meetings.

Consent to care and treatment

Patients' consent to care and treatment was sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and where appropriate, recorded the outcome of the assessment.

We saw that patients' consent had been recorded clearly using nationally recognised standards. For example, in do not attempt cardio-pulmonary resuscitation (DNACPR) records.

Health promotion and prevention

Patients with conditions that may progress and worsen received additional support to keep them healthier for

Good

Are services effective?

(for example, treatment is effective)

longer. Eighty-five per cent of patients diagnosed with diabetes had received the seasonal influenza immunisation. This was higher than the CCG average of 73.5% and national average of 78.6%.

The rate of eligible female patients attending the practice for cervical cytology screening was 80.7%; this was higher than the CCG average of 76.6% and national average of 76.9%.

Childhood immunisations were mostly in line with the local average. For example, 93.7% of children aged two had received the measles, mumps and rubella (MMR) vaccine. This was higher than the CCG average of 92.4%.

The practice healthcare assistant offered annual health assessments for patients with a learning disability. This assessment included weight, blood pressure and blood sample analysis. Any concerns identified were forwarded to a GP. New patients were also offered a health assessment with healthcare assistant. Any existing medicines taken were reviewed by a GP to ensure they were appropriate.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included comments made to us from patients and information from the national GP patient survey published in July 2015. The survey invited 442 patients to submit their views on the practice, a total of 86 forms were returned. This gave a return rate of 19.5%.

The results from the GP national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example;

- 85.7% described their overall experience of the GP practice as good. This was similar to the clinical commissioning group (CCG) average of 80.4% and national average of 84.8%.
- 79.2% said the GP was good at treating them with care or concern compared to the CCG average of 79.3% and national average of 85.1%.
- 95.6% said that the nurse was good at giving them enough time compared to the CCG average of 90.7% and national average of 91.9%.

We spoke with nine patients and invited patients to complete Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received one completed card which was positive about the caring and compassionate nature of staff. All of the patients we spoke with told us they were treated with care dignity, respect and understanding.

Care planning and involvement in decisions about care and treatment

The GP patient survey information we reviewed showed a comparable patient response to questions about their involvement in planning and making decisions about their care and treatment with GPs. The GP patient survey published in July 2015 showed;

- 78.5% said the last GP they saw was good at involving them about decisions about their care compared to the CCG average of 75.2% and national average of 81.4%.
- 91.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.

The GP national patient survey results about patients involvement in planning and decisions about their care and treatment with the practice nurses were higher than local and national averages;

- 94.8% said the last nurse they saw was good at involving them about decisions about their care compared to the CCG average of 89.4% and national average of 90.4%.
- 91.7% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 89.6%.

All of the comments we received from patients were positive about their own involvement in their care and treatment.

Patient/carer support to cope emotionally with care and treatment

Patients and carers gave positive accounts of when they had received support to cope with care and treatment. We heard a number of positive experiences about the support and compassion they received. For example, a patient told us they had received tremendous support and advice whilst receiving treatment for a serious medical condition.

Written information was provided to help carers and patients to access support services. This included organisations for poor mental health and advocacy services. Subject to a patient's agreement a carer could receive information and discuss issues with staff.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The lead GP told us that they attended clinical commissioning group (CCG) meetings and they were aware of the practice performance in benchmarking with local practices.

We spoke with two members of the patient reference group (PRG) about how the practice and PRG interacted. (PRGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). Both members told us that they were happy with services provided at the practice and they felt involved with planning services.

We received a comment that although they were satisfied with the overall care provided at the practice, although they were disappointed that the practice did not offer formal annual health assessments for patients with a learning disability. This type of annual health assessment forms part of an enhanced service that is not part of a GPs contracted obligations. The GP told us that they did offer annual health checks for all patients with a learning disability, although they felt they did not have the resources to sign up to the extra enhanced service.

The practice had considered the needs of patients when planning services:

- Patients who were at the highest risk of unplanned admission were supported by individual care plans. If they were admitted to hospital, a GP contacted them when they were discharged to reassess their care needs.
- The practice was not contracted to undertake enhanced service annual health assessments on patients with a learning disability. However, the GP told us all patients in this group were invited to an annual health check with a member of the nursing team. We saw examples of patients being invited for health checks
- The availability of same day walk in appointments had increased. Patients told us this had made it easier to get a same day appointment.

Access to the service

The practice was open from 8am to 6:30pm on Monday, Tuesday, Wednesday and Friday and from 8am to 7:30pm on a Thursday. During these times the reception desk and telephone lines were always staffed. On Monday and Friday patients could access a walk in appointment between 9am and 11am. Patients could book appointments in person, by telephone and by using an online system for those had registered to access appointments in this way. We saw that there were urgent appointments available on the day of our inspection and also pre-bookable appointments the within two working days.

We received feedback on appointments from 10 patients. All were happy with contacting the practice, availability and the timeliness of appointments.

Results from the national GP patient survey published in July 2015 were positive

- 85.6% of patients found it easy to contact the practice by telephone. This was higher than the CCG average of 75% and national average of 73.3%.
- 95.3% of patients said the last appointment they made was convenient. This was higher than the CCG average of 89.8% and national average of 91.8%.
- 69.4% of patients felt they did not have to wait too long to be seen. This was higher than the CCG average of 56.9% and national average of 57.7%.
- 77.1% of patients were satisfied with the practice's opening hours. This was higher than the CCG average of 71.7% and national average of 74.9%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

Information was available to help patients understand the complaints system and the complaints process was displayed on notice boards and in the practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at four complaints received in the last 12 months. We tracked two complaints and saw they had been acknowledged, investigated and responded to in line with the practice complaints policy. There were no trends to the complaints received. Complaints were discussed at both practice and PRG meetings. Learning from complaints was evident and when appropriate the practice issued an apology and explained how systems had been changed to limit the risk of reoccurrence.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a written vision and values statement:

- To maintain the practice team and environment which are welcoming, caring and accessible for all our patients.
- To treat our patients fairly and equally, and with dignity and respect.
- To provide highly effective, efficient and safe healthcare services for our patients.
- To listen, communicate and collaborate with patients effectively.
- To offer evidence based effective primary care medical services, in collaboration with other stakeholders.

The vision and values were displayed on their website and within the waiting room. Staff we spoke with knew the essence of these values and displayed them in performing their duties.

Succession planning was ongoing and discussions with the NHS commissioners of services were underway for the lead GP to retire. This was to allow continuation of services at the practice under a new provider.

Governance arrangements

Governance for clinical risks such as medicines, changes in care and treatment and acting on information about patient care had been well managed.

- The practice performance for being effective prescribers was known and benchmarked.
- Performance in the Quality and Outcomes Framework (QOF) was higher than average. Clinical staff had ownership led on different condition areas, which led to higher than average results.
- The process for assessing the risks from patient attendances at A&E and walk in centres for potential non-accidental injuries involving children and vulnerable adults was robust.

We found that this was not supported by the necessary management infrastructure and leadership and that governance processes and systems were not operated effectively or were applied inconsistently. Risk management in this area had improved in recent months, although needed further improvements:

- The practice had commissioned a risk assessment for legionella (a bacterium which can contaminate water systems in buildings). The practice had made a number of improvements to the premises minimise the risks.
- Health and safety risk assessments had been conducted to limit risks from premises and environmental factors.
- Equipment was checked for safety and accuracy.
- Identified risks from an infection control audit conducted in July 2015, including the immunity status of staff to vaccine preventable illnesses had not been corrected quickly enough.
- The management team did not have comprehensive oversight of the risks arising from staffing. For example, they had not recently checked that clinical staff held current professional registration and that each member of staff had attended the training they needed to perform their role effectively.

Leadership, openness and transparency

Staff told us that the lead GP and practice manager were visible within the practice and were approachable. There was an open an honest culture which was evident through sharing of complaints and significant event reporting. Clinical staff met on a weekly basis to discuss clinical performance and changes to clinical guidelines. Staff commented on the usefulness of sharing information in this way. Practice meetings were held on a monthly basis, minutes were taken and staff were encouraged to give suggestions on how services could be improved.

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

The practice had previously undertaken satisfaction surveys on patients' views about services. The most recent survey had taken place in November/December 2013. It had been planned to use the NHS Friends and Family Test (FFT) to gather patients' views and use within PRG meetings to determine priorities for service improvement. (FFT was created to help practices and commissioners to understand if patients are happy with the service provided and if they would recommend it).

Records of the PRG meetings in 2015 showed that services had been discussed at meetings. We spoke with two members of the PRG who told us that they were encouraged to raise any concerns they had. They also told us that staff from the GP practice raised points for discussion, including items that had been brought to their

Are services well-led?

Requires improvement

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

attention. Although this was a useful way of gaining individual experiences, it could not be relied on to be reflective of the experiences of the wider range of patients at the practice.

The most recent way of gathering feedback had not been wholly representative of patients' views as it had been in previous years. We reviewed the latest action plan produced by the practice in October 2015. This document had been mirrored to state the actions planed for completion in 2014 had been met in 2015. Patients had not been asked if they felt the action points from 2014 had been met.

The lead GP had introduced a walk in clinic at Tilbury on a Monday morning to allow patients increased access to appointments. They told us this had been in response to direct feedback from patients including members of the PRG. They also told us patients and PRG members had expressed this was a positive change to accessing a GP.

The practice manager told us that they had changed a number of services by listening to comments from patients. This included removing restrictions from patients to get same day appointments. Previously patients needed either call first thing in a morning to get an appointment in the morning and in the early afternoon to get an afternoon appointment. They said by allowing patients to call at a time suitable for them, patient frustration had been greatly reduced. The method of determining success of the changes was receptionists reporting that patients seemed happier with the less restrictive method. The practice manager told us the future plans for the PRG included formulating an internal patient satisfaction survey and inviting PRG members to be present in the waiting room at times to ask patients for their feedback.

Management lead through learning and improvement

All staff had received recent appraisals and told us they were supported to develop their skills to meet the needs of their role.

The practice was a training practice to support training qualified doctors to become GPs. The lead GP told us they had a well-established background in providing training opportunities, although had not taken a trainee in recent months due to planned changes to the provider. A number of GPs that had been employed at the practice, had themselves been trained there.

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 **The provider did not fully assess or mitigate the risk to patients, staff and visitors from healthcare associated infection. The immunity of staff to vaccine preventable illnesses was not known.** **Regulation 12 (2) (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 **The provider did not maintain accurate records in relation to persons employed in the carrying on, and management of the regulated activities. The recorded information in staff records did not reflect legislative requirements under Regulation 19, Schedule 3 of the HSCA (RA) Regulations 2014. The provider did not have oversight of training undertaken by staff to ensure their skills met the requirements of their role.** **Regulation 17 (2) (d) (i) (ii)**