St Clements PCT Medical Services (PCTMS) Practice

Quality Report

St. Clements Health Centre
London Road
West Thurrock
Grays
RM20 4AR
Tel: 01708 891 007
Website: No website

Date of inspection visit: 25 January 2017
Date of publication: 26/04/2017

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

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
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 St. Clements PCT Medical Services (PCTMS) Practice on 25 January 2017. Overall the practice is rated as requires improvement.

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

- There were systems in place for reporting, recording, investigating, responding and learning from significant events. However, the practice did not evidence consideration of wider risks and that changes had been embedded to mitigate against a reoccurrence.
- There was an effective system in place to receive and respond to Medicine and Healthcare products Regulatory Agency (MHRA) alerts. However, historical alerts from prior to 2015 still required actioning.
- The practice achieved 96% of the total points available under Quality and Outcomes Framework (QOF).
- We found there was no defined system in place to disseminate and check adherence to NICE guidance.
- We found some patients were incorrectly coded for health conditions they did not have.
- Improvements were required to ensure timely reviews of medicines and discussions of associated risks.
- There was an absence of clinical audit to inform quality improvement.
- Care plans were not in place for all patients on their admission avoidance programme.
- Patients had been appropriately identified and included in multidisciplinary discussions.
- The practice did not monitor their patient's attendance for national screening programmes or have specific strategies to improve uptake.
- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care. This included satisfaction with the opening hours and ease of contacting the practice by phone.
- Patients we spoke with including members of the patient participation group spoke highly of the care, commitment and professionalism of the practice nurse.

Summary of findings

- The practice had identified 0.4% of their patient list as carers and was improving their identification and services to such patients.
- The practice offered a range of services to their patients who could access the practice or North Essex Partnership University NHS Foundation Trust (NEPT) neighbouring practices (The Acorns and Dilip Sabnis).
- The practice followed up on patients who failed to attend their appointments.
- The practice had a complaints procedure. It was accessible and supported patients to make a complaint including their right to advocacy services.
- The Trust responsible for the oversight of the practice had commissioned an external specialist to assist them to develop an overarching strategy regarding how they were to deliver their services individually or across the three practices within Grays, Essex.
- The overarching governance systems had not been effectively embedded into the practice.
- There was a lack of permanent clinical oversight. This role was currently being fulfilled by the external specialist GP advisor in partnership with the pharmacist.
- There was often only remote managerial oversight available for most of the week.
- Regular team meetings had been introduced and rotated between days to ensure all staff had an opportunity to attend and contribute to discussions.
- Systems were in place to support patients to provide feedback. However these were in their infancy and the practice could not demonstrate changes made in response to patient feedback.

Since the date of the inspection, the provider of this service has de-registered this location with the Care Quality Commission and another provider has registered with us. Had this not been the case we would have issued the provider with an improvement action for the following areas.

The areas where the provider must make improvements are:

- Ensure the dissemination and adherence to NICE guidance.
- Conduct reviews of high risk medicines in line with guidance, explaining potential risks to patients.
- Embed accessible and sustainable governance systems and processes to identify and implement quality improvements, including clinical and managerial oversight.
- Ensure the accurate coding of patient records and ensure that care plans are completed for patients on the admission avoidance register.
- Respond to patient feedback and use it to inform changes to the service.

The area where the provider should make improvement is;

- Review and action medicine safety alerts from prior to January 2015.
- Improve the analysis of risks and evidencing of actions taken to mitigate a reoccurrence.
- Monitor patient's attendance for national screening programmes and improve uptake.
- Improve the identification of patients who are carers**.**
- Maintain accessible clinical and administrative leadership.

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 providing safe services.

- There were systems in place for reporting, recording, investigating, responding and learning from significant events. However, the practice did not evidence consideration of wider risks and that changes had been embedded to mitigate a reoccurring.
- There was a system in place to receive and respond to Medicine and Healthcare products Regulatory Agency (MHRA) alerts. However, historical alerts from prior to 2015 still required actioning.
- Improvements were required to ensure timely reviews of high risk medicines and discussions of associated risks.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and managed.
- Prescribing practices required improvement to reflect their medicine management policy.
- Staff had undertaken appropriate emergency life support training.
- The practice held appropriate emergency medicines which were accessible to staff.
- We found appropriate recruitment checks had been undertaken prior to employment.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- The practice achieved 96% of the total points available under QOF.
- We found there was no defined system in place to disseminate and confirm adherence to NICE guidance.

Summary of findings

- We found some patients were inappropriately coded for conditions they did not have. We found administrative staff coding clinical records based on guidance received through external training. This was not quality assured by a clinician or supported by a practice protocol.
- There was an absence of clinical audit to inform quality improvement.
- Care plans were not in place for all patients on their admission avoidance programme.
- Patients had been appropriately identified and included in multidisciplinary discussions.
- The practice did not monitor their patient's attendance for national screening programmes or have specific strategies to improve uptake.

Are services caring?

Requires improvement 

The practice is rated as requires improvement for providing caring services.

- The patients told us the staff were polite, supportive and would go out of their way to assist them.
- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care.
- The practice had translation services and had translated some health literature to assist patients from Poland and the Ukraine.
- Patients we spoke with including members of the patient participation group spoke highly of the care, commitment and professionalism of the practice nurse.
- The practice had identified 0.4% of their patient list as carers and was improving their identification and services to such patients.

Are services responsive to people's needs?

Requires improvement 

The practice is rated as requires improvement for providing responsive services.

- The practice offered a range of services to their patients who could be accessed at the practice or NEPT neighbouring practices (The Acorns and Dilip Sabnis).
- The practice followed up on patients who failed to attend their appointments.
- Patient satisfaction score were below the local and national average for the practice opening hours and easy of contacting the practice. For example, 52% of respondents were satisfied with the practice's opening hours compared to the local average of 71% and the national average of 76%.

Summary of findings

- The practice had a complaints procedure. It was accessible and supported patients to make a complaint including their right to advocacy services.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for providing well-led services.

- The Trust had commissioned an external specialist to assist them to develop an overarching strategy regarding how they were to deliver their services individually or across the three practices within Grays, Essex.
- The overarching governance systems had not been effectively embedded into the practice.
- There was a lack of permanent clinical oversight. This role was currently being fulfilled by the external specialist GP advisor in partnership with the pharmacist.
- There was often only remote managerial oversight available for most of the week.
- Regular team meetings had been introduced and rotated between days to ensure all staff had an opportunity to attend and contribute to discussions.
- Systems were in place to support patients to give feedback. However these were in their infancy and the practice could not demonstrate changes made in response to patient feedback.

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 requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- We found the practice worked with partner services to deliver care to housebound patients.
- The practice participated in admission avoidance but not all patients on their register had care plans as required.
- The practice had systems, processes and practices in place to keep older patients safe and safeguarded from abuse.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

People with long term conditions

Requires improvement

The provider was rated as requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- Performance for diabetes related indicators were above the national average. For example, the percentage of patients with diabetes, on the register in whom the last IFCC-HbA1C is 64mmol/mol or less in the preceding 12 months was 79%.
- 98% of the practices patients on the diabetic register had the influenza immunisation. This was above the local average by 4.2% and the national average by 2.9%.
- Improvements were required in the practices response to Medicine and Healthcare products Regulatory Agency (MHRA) alerts to ensure that patients with long-term conditions taking certain medicines were safe.
- The practice nurse led on long term conditions and was highly regarded by the patients.

Families, children and young people

Requires improvement

The provider was rated as requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- Patients could access midwifery services at the practice.

Summary of findings

- Patient group directives had been appropriately authorised for the administration of immunisations to pregnant women.
- The temperatures of fridges storing vaccines were monitored in line with guidance.
- We saw appropriate written consent was obtained for patients who received contraceptive devices.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. .

Working age people (including those recently retired and students)

Requires improvement

The provider was rated as requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- Patients could access GP and nursing services at all three of the provider's locations within Grays.
- Weekend appointments with a GP or nurse could be booked at the local GP health hub.
- There was no website to enable patients to translate information or provide useful information such as directions and health promotion advice.
- Patients could book appointments on-line.
- Health screening services were available at the practice and via an external health provider throughout Grays.

People whose circumstances may make them vulnerable

Requires improvement

The provider was rated as requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- Literature was available in other languages for non-English speaking patients
- Carers were identified and advised of additional services. The nurse sent text reminders to carers.
- We found the practice worked with partner health services to deliver care to housebound patients.
- The practice had an accessible complaints procedure advising patients of their right to advocacy services and supporting them to make a complaint.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Summary of findings

People experiencing poor mental health (including people with dementia)

Requires improvement

The provider was rated as requires improvement for safe, effective, caring, responsive and for well-led. The issues identified as requires improvement overall affected all patients including this population group.

- The practice achieved above the national average for their management of patients with poor mental health. For example, 100% of their patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their records within the last 12 months.
- The practice achieved 100% for the percentages of their patients diagnosed with dementia receiving a face to face review within the preceding 12 months.
- Clinicians worked with community health professionals to provide dementia screening and for on-going support by the community geriatrician.
- The practice followed up with patients who failed to collect their prescriptions.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing below local and national averages. 361 survey forms were distributed and 89 were returned. This represented a response rate of 25%.

- 44% of respondents found it easy to get through to this practice by phone compared to the local average of 73% and the national average of 73%.
- 61% of respondents were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 82% and the national average of 85%.
- 54% of respondents described the overall experience of this GP practice as good compared to the local average of 80% and the national average of 85%.
- 44% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 70% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. Eleven of the 15 reported positive experiences in respect of the staff being helpful, polite and treating them with dignity and respect. The patient participation group spoke highly of the kindness and professionalism of the practice nurse.

We reviewed the patient NHS Friends and Family Test feedback for October, November and December 2016. Patients had completed and submitted 11 cards, 10 patients stated they were likely or extremely likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

Since the date of the inspection, the provider of this service has de-registered this location with the Care Quality Commission and another provider has registered with us. Had this not been the case we would have issued the provider with an improvement action for the following areas.

- Ensure the dissemination and adherence to NICE guidance.
- Conduct reviews of high risk medicines in line with guidance, explaining potential risks to patients.
- Embed accessible and sustainable governance systems and processes to identify and implement quality improvements, including clinical and managerial oversight.
- Ensure the accurate coding of patient records and ensure that care plans are completed for patients on the admission avoidance register.
- Respond to patient feedback and use it to inform changes to the service.

Action the service SHOULD take to improve

Since the date of the inspection, the provider of this service has de-registered this location with the Care Quality Commission and another provider has registered with us. Had this not been the case we would have issued the provider with an improvement action for the following areas.

- Review and action medicine safety alerts from prior to January 2015.
- Improve the analysis of risks and evidencing of actions taken to mitigate a reoccurrence.
- Monitor patient's attendance for national screening programmes and improve uptake.
- Improve the identification of patients who are carers.
- Maintain accessible clinical and administrative leadership.

St Clements PCT Medical Services (PCTMS) Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist adviser and a second CQC inspector.

Background to St Clements PCT Medical Services (PCTMS) Practice

St. Clements PCT Medical Services (PCTMS) Practice is one of three practices provided by North Essex Partnership University NHS Foundation Trust (NEPT). The practice holds its own patient list of 4004 patients. The other two practices (Dilip Sabnis and The Acorns) are also situated in Grays, Essex. Patients are able to attend any of the practices to access care and treatment. They provide services to a deprived patient population.

We have previously inspected the other two practices and found various breaches of the regulations. As a result of these findings NEPT has put an improvement plan in place across all three practices and at the time of this inspection, some of those improvements had been actioned or were in the process of being actioned.

The clinical team consisted of a permanent female GP employed at St. Clements PCT Medical Service (PTMS) Practice who works four days providing eight clinical sessions. The practice also has three regular locums (two male GPs and one female GP) who work throughout the week. There is a male and female GP available daily. There is a permanent full time practice nurse, a nurse prescriber and a health care assistant at the practice. The practice manager works across all three of the provider's practices in Grays, Essex. They are being assisted by an external consultancy service providing GP clinical leadership, Trust lead pharmacist and overseen by an operational improvement manager.

The practice is open between 8am and 6.30pm and GP appointments are available between 9am and 5.30pm. The practice nurse appointments are available from 9am to 5.30pm every day except Wednesday. A locum nurse prescriber works at the practice on a Thursday.

The practice does not operate extended hours but the patients benefit from access to an out of hours GP hub service. Appointments are pre-bookable via the practice for both GPs and nurse. In addition, GP appointments may be booked two weeks in advance and the nurse may book up to four weeks in advance. Urgent appointments are available for people that needed them. There are limited parking facilities at St. Clements PCT Medical Service (PTMS) Practice.

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. The inspection was planned to check whether the provider is meeting the legal

Detailed findings

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 25 January 2017. During our visit we:

- Spoke with a range of staff (operational improvement manager for the practice, the lead GP and a locum GP, the external specialist GP advisor, practice nurse and administrative team) and spoke with patients who used the service.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

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

Safe track record and learning

Staff reported incidents on paper and also via the central recording system. Incidents were then classified on North Essex Partnership University NHS Foundation Trust (NEPT) risk framework. We found administrative and clinical significant incidents had been recorded. We reviewed the two clinical entries relating to inappropriate administration of medicines. Both had been documented on the central recording system, staff had been spoken to but the potential wider issues such as the identification of risks were not clearly documented. It was not evident what improvement to practices had been made in response, other than staff training.

We asked the practice how they managed Medicines and Healthcare Regulatory products Agency (MHRA) alerts and patient safety alerts. The MHRA is sponsored by the Department of Health and provides a range of information on medicines and healthcare products to promote safe practice. The practice told us that their Trust Pharmacist was leading on educating staff and monitoring compliance with alerts. All alerts were shared with their clinical team who confirmed they had read, understood and actioned them. The pharmacy team had reviewed the practices response to all MHRA alerts since January 2015. However, they had not conducted searches on historical safety alerts.

When we checked patient records we found three patients who remained at risk due to being co-prescribed medicines (simvastatin and amlodipine). This was contrary to guidance highlighted in a 2012 MHRA alert and placed the patients at risk. The Trust told us patient records were scheduled to be audited in respect of MHRA alerts and associated actions were to be completed within a month.

Overview of safety systems and processes

The practice had systems, processes and practices in place these were sufficient to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. The Trust required all practice staff working with children and adults to have a DBS check. (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 found all administrative staff had DBS checks commissioned.
- Safeguarding policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead GP for safeguarding.
- The practice told us the GPs provided safeguarding reports where necessary for other agencies. Staff we spoke with demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. We checked staff files and found they had been trained to the appropriate level, for the GPs child safeguarding level 3.
- The practice had a number of children who were at risk and they were identified within their clinical record. Where a child had failed to attend for vaccinations and hospital appointments, the practice had spoken to the family of the child and invited them to attend the practice.
- A notice in the waiting room advised patients that chaperones were available if required. Members of the nursing team and reception staff acted as chaperones. They had received training and received a Disclosure and Barring Service (DBS) check.
- The practice appeared to be clean and tidy. The practice nurse was the infection control clinical lead. We reviewed the practices infection control audit which had been concluded in August 2016. The practice found they were 91% compliant. The audit highlighted that records had not been updated to demonstrate when and how risks had been mitigated. All outstanding actions had been resolved. We asked to look at cleaning schedules for rooms and found these were maintained weekly and staff had received appropriate training.
- The practice had revised their arrangements for managing medicines. Some policies were awaiting approval and staff were still to receive training on proposed systems and processes designed to keep patients safe. The Trust Pharmacist had reviewed the practice medicine management policies including the cold chain procedure. We found these policies were being adhered to. We also found the practice had improved their monitoring of high risk medicines such as Methotrexate and Azathioprine.

Requires improvement

Are services safe?

- We found improvements were required in the management of repeat prescriptions which included the review of high risk medicines. For example:
- We found 41 patients out of 145 patients (accounting for 28%) on ACE inhibitors who required a minimum of annual blood tests had not had these conducted in over 12 months. Twenty three of the patients had not had monitoring within 13 months. We sampled four patient records and found that all the patients had received a blood test within 18 months. We saw that the practice had started to make improvements to their system and had made multiple attempts to contact each patient such as phone calls, text messages and sending letters to request blood tests. The last requests were sent in January 2017.
- We also found medication reviews did not consistently demonstrate evidence of appropriate monitoring. For example; a medication review had been held for a patient on ACE inhibitors without blood pressure or discussion of being monitored.
- We checked the monitoring of the practice fridges to ensure medicines were being kept at appropriate temperatures. We noted improvements in the practice recording of temperatures since December 2016. Where the fridge temperatures had exceeded the recommended storage requirements the practice had followed their cold chain procedure.
- The practice recorded the movement of prescription stationery and stored them securely. We asked the practice team what they did with prescriptions that were not collected by patients. Staff told us they followed up with patients who had not collected their prescriptions within two weeks to ensure they had no welfare concerns. Prescriptions no longer required were destroyed in accordance with their destruction policy.
- Patient Group Directions (PGDs) had been adopted in all documents reviewed to allow nurses to administer medicines in line with legislation.
- We reviewed personnel files for locum GPs, administrative staff and the clinical team. We found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and Disclosure and Barring Service for clinical staff.

Monitoring risks to patients

Risks to patients had been appropriately assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had conducted COSHH assessment and both administrative and clinical staff had signed to say they had read and understood.
- The practice had revised their fire risk assessment. Oxygen was held on the premises and appropriately signposted for the information of staff and emergency services. We checked four personnel files for clinical and non-clinical and staff had received fire safety training. The fire alarms were tested weekly and records were kept.
- We found electrical equipment was last checked in February 2016 to ensure it was safe to use. Clinical equipment had been calibrated to ensure it was working properly.
- The practice had reviewed their legionella assessment and monitored their water temperatures monthly. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff was on duty. The practice benefited from sharing clinical and administrative resources across their sites.

Arrangements to deal with emergencies and major incidents

The practice had sufficient arrangements in place to respond to 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.
- We found that all personnel files checked included evidence that annual basic life support training had been undertaken.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. Records were maintained of the checks conducted on the defibrillators and nebuliser. A first aid kit was available.

Requires improvement

Are services safe?

- Emergency medicines were easily accessible and their location known to staff. All the medicines we checked were in date and stored securely and covered the full scope of their activities.
- The practice had several contingency plans in plan for a range of incidents. These included a business continuity plan in place for major incidents such as power failure or building damage. The plan included escalation procedures and alternative accommodation. The practice told us they had experienced a power failure at the practice and the process had been tested and found to be effective.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found there was no established system in place to disseminate National Institute for Health and Care Excellence (NICE) best practice guidelines. Specifically there was a lack of awareness of the recent guidance issued on diagnosing sepsis. Whilst, clinicians did have access to relevant reference material the practice acknowledged this as an area for improvement. Following the inspection the practice appointed their external clinical GP advisor and the Trust lead Pharmacist to disseminate and monitor adherence to guidance through audit and peer review.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 96% of the total number of points available. The practice had an exception reporting rate of 11%; this was 3% above the local average and 1.4% above the national average. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was above the national average. For example, the percentage of patients with diabetes, on the register in whom the last IFCC-HbA1C is 64mmol/mol or less in the preceding 12 months was 79%. This was 4.8% above the local average and 1% above the national average. The practice had an exception rate of 11.8% in respect of this area and this was above the local average by 3.2%, but below the national average by 0.7%.
- 98% of the practice's patients on the diabetic register had the influenza immunisation. This was above the local average by 4.2% and the national average by 2.9%. The practice had a higher than local and national average for their exception rate in this area with 29%. This was 4.6% above the local rate and 9.4% above the national rate.
- The practice achieved above the national average for their management of patients with poor mental health. For example, 100% of their patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in their records within the last 12 months. This was 13.9% above the local average and 11.2% above the national average. They had a 0% exception rate which was 9.8% below the local average and 12.7% below the national average.
- The practice achieved 100% for the percentages of their patients diagnosed with dementia receiving a face to face review within the preceding 12 months. This was 15.2% above the local average and 16.2% above the national average. Their exception rate was 20%, above the local average by 9.1% and the national average by 13.2%.
- The percentage of patients with hypertension having regular blood pressure tests was 84.6%. This was 1.7% above the local and the national average. Their exception rate was 4.7%, 2.4% above the local average and 0.8% above the national average.

We found there were some coding discrepancies within their patient records. For example; we found a patient who had received an asthma check, who was not asthmatic but had an alternative respiratory diagnosis and had not been removed from the asthma register. We found a patient on the epilepsy register but a free text comment on their record reflected that they had not had the condition. The practice confirmed some administrative staff were coding clinical records based on guidance received through external training. This was not quality assured by a clinician or supported by a practice protocol. The practice confirmed all staff would receive training on the correct coding of patient information within a month.

We checked three diabetic patients' records to ensure that their clinical conditions were being monitored effectively. We found one of the three patients was being appropriately monitored and treated. All three patients had received a comprehensive annual review performed by the practice nurse. However, we found;

Requires improvement

Are services effective?

(for example, treatment is effective)

- One patient had not been prescribed blood/sugar monitoring equipment in order to manage their condition effectively. This was contrary to NICE guidance and put the patient at risk.
- The second patient had received blood sugar monitoring equipment but had not been prescribed testing strips since November 2015 to enable them to monitor their condition. We found no system to alert clinicians to revisit clinical risks with patients such as hypoglycaemia.

We shared our findings with the clinical team who shared our concerns. They held a clinical meeting and produced an action plan in response to the risks identified to ensure their timely and appropriate review of the patient records.

The practice had introduced an audit schedule. They had identified 16 audits, 15 were administrative audits. For example, emergency medicines policy and a diabetes device protocol review. The practice told us and we saw improvements had been made as a result of the audits with the introduction of effective processes for checking expiry dates of emergency drugs kept on site. However, there was an absence of clinical audits. We reviewed the single clinical diabetes audit for patients with type 2 diabetes. We found the audit lacked any clear criteria, standards or evidence of proposed intervention for the patient group identified in need of review.

Effective staffing

Some staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. Staff administering vaccines and taking samples for the cervical screening programme had received specific training.
- We found administrative staff coding clinical records based on guidance received through external training. This was not quality assured by a clinician or supported by a practice protocol and we found a number of errors.
- The learning needs of most staff had been identified through a system of appraisals, meetings and reviews of practice development needs. All staff had received an appraisal within the last 12 months.
- Staff had received some training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was not consistently available to relevant staff in a timely and accessible way through the practice's patient record system. For example: the practice participated in the admission avoidance programme and had identified 2% of their registered patients as appropriate (95 patients). They accepted that they had very few patient care plans. They confirmed that there was no process in place to identify patients on their admission avoidance programme who had been admitted to hospital. They had no system to prioritise the review of vulnerable patients care and produce care plans in response.

The practice conducted regular multidisciplinary meetings and shared information and coordinated care with partner health and social care services. We checked the practice register for cancer patients. There were 37 patients on the register and we sampled six patient records. We found all patient records had been coded correctly. However, their diagnosis did not always appear in the medical history summary to assist the clinician.

We checked the practices management of pathology results and found they were appropriately managed. We were told they were checked daily.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- We saw appropriate written consent was obtained for patients who received contraceptive devices.
- 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, staff carried out assessments of capacity to consent in line with relevant guidance.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP conducted an assessment.

Supporting patients to live healthier lives

The practice conducted appropriate health assessments and checks. These included health checks for new patients. NHS health checks for patients aged 40 were conducted via a local commissioned service provided by another healthcare provider.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We saw members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a room to discuss their needs confidentially.

Twelve of the 15 patient Care Quality Commission comment cards we received were positive about the service experienced. They reported positive experiences in respect of the staff being helpful, polite and treating them with dignity and respect. The patient participation group spoke highly of the kindness and professionalism of the practice nurse.

Results from the national GP patient survey, published in July 2016 showed patients reported below average levels of satisfaction regarding their experiences of consultations with GPs and experience of the service. For example:

- 64% of respondents said the GP was good at listening to them compared to the local average of 82% and the national average of 89%.
- 60% of respondents said the GP gave them enough time compared to the local average of 80% and the national average of 87%.
- 75% of respondents said they had confidence and trust in the last GP they saw compared to the local average of 91% and the national average of 95%.
- 60% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the local average of 78% and the national average of 85%.
- 79% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the local average of 88% and the national average of 91%.
- 69% of respondents said they found the receptionists at the practice helpful compared to the local average of 88% and the national average of 87%.

The practice told us they were concerned regarding the integrity of the survey data. The survey did not account for their patients being able to attend all three of the Trust's GP practices. To address this, the practice had conducted an individual site survey of 25 of their patients between November 2016 and January 2017. Twenty-four of the 25 patients reported the receptionists to be helpful and 12 would recommend the service to their friends and family.

We reviewed the patient NHS Friends and Family Test feedback for October, November and December 2016. Patients had completed and submitted 11 cards, 10 patients stated they were likely or extremely likely to recommend the practice.

Care planning and involvement in decisions about care and treatment

Patient feedback from the comment cards was generally positive in relation to the care and treatment they had received. We spoke to four patients including members of the practice patient participation group they spoke highly of the nursing care they received.

Results from the national GP patient survey, published in July 2016 relating to St. Clements PCT Medical Services (PCTMS) Practice showed patients reported below average levels of satisfaction regarding their involvement in planning and making decisions about their care and treatment. Results were below the local and national averages for their patient experiences of GPs. For example:

- 60% of respondents said the last GP they saw was good at explaining tests and treatments compared to the local average of 80% and the national average of 86%.
- 57% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the local of 74% and the national average of 82%.
- 78% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 85% and the national average of 85%
- 79% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern. The local average was 88% and the national average was 91%.
- 93% of respondents had confidence and trust in the last nurse they saw or spoke to. This was below the local and national average of 97%.

Requires improvement

Are services caring?

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. The practice served a diverse community with more patients registering from Polish, Ukraine and African Caribbean communities.
- The practice had patients with poor literacy skills and supported them to understand and access relevant health material.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. The practice had translated some health information leaflets into Polish and Ukraine to assist their patients.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 15 patients as carers, 0.4% of their patient list. They acknowledged this as an area for improvement and had arranged for an audit of their data to ensure it was reflective of their patient's needs. They were currently identifying carers at initial registration with the practice or during GP consultations. They had also identified improvements could be made in the coding of this data.

The practice offered carers more appointment availability and they were informed of their entitlement to receive free flu vaccinations. We spoke to the practice nurse who told us they verbally invited carers to attend for their vaccinations and reception sent text reminders and informed patients.

Staff told us that if families had suffered bereavement, their records were updated. The patients usual GP may contact the immediate family to provide advice, support and send a sympathy card.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice told us how their patient demographic was changing with a growing young population and few patients over 70 years of age. The practice had commissioned an independent company to conduct a review of the service to assess their care model and inform their future business strategies. Currently, they offered the following services to meet their patient's needs;

- The practice offered online appointment booking.
- Patients could order repeat prescriptions on line and nominate a pharmacy of their choice to dispense their medication.
- Patients were able to access and view their medical summary record online.
- The practice could access GP services Monday to Friday at the practice or their neighbouring practices (The Acorns and Dilip Sabnis) and GP hub services Saturday and Sunday.
- There were longer appointments available for patients with a learning disability and this was identified on the patient record for the information of staff.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS.
- There was automatic door entry to the premises.
- Female patients were able to access long acting reversible contraception at the practice.
- Daily telephone consultations were available with the GPs.
- The practice nurse held chronic disease management clinics.
- The practice facilitated 40 year old health checks conducted by a commissioned service provided by another healthcare provider. These were also conducted at weekends at various locations within the local area.
- The practice had translation facilities which they offered to patients whose first language was not English.
- Patients were able to access midwifery services at the St. Clements and The Acorns practices.
- Retinal screening clinics were held at the practice linking in with the local diabetic team.

The practice told us they conducted home visits for older patients and those who had clinical needs. The practice had six patients on their palliative care register. We checked all of the patient records and found most face to face care was delivered by specialist palliative care nurses, chronic obstructive pulmonary disease team, district nurses and dieticians. We found a patient on end of life care was last visited in June 2015 and ongoing care was provided by telephone consultation and communication with other health professionals. The practice told us they were revising how they supported some of their most vulnerable patients.

Access to the service

The practice was open between 8am and 6.30pm and GP appointments were available between 9am and 5.30pm. The practice nurse appointments were available from 9am to 5.30pm but not on a Wednesday. A locum nurse prescriber worked at the practice on a Thursday.

The practice did not operate extended hours but the patients benefited from access to an out of hours GP hub service. Appointments were pre-bookable via the practice for both GPs and nurse. In addition, GP appointments may be booked two weeks in advance and the nurse may book up to four weeks in advance. Urgent appointments were available for people that needed them. There were limited parking facilities at St. Clements PCT Medical Services (PCTMS) Practice.

Results from the national GP patient survey, published in July 2016 showed that patient's satisfaction with how they could access care and treatment were below local and national averages.

- 52% of respondents were satisfied with the practice's opening hours compared to the local average of 71% and the national average of 76%.
- 44% of respondents said they could get through easily to the practice by phone compared to the local average of 73% and the national average of 73%.

The practice had conducted a patient feedback questionnaire during November 2016 to January 2017. Out of the 25 patients who provided feedback 15 described their experience as fairly good or very good. Twenty-four of the patients stated their consultations with the nurse they last saw was good or very good.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We asked the practice when the next available appointments were with the practice nurse. They told us there was availability on the day of the inspection. The next available GP appointment for a patient presenting with a non-urgent condition was within three working days.

The practice told us they had 317 patients who had not attended appointments between October 2016 and January 2017. The practice had not differentiated between the non-attendance of patients for nurse appointments and GPs. The practice showed us their patient non-attendance policy. Patients were invited to speak with the practice manager regarding any concerns that resulted in them being unable to attend. Staff told us they were following the policy and patients who had failed to attend their appointment twice without notifying them had been written to. They were hopeful this would reduce the number of wasted appointments in the future.

Listening and learning from concerns and complaints

The practice had a system in place for handling all complaints and concerns.

- The practice used the Trust's complaints policy and procedures. Staff raised incidents centrally.
- The practice manager was the designated responsible person who handled all complaints in the practice and over the three sites.
- We saw that information was available to help patients understand the complaints system, including reference to the Trust advocacy services.
- Leaflets were available within the patient waiting area.

The practice team were capturing verbal complaints and monitored the NHS choices website for patient opinions. They told us their preference was to address issues and they arose and try to resolve them to the satisfaction of parties at the time of reporting.

The practice had recorded 14 incidents for actioning, six were complaints and these related to access to services including a lack of available appointments. We reviewed a complaint and found that the practice had acknowledged the patients concerns, investigated the incident, identified learning and shared this with the team. However, the complaint record did not detail all enquiries conducted including discussions with the staff member to identify areas for improvement. The practice told us trends and themes were identified and discussed at practice meetings and centrally by the Trust.

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 was part of the North Essex Partnership University NHS Foundation Trust (NEPT) and held a contract to provide primary medical services until 2018. The practice had published their values that included providing humanity, excellence, maintaining passion and keeping things simple. The Trust had commissioned an external specialist GP advisor to assist them to develop an overarching strategy regarding how they were to deliver their services individually or across the three practices within Grays, Essex.

Governance arrangements

The practice had acknowledged that improvements were required to establish and strengthen their governance systems. In response, they had commissioned external specialists in primary care and were using their own Trust clinical resources within medicine management to drive improvements. This had come about as a result of inspections of their two affiliated practices also managed by the Trust. The areas for improvement identified at these practices were the subject of an improvement plan across all three practices and implementation of this plan had begun prior to our inspection.

The practice benefited from a permanent GP but needed to ensure they were sufficiently supported to lead in areas of appointed responsibility. The Trust was actively recruiting to the clinical team to provide greater stability and continuity in clinical care.

The clinical performance of the practice under QOF was strong and the practice was introducing a programme of audits to assess, monitor or improve the quality and safety of services. These were in their infancy and needed time to be established and reviewed to demonstrate improvements in the performance of the practice.

Leadership and culture

The Trust had acknowledged there had been an absence of visible leadership within the practice. Whilst it was intended that the practice manager would continue to divide their time between the three practices, they would be supported by a senior administrator at each site. The practice manager had also received a development review and appropriate training had been identified for them to develop their leadership and governance skills further.

We found regular operational and clinical meetings had been introduced in 2017. These presented clinical and non-clinical staff with an opportunity to meet, discuss concerns and develop an understanding and appreciation of one another's roles. We reviewed the last three practice meeting minutes from the 11 January 2017 to the 23 January 2017. They was a clear agenda with stand items for discussion, such as safeguarding, significant events, staff training and development and practice performance. Actions were documented where areas required improvement. However, we found issues from previous minutes were not revisited to ensure they had been completed.

We found that the provider had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). We found staff were following policies and procedures to ensure staff knew and understood processes. Where mistakes were made staff reported these to management and apologised to patients and their families if appropriate. The practice showed us how they were learning from concerns raised to mitigate the risk of reoccurrences. However, there was an absence of documentary evidence to support this.

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

- The practice told us they were asking patients for feedback but had experienced difficulties attracting patients to their patient participation group (PPG). The practice had received seven expressions of interest and three of the patients had attended their first meeting held in January 2017. They had nominated a PPG Chair but the group were in their infancy and had met only once to provide initial feedback on patient experiences.
- A staff survey had been conducted at the end of 2016. The practice was reviewing the data at the time of the inspection to inform their improvement plans. The practice told us how they had responded to staff feedback and had introduced regular team meetings. The meetings were held on alternate days to ensure all staff had an opportunity to attend them. All staff had received appraisals.