Dilip Sabnis PCT Medical Services (PCTMS) Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Dilip Sabnis on 23 November 2016. Overall the practice is rated as inadequate.

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

- There was no effective system in place for reporting, recording, investigating, responding and learning from significant events.
- There was an insufficient system in place to receive or respond to Medicine and Health products Regulatory Agency (MHRA) alerts.
- The practice did not have defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were not assessed and well managed. We found the infection prevention control audit was incomplete.
- Prescribing practices were unsafe and patients receiving high risk medicines had not been appropriately reviewed.
- Medicines were not being stored appropriately and cold chain procedure followed.
- Patient group directives had not been appropriately authorised for the administration of immunisations to pregnant women.
- Not all clinical staff had undertaken appropriate emergency life support training.
- The practice did not hold appropriate emergency medicines for patients allergic to penicillin and who may experience a diabetic hypoglycaemia episode.
- We found patients were inappropriately coded for conditions they did not have.
- The practice had no quality improvement processes in place to identify where they might improve.
- Care plans were not in place for all patients on their admission avoidance programme.
- Some referrals lacked relevant information and did not meet guidelines for referrals.

Summary of findings

- Patients had not been appropriately identified, placed on risk registers and included in multidisciplinary discussions.
- Patients had not received appropriate medicine reviews.
- The practice was performing below averages in relation to most responses relating to involvement in decisions with the GPs.
- We found the practice performed infrequent home visits and did not schedule home visits to the most vulnerable such as those receiving end of life care.
- Patient satisfaction score were below the local and national average for the practice opening hours and easy of contacting the practice.
- The practice did not have an effective complaints procedure in place. It failed to advise patients of their right to advocacy services to support them making a complaint.
- There were no translation services available for patients whose first language was not English.
- The overarching governance systems for the practice had not been effectively embedded into the practice.
- The practice did not have a clear vision and strategy for delivering primary medical services.
- The practice had a number of policies and procedures to govern activity, but these were not reflective of the practice.
- There was a lack of clinical oversight. There were no checks to ensure that the GP locums were referring appropriately and prescribing in accordance with NICE guidelines.
- Staff had received training to undertake chaperone duties but had not received Disclosure and Barring Service (DBS) checks.

The areas where the provider must make improvements are:

- Ensure staff understand, recognise, record, investigate and identify and learn from significant incidents.
- Establish an effective system to action medicine safety alerts and monitor and prescribe safely in accordance with guidance.
- Undertake a risk assessment in relation to emergency medicines held at the practice to enable staff to respond to a medical emergency.
- Follow published guidance in relation to the storage of medicines in fridges.
- Ensure staff are suitably trained to undertake their roles, for example, receiving training in basic first aid.
- Ensure the appropriate supervision of clinical staff in the administration of vaccinations.
- Maintain accurate records on patients, including coding, completion of care plans and inclusion on risk registers to enable the monitoring of their health.
- Implement an effective system of governance and clinical oversight to assess, monitor and improve the quality of safety for patients and identify and mitigate risks relating to the health, safety and welfare of patients.
- Seek and act on patient feedback.
- Operate an effective and accessible complaint system.
- Implement a system of quality assurance to include clinical audit.
- Staff undertaking chaperone responsibilities should have disclosure and barring service checks or be risk assessed for the role.
- Ensure the secure storage of blank prescription stationery and record their issue to clinicians.

The area where the provider should make improvement is;

- Identify a system for improving the screening rates of bowel cancer.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services.

- There was no effective system in place for reporting, recording, investigating, responding and learning from significant events.
- There was an insufficient system in place to receive or respond to Medicine and Health products Regulatory Agency (MHRA) alerts.
- The practice did not have defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were not assessed and well managed.
- Prescribing practices were unsafe and patients receiving high risk medicines had not been appropriately reviewed.
- Medicines were not being stored appropriately and the cold chain procedure was not being followed.
- The practice failed to record the issue of blank prescription stationery and they were not being stored securely.
- Patient group directives had not been appropriately authorised for the administration of immunisations to pregnant women.
- Not all clinical staff had undertaken appropriate emergency life support training.
- The practice did not hold appropriate emergency medicines for patients allergic to penicillin or those who may experience a diabetic hypoglycaemia episode.
- 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?

Inadequate

The practice is rated as inadequate for providing effective services.

- The practice achieved 96% of the total points available under QOF.
- We found patients were inappropriately coded for conditions they did not have.
- The practice had no evidence of clinical audit or other quality improvement processes in place to improve and inform quality improvement.
- Care plans were not in place for all patients on their admission avoidance programme.

Summary of findings

- Patients had not been appropriately identified, placed on risk registers and included in multidisciplinary discussions.
- Patients had not received appropriate medicine reviews.
- The practice had below national screening rates for bowel cancer.

Are services caring?

Requires improvement

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

- Data from the national GP patient survey showed patients rated the practice lower than others for many aspects of care. 62% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 78% and the national average of 85%.
- The practice was performing below averages in relation to most responses relating to involvement in decisions with the GPs.
- The patients told us the staff were polite, supportive and would go out of their way to assist them.
- The practice had identified 1.5% of their patient list as carers and was improving their identification and services to such patients.

Are services responsive to people's needs?

Inadequate

The practice is rated as inadequate for providing responsive services.

- The practice offered a range of services to their patients who could be accessed at Dr Dilip Sabnis or NEPT neighbouring practices (Acorns and St. Clements).
- We found the practice performed infrequent home visits and did not schedule home visits to the most vulnerable such as those receiving end of life care.
- Patient satisfaction score were below the local and national average for the practice opening hours and easy of contacting the practice.
- The practice did not have an effective complaints procedure. It failed to advise patients of their right to advocacy services to support them making a complaint.
- Patients could book appointments on-line. Translation services were available for patients.

Are services well-led?

Inadequate

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

Summary of findings

- The overarching governance systems had not been effectively embedded into the practice.
- The practice did not have a clear vision and strategy for delivering primary medical services.
- The practice had a number of policies and procedures to govern activity, but these were not reflective of the practice.
- There was a lack of clinical oversight. There were no checks to ensure that the GP locums were referring appropriately and prescribing in accordance with NICE guidelines.
- There was often only remote managerial oversight available for most of the week.
- Most of the locum GPs did not attend practice meetings where safeguarding concerns, significant events, complaints and learning were discussed and it was unclear how the clinical team was being effectively led.
- Systems were not in place to support patients to give feedback. The practice was engaging with their CCG and Healthwatch to encourage patient participation.

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

Inadequate

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

- We found the practice had no system in place to ensure housebound patients were visited where required for medicine reviews.
- Patients receiving end of life were not visited appropriately.
- The practice participated in admission avoidance but not all had care plans as required.
- The practice offered flu vaccinations to patients over 65.
- The practice did not have defined and embedded 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

Inadequate

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

- The practice achieved 100% for their management of patients with long term conditions such as Asthma, chronic kidney disease, heart disease and chronic obstructive pulmonary heart disease.
- There were insufficient systems to receive or respond to Medicine and Health products Regulatory Agency (MHRA) alerts to ensure that patients with long-term conditions taking certain medicines were safe.
- Prescribing practices were unsafe and patients receiving high risk medicines had not been appropriately reviewed.
- The practice did not hold appropriate emergency medicines for patients who may experience a diabetic hypoglycaemia episode.

Summary of findings

Families, children and young people

Inadequate

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

- Patients could access midwifery services at one of the providers other locations.
- Not all systems, processes and practices kept patients safe and safeguarded from abuse.
- Patient group directives had not been appropriately authorised for the administration of immunisations to pregnant women.
- The temperatures of fridges storing vaccines were not being monitored in line with guidance.
- Not all locum GPs working at the practice were trained to an appropriate safeguarding children level three.
- The practice conducted postnatal checks including comprehensive physical and mental health questionnaires.
- 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.
- The practice followed up with guardians where a child had failed to attend for vaccinations and hospital appointments.
- The practice showed a consistent cervical screening rate comparable to the national average.

Working age people (including those recently retired and students)

Inadequate

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

- Patients could access GP and nursing services at all three of the provider's locations within Thurrock.
- Weekend appointments with a GP or nurse could be booked at the local GP health hub.
- There was no website to enable patients to request services online, translate information and provide useful information such as directions and health promotion advice, for example.
- Patients could book appointments on-line.
- Health screening services were available at the practice and via an external health provider throughout Grays.
- The practice had below the national average rates for their screening of bowel cancer.

Summary of findings

People whose circumstances may make them vulnerable

Inadequate

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

- Some 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.
- Patients with learning disabilities had received their annual reviews from the community health team.
- We found the practice had no system in place to ensure housebound patients were visited where required for medicine reviews.
- The practice did not have an effective complaints procedure that reflected practice. It failed to advise patients of their right to advocacy services to support them making a complaint.
- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

People experiencing poor mental health (including people with dementia)

Inadequate

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

- The practice achieved 100% for their management of patients with dementia above the local average by 2.4% and the national average 3.4%.
- The practice achieved 100% for their management of patients with depression. This was above the local average 14.7% and the national average of 7.8%.
- Clinicians could refer patients to the dementia clinic for screening and for on-going support by the community geriatrician.
- There were insufficient safeguarding systems in place should a patient fail to collect their medicines.
- Prescribing practices were unsafe and patients receiving high risk medicines had not been appropriately reviewed.
- We found poor medicine management by the GPs. Patients had been prescribed medicines in excess of their monitoring periods.

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. 324 survey forms were distributed and 100 were returned. This represented a response rate of 31%.

- 60% of respondents found it easy to get through to this practice by phone compared to the local average 73% and the national average of 73%.
- 66% 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%.
- 68% 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%.
- 47% of respondents said they would recommend this GP practice to someone who has just moved to the local area compared to the local average 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. We received 14 comment cards which were all positive about the standard of care received and the support and kindness of the practice team.

We reviewed the patient NHS Friends and Family Test feedback for August 2016 to October 2016. There were 45 cards submitted and 37 patients had commented that they were likely or extremely likely to recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure staff understand, recognise, record, investigate and identify and learn from significant incidents.
- Establish an effective system to action medicine safety alerts and monitor and prescribe safely in accordance with guidance.
- Undertake a risk assessment in relation to emergency medicines held at the practice to enable staff to respond to a medical emergency.
- Follow published guidance in relation to the storage of medicines in fridges.
- Ensure staff are suitably trained to undertake their roles, for example, receiving training in basic first aid.
- Ensure the appropriate supervision of clinical staff in the administration of vaccinations.
- Maintain accurate records on patients, including coding, completion of care plans and inclusion on risk registers to enable the monitoring of their health.
- Implement an effective system of governance and clinical oversight to assess, monitor and improve the quality of safety for patients and identify and mitigate risks relating to the health, safety and welfare of patients.
- Seek and act on patient feedback.
- Operate an effective and accessible complaint system.
- Implement a system of quality assurance to include clinical audit.
- Staff undertaking chaperone responsibilities should have disclosure and barring service checks or be risk assessed for the role.
- Ensure the secure storage of blank prescription stationery and record their issue to clinicians.

Action the service SHOULD take to improve

- Identify a system for improving the screening rates of bowel cancer.

Dilip Sabnis 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.

Background to Dilip Sabnis PCT Medical Services (PCTMS) Practice

Dr Dilip Sabnis PCT Medical Services (PCTMS) Practice is one of three practices provided by North Essex Partnership University NHS Foundation Trust. The practice holds its own patient list of approximately 3101 patients. The other two practices 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 relatively stable but deprived patient population.

There are no permanent GPs employed at Dr Dilip Sabnis. However, the practice has one male locum GP who has been working there for the past two years. There is a permanent part-time nurse employed at the practice. The practice manager works across all three of the provider's practices in Grays, Essex.

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 but not 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 are pre-bookable via the practice for both GPs and nurse. For specific interventions such as flu vaccinations the practice offered earlier appointments throughout the year and including specified weekends.

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 Dr Dilip Sabnis practice.

The practice did not have a website. Information was available on the NHS choices website but we found this was not accurate.

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 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 23 November 2016. During our visit we:

Detailed findings

- Spoke with a range of staff (senior manager for the practice, practice manager, GP locum, 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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice had a central recording system used by staff for reporting and recording incidents. Incidents were then classified on North Essex Partnership University NHS Foundation Trust (NEPT) risk framework. We found no clinical significant incidents had been recorded. Eight entries had been made; we reviewed four forms relating to a breach of patient data, poor administrative processes, arrangements for booking appointments and the inappropriate administration of medicine by a patient. All incidents were referred to the practice manager for investigation and then overseen by the Trusts head office. We found that there had been no clinical input into the incident where a patient had inappropriately administered a medicine. The practice had not reviewed the information given to patients or recommended systems were introduced to mitigate it occurring again.

We concluded the incident recording system was insufficient to support the recording of notifiable incidents under 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). There was no evidence of quality improvement activities.

We asked the practice how they managed Medicines and Health 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 they shared the alerts with their clinical team, conducted a search of patients who may be adversely affected and discussed them. When we checked patient records in respect of previous MHRA alerts we found patients remained at risk;

- In 2012 an MHRA alert related to the prescribing of conflicting medicines. We found two patients had received the medicines above the recommended dosage placing them at risk of harm. They had been prescribed the conflicting medicines monthly since June 2016 and were last issued the medicines on the 1 November 2016. One patient had received a six month issue of prescription contrary to policy and NICE guidance.
- In February 2016 an MHRA alert related to the prescribing of conflicting medicines. The practice told us they had reviewed their prescribing of Spironolactone following the inspection of their other practice. We found they had conducted a search of their patient records in October 2016 relating to the alert, eight months later. We found all four of the patients receiving the medicines were appropriately monitored under the care of community heart failure team.
- In September 2016 an MHRA alert related to a batch of glucagon hypo kits with faulty needles. The device contained medicine used to treat a diabetic in an emergency if hypoglycaemic. Without fast response this condition can result in loss of consciousness and coma for the patient. The surgery had no evidence that they had acted on this alert. However, when we checked the patient record we found none of their registered patients with the surgery were adversely affected.
- In February 2016 an MHRA alert related to children exposed to anti-epileptic medicines to be at high risk of developmental disorders. We found no evidence of the surgery acting on the alert.

Overview of safety systems and processes

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

- Arrangements were insufficient to safeguard children and vulnerable adults from abuse. We reviewed the practice safeguarding children policy dated September 2016. It required all practice staff working with children and adults would undergo 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 not all administrative staff had been appropriately checked.
- 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. However, the GP was not full time and had never visited the practice or spoken directly with the practice team.
- The practice told us the GPs provided 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. However,

when we checked staff files we found the Trust were unable to demonstrate that two GPs who worked for the Trust at Dr Dilip Sabnis had not been trained to the appropriate level, 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. Reception staff acted as chaperones. They had received training for the role but had not received a Disclosure and Barring Service (DBS) check and there was no risk assessment in place. They recorded their presence during examinations directly onto the patient record.
- 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 concluded the practice to be 91% compliant. However, the document was incomplete and stated not all rooms had been reviewed due to being in use at the time of the audit. The recommendations and actions did not include issues identified in their report and there were no dates given for the service to achieve full compliance.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice failed to keep patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). We reviewed the practice prescribing policy and found it was not being adhered to and the policy was out of date.
- We found the processes were inadequate for handling repeat prescriptions which included the review of high risk medicines. For example:

We found the practice were issuing six monthly prescriptions in advance of three monthly monitoring checks required for high risk medicines such as Methotrexate. We found one patient had been issued six months of prescriptions on 7 November 2016 until April 2017 with no records of patient blood tests having been undertaken included with documentation with their rheumatologists. This placed the patient at risk.

We found patients were not consistently receiving appropriate medicine reviews. We reviewed the care of a housebound patient with comorbidities who last had a medicine review in July 2013. Reviews had been conducted over the phone with their carer.

We found seven patients were being prescribed highly addictive medicines in excess of their monitoring period. The practice policy stated these were not to be issued on repeat prescription and patients were required to be assessed every twelve months. We looked at three of the seven patients and they had not been reviewed within the last year and they were being issued six monthly prescriptions at a time.

We found 36 patients on ACE inhibitors who required a minimum of annual blood tests if not more regularly and had not had these conducted in over 13 months. We reviewed four patient records. All the patients were on repeat prescriptions and had last had their blood tests between July 2014 and September 2015. The practice told us they had sent letters to potentials patients at risks asking for them to attend for monitoring checks but had continued to prescribe.

- The practice told us they were drafting a medicine management policy for patients who failed to comply with monitoring. We reviewed the practice clinical supervision meeting minutes from March 2016 and found that clinical staff had been told to advise patients that their medicine would be halved unless they attended a medicine review.
- We checked the monitoring of the practice fridges to ensure medicines were being kept at appropriate temperatures. We found that the fridge temperatures had exceeded the recommended storage requirements on six occasions in November 2016. No explanation had been recorded in the practice records to explain this and they had failed to follow their cold chain medicine management procedure.
- The practice did not log the receipt or issue of blank prescription stationery and were not storing them securely. We asked the practice team what they did with prescriptions that were not collected by patients. They told them they left them for approximately six months, recorded they had not been collected and then shredded them. The GPs were not notified that the patient had failed to collect their prescription and no safeguarding checks were conducted.

Inadequate

Are services safe?

- We found the PGD for the administration of a national immunisation to pregnant women had not been appropriately authorised. Patient Group Directions (PGDs) 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

Not all 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 but only three administrative staff had confirmed they had read the file and no members of the clinical team.
- The practice had revised their fire risk assessments annually as required by law. Oxygen was held on the premises and appropriately signposted for the information of staff and emergency services. Staff had not received fire safety training. This had been scheduled for all staff to complete in November 2016 following our inspection. The fire alarms were tested weekly and records were kept.
- We found electrical equipment was last checked in October 2015 to ensure it was safe to use. It had been scheduled to be revisited on 30 November 2016. Clinical equipment had been calibrated to ensure it was working properly.
- The practice had conducted a legionella assessment and monitored their water temperatures. (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 did not have 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 three GPs and a practice nurse had not undertaken annual basic life support training.
- 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.
- Staff knew where the emergency medicines were held, but they were not easily accessible. All the medicines we checked were in date and stored securely. However, the practice did not hold appropriate emergency medicine for patients with suspected meningitis and an allergy to penicillin and there was no glucagon available to patients who may have diabetic hypoglycaemia. We reviewed practice management meeting minutes and saw the GPs had requested diazepam (to treat persistent seizures) to be included in their emergency medicines. This had not been addressed and there was no explanation recorded as to why this had not been actioned. There was no risk assessment in place in relation to the absence of these medicines.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included escalation procedures and alternative accommodation. Emergency contact numbers for staff and the emergency control room were not referred but we were told they were held centrally. The practice told us they had experienced a power failure at St. Clements and the process had been tested and found to be effective. However, we found no record of the incident being recorded as a significant event.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We spoke with clinicians and reviewed patient records of consultations and prescribing practices. We found on the records reviewed that patients had received appropriate assessments of their needs. However, the practice had failed to consistently adhere to National Institute for Health and Care Excellence (NICE) best practice guidelines regarding their prescribing practices.

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 10.6%; this was 2.4% above the local average and 0.8% 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). We looked at exception reporting for patients with hypertension and saw that it was appropriate.

Data from 2015/2016 showed:

- The practice achieved 100% for their management of patients with long term conditions such as asthma, chronic kidney disease, heart disease and chronic obstructive pulmonary heart disease. Exception reporting was comparable with other practices locally and nationally.
- The practice achieved 100% for their management of patients with dementia which was above the local average by 2.4% and the national average of 3.4%. Exception reporting was comparable with other practices locally and nationally.
- The practice achieved 100% for their management of patients with depression. This was above the local average by 14.7% and the national average of 7.8%. For this clinical indicator the practice exception reporting rate was much higher than the local and national averages by 26% and 25% respectively.

We reviewed how the practice managed patients with hypertension. We found there was coding discrepancies with their patient records. For example; we found a patient who had no history of hypertension, was not on any medicine but highlighted on their practice register as having hypertension. Poor coding on patient records was also found in the practices management of patients with cancer. For example, we found;

- A patient had been placed on the practice cancer register but did not have the condition.
- There were two patients not on the palliative care register but had been discussed during the Multidisciplinary meeting in October 2016.
- A patient with metastatic cancer was also not on the cancer register.

We reviewed clinical meeting minutes and found no evidence of discussions of patient risks. The practice had no completed clinical audits to demonstrate quality improvement. The practice had produced a clinical audit schedule in October 2016. The scheduled proposed the monitoring of palliative care patients and management of patients with urinary tract infections. The practice confirmed none of the actions had been completed. There was also no other quality improvement process in place.

Effective staffing

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.
- The learning needs of staff had not been effectively identified through a system of appraisals, meetings and reviews of practice development needs. Some staff had failed to receive appropriate training in safeguarding of health and fire safety despite having access to resources to cover the scope of their work. All staff had received an appraisal within the last 12 months.

Inadequate

Are services effective?

(for example, treatment is effective)

- Some 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 and their intranet system. For example: the practice participated in the admission avoidance programme and had identified 2% of their registered patients as appropriate (63 patients). However, when we checked five patient records we found only three had care plans all of which had been entered the previous week.

We checked the practices management of pathology results and found they were appropriately managed with none outstanding. We also reviewed fourteen patient referrals. We found the regular locum GP had made appropriate referrals. However, two of the referrals lacked relevant information and did not meet guidelines for referrals.

We found three patients with cancer or who had advanced cancer that were not on the palliative care register, all of which would be appropriate. They were listed on the multidisciplinary meeting minutes for discussion. We found one patient receiving anticipatory medicines due to poor health who was not included on the register. Therefore, the clinical team would be unaware of their immediate clinical needs.

We found an elderly house bound patient with multiple co-morbidities (kidney, heart disease) had not been seen by a GP since July 2013. The practice had spoken with the patients carers but not spoken with the patient and met with them. The patient had continued to be prescribed medicine without review and contrary to NICE guidelines.

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.
- 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.

The practice encouraged their patients to attend national screening programmes. However the practice did not monitor their patient's attendance or have specific strategies to improve uptake. Data from the National Cancer Intelligence Network showed the percentages of eligible patients who undertook screenings were below local and national averages. For example,

- The practice showed a consistent cervical screening rate were low when compared to the national average. In 2014/2015 the practice's uptake for the cervical screening programme for 25- 64year old women in the target period or 5.5 years was 74%, which was below the national average of 81%.
- In 2015/2016 72% of the eligible female patients aged 50-70 years of age had been screened for breast cancer within six months of their invitation. This was comparable to the national average of 73%.
- In 2014/2015 42% of the eligible patients aged 60-69 years of age had been screened for bowel cancer in six months of their invitation. This was below the national average of 58%. Their screening rates remained below the national averages in 2015/2016. The achieved 42% of their patients aged 60-69 years of age for bowel cancer in six months of their invitation. This was below the national average 56%.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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.

All of the 14 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an attentive service and staff were helpful, caring and treated them with dignity and respect.

Results from the national GP patient survey, published July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was below average for its satisfaction scores on consultations with GPs and experience of the service. For example:

- 67% 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%.
- 88% 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%.
- 62% of respondents said the last GP they spoke to was good at treating them with care and concern compared to the local average 78% and the national average of 85%.
- 91% of respondents said the last nurse they spoke to was good at treating them with care and concern compared to the local average 88% and the national average of 91%.
- 77% 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. Their patients could attend all three of the Trust's GP practices and therefore they were not confident the patients reported their experience of Dr Dilip Sabnis alone. To address this, the practice was conducting an individual site survey of their patients at the time of our attendance. The findings were still to be collated and analysed. The practice was unable to provide examples of how they had responded to previous patient feedback.

We reviewed the patient NHS Friends and Family Test feedback for August 2016 to October 2016. Patients had completed and submitted 45 cards, 37 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 we received was positive in relation to the care and treatment they had received.

Results from the national GP patient survey, published in July 2016 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:

- 67% 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%.
- 60% of respondents said the last GP they saw was good at involving them in decisions about their care compared to the local 74% and the national average of 82%.

Patient feedback was more positive in respect of the care patients received from the nursing team. For example;

- 89% of respondents said the last nurse they saw was good at involving them in decisions about their care compared to the local average 85% and the national average of 85%.
- 91% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern.
- 97% of respondents had confidence and trust in the last nurse they saw or spoke to.

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 predominately English speaking community. However, their other surgeries had high representation from non-English speaking 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's computer system alerted GPs if a patient was also a carer. The practice had identified 46 patients as carers, 1.5% of their patient list. They acknowledged this as an area for improvement and were identifying carers at initial registration with the practice or during GP consultations. Currently 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 sent text reminders.

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

Inadequate

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 from an aging population to patients under 40years of age with young families. 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 St. Clements) 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, although this was not working at the time of the inspection. It had been reported for repair.
- Female patients were able to access long acting reversible contraception at the practice.
- Daily telephone consultations were available with the GPs and practice nurses
- The practice nurse held chronic disease management clinics.
- The practice facilitates 40 year old health check conducted by a commissioned service provided by another healthcare provider. These were also conducted at weekends at various locations within the local area.
- There were translation facilities offered to patients whose first language was not English.
- Patients were able to access midwifery services at the St. Clements and Acorns practices.
- Retinal screening clinics were held at the St. Clements practice linking in with the local diabetic team.

The practice told us they conducted home visits for older patients and patients who had clinical needs which resulted in difficulty attending the practice. However, we found the practice had conducted only one home visit from 31 October to 23 November 2016. We found patients on end of life care had not been seen in the last month.

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 Monday, Tuesday, Wednesday and Friday. The practice did not operate extended hours but the patients benefited from access to an out of hours GP hub service open on Saturday and Sunday. Appointments at the practice were pre-bookable via the practice for both GPs and nurse. For specific interventions such as flu vaccinations the practice offered earlier appointments throughout the year including weekends. In addition, appointments could be booked two weeks in advance for the GP and up to four weeks in advance for the nurse. Urgent appointments were also available for people that needed them.

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.

- 64% of respondents were satisfied with the practice's opening hours compared to the local average of 71% and the national average of 76%.
- 60% 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 told us they had high rates of non-attendance by their patients with 135 recorded in October 2016. The practice had not differentiated between the non-attendance of patients for nurse appointments and GPs. However, the practice showed us their patient non-attendance policy. We found this did not reflect their practice whereby they would write to patients regarding their non-attendance. They told us how they would review the patients care and ensure there were no safeguarding concerns prior to escalation to a senior decision maker.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice did not have an effective system in place for handling complaints and concerns.

- The practice used the Trust's complaints policy and procedures. It did not reflect the current practice which required staff to raise an incident centrally or include reference to advocacy services.
- 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. A poster was displayed within the waiting area and in consulting rooms advising patients that the manager or a nominated member of staff in her absence is available to speak with.

The practice told us they had no reported formal written complaints raised with them directly or via their Patient Advice and Liaison Service (PALS). The practice told us they would record verbal complaints and monitored the NHS choices website to capture patient opinions. However, they told us their preference was to address issues and try to resolve them to the satisfaction of parties at the time of reporting.

The practice had recorded a single incident where a patient had been abusive to a staff member in 2016. We checked the Trust incident record system and found it had been reported. The practice manager had formally written to the patient advising them that their behaviour was not acceptable. However, no records were retained of enquiries made or staff accounts. No explanation of the incident was documented as to why the patient presented in the manner they did. The practice told us trends and themes were identified centrally by the Trust and then shared with the practice.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The practice 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 values including providing humanity, excellence and maintaining passion. The practice had no overarching strategy regarding how they were to deliver their services individually or across the three practices within Grays, Essex.

Governance arrangements

We found an absence of governance systems in place to maintain safe, effective, caring and responsive services. There was no permanent member of the clinical team who led on providing clinical oversight of the services provided. The GPs were appointed to see patients and were not provided with protected time to undertake clinical audits or performance improvement activities.

We found that the practice had ineffective systems in place to identify, analyse and manage risks to patients and staff. There was a lack of clinical oversight and governance. In particular there was a lack of systems in place to act on patient safety and medicines alerts, the identification and investigation of significant events, the storage of emergency medicines and the monitoring of fridges and the training of staff to carry out their roles.

Whilst the clinical performance of the practice under QOF was comparable with other practices there were no systems in place to assess, monitor or improve the quality and safety of services. There was a lack of clinical audit or any other quality improvement process.

The practice used policies provided by the registered provider NEPT. However, these policies were not bespoke to the practice and did not guide staff to carry out their roles.

We were shown the last minutes for the meeting held at the practice in February 2016. The provider's three practices (Acorns, St. Clements and Dr Dilip Sabnis) combined their meetings. The practice meeting focused on their financial performance and did not assess the broad performance of the service as a whole. There was no evidence available to demonstrate that the practice was discussing the performance of the practice with their staff to identify risk and to identify where they might improve.

Locum and part time staff did not always attend practice meetings where safeguarding concerns, significant events, complaints and learning were discussed. We found that requests by the clinical team for additional emergency medicines had not been responded to.

Leadership and culture

There was an absence of visible leadership within the practice as the practice manager divided their time between three practices. They had received no specific training in undertaking the role although they had worked within the healthcare sector for a number of years and regularly attended practice manager meetings for peer support and guidance. There was no clinical leadership or oversight.

The practice clinical team consisted of locums or part time staff. Opportunities to meet with all the team were limited and often clinical and practice meetings were jointly held with the other practices. Where lead roles had been appointed to a member of the clinical team such as safeguarding and medicine management, it was not clear what their role and responsibilities entailed. They were not asked to account for performance in these respective areas and we found prescribing practices to be unsafe.

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). However, we found them to be ineffective. They were not detailed within the NEPT policies and procedures to ensure staff knew and understood the processes. We found an absence of complaints or concerns recorded and no clinical significant incidents had been identified by any staff.

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

- The practice told us they encouraged and valued feedback from patients, the public and staff. The practice did not have a patient participation group (PPG). They had actively engaged with Healthwatch to capture patient opinions and to recruit a representative patient group. The practice did review patient experiences recorded on public websites such as NHS Choices and NHS Friends and Family Test cards. However, there was little evidence of changes being made in response to the feedback.

Are services well-led?

Inadequate

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

- The practice staff were supportive of one another. Staff meetings were held but these were often informal and infrequent. Staff had received appraisals.

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
Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The registered person had not put in place effective and accessible complaint systems. Regulation 16(1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not ensured appropriate supervision of clinical staff in the administration of vaccinations. Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.