# Dr Abiodun Obisesan

## 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? | Requires improvement |
| 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 Abiodun Obisesan, also known as Winstree Medical Practice on 9 August 2016. Overall the practice is rated as inadequate.

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

- There was a system in place for reporting and recording significant events which were discussed at practice meetings, although there was little evidence of the learning discussed.
- Some policies were incomplete, identified the incorrect lead clinician or were not easy to locate.
- Recruitment checks were not being undertaken consistently and in line with legislation and guidance. Staff carrying out chaperone duties had not received a disclosure and barring service check or a risk assessment as to why one was not necessary.
- The practice did not have adequate systems to manage medicines.
- There was a dispensary located at the branch surgery. Not all controlled drugs were not being recorded in line with legislation and there was no system to record or investigate near misses.
- Some medicines were stored at the main surgery. A risk assessment had not been carried out for the safe storage of these medicines. Room temperatures were not being monitored to ensure these were stored within the recommended range. We found out of date medicines in one of the treatment rooms and prescription stationery not being stored in line with national guidance.
- At both the branch and main practice, the temperatures of fridges used for the storage of vaccines were not being monitored and specialist fridges were not being used.
- The system for reviewing patients taking medicines that required monitoring was not effective. This included patients on high risk medicines.

# Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were below or in line with the national average, including those which related to diabetes, blood pressure, asthma reviews and irregular heart function.
- The practice had identified 1.4% of the practice list as being carers. The GP care advisor held regular clinics at the practice and was able to signpost carers to support in relation to benefits, grants and other means of support and assessment.
- There were measures in place which sought to address the needs of the practice population, including clinics held at the practice and online services, although there were continued issues with delayed appointments and waiting times.
- There was no effective, overarching strategy or oversight to ensure that the care provided was safe, effective, responsive and well-led.
- Governance systems were not effective and required improvement. There was not a comprehensive overview of performance and staff were unsure where to find required information, such as admission avoidance registers.
- There were some positive examples of the practice acting on patient feedback, such as initiating a monthly meeting with a local care home when issues were identified; however, effective responses when general concerns were raised was inconsistent.
- The practice was identified as the only practice in Essex to have been recognised as a dementia friendly practice. This meant that the practice was awarded for being accessible for patients with dementia, which included the use of visual aids to support patients to navigate around the practice.

Action the provider MUST take to improve:

- Implement processes to monitor the refrigerators storing vaccines to ensure that recommended temperatures are maintained and risks to patients are mitigated.
- Follow recognised processes in relation to the management of controlled drugs and implement effective systems to ensure that staff are following them.
- Monitor patients prescribed high risk medicines.
- Implement effective systems to ensure that prescriptions for repeat medicines are signed by the doctor before being dispensed.
- Monitor prescription stationery to ensure this handled in line with national guidance.
- Mitigate risks to patients by ensuring patients' records include a full list of medicines that they are taking.
- Implement effective processes to ensure that all medicines in use have not expired and are suitable for use.
- Update policies and procedures to reflect leads, contacts and current arrangements and ensure these are easily located.
- Mitigate the risks associated with the area where medicines are stored at the Stanway location by completing a risk assessment to ensure these are secured appropriately.
- Ensure recruitment processes are followed to ensure that staff are suitable and trained for the role for which they are employed.
- Mitigate the risks associated with staff acting as chaperones by ensuring relevant staff receive a disclosure and barring service check or a risk assessment is in place as to why one was not necessary.
- Improve the leadership and governance at the practice so that risks to patients are identified and mitigated, the quality of the services provided are monitored and assessed and health outcomes for patients are improved.
- Ensure atropine is available in the event of a medical emergency or assess the risk of not doing so.

Action the provider SHOULD take to improve:

- In the dispensary, ensure there is a clear process in place to monitor, record and review near misses in relation to medicine errors.
- Record detailed meeting minutes.
- Take steps to improve access and respond to the issues raised in the National GP Patient Survey.
- Ensure that the learning from significant events is cascaded to all relevant staff to reduce the risk of reoccurrence.

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

# 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.

- Safeguarding policies identified the incorrect lead clinician and were not easy to locate.
- There were no processes for recording near misses at the dispensary in relation to medicines.
- Chaperones were not DBS checked or risk assessed to consider whether this was required.
- Recruitment checks were not being followed consistently in line with published guidance.
- There was no room temperature monitoring in the medicines area of the Stanway practice to ensure medicines were kept within the recommended temperature range.
- The practice did not have in place adequate systems to manage medicines especially vaccines that required cold storage.
- There was no effective system in place to ensure that patients taking certain medicines were receiving regular blood tests and monitoring. We found 153 patients who took medicines for their heart, 76 patients who took medicines for their thyroid function and 13 patients who took medicines to thin their blood who had not had necessary checks completed in the required time frame.
- Not all controlled drugs were not being recorded in line with legislation.
- We found out of date medicines in one of the treatment rooms and prescription stationery not being stored in line with national guidance.
- There was a system in place for reporting and recording significant events which were discussed at practice meetings; however, there was little evidence of the learning discussed.
- There were appropriate standards of cleanliness and hygiene.

**Are services effective?**

Inadequate

The practice is rated as inadequate for providing effective services.

- Data from 2014/2015 showed that the practice was an outlier for four indicators including those which related to diabetes, blood pressure, asthma reviews and irregular heart function.
- National Institute for Health and Care Excellence (NICE) best practice guidelines were discussed and considered during clinical audit, although learning was not always apparent.

# Summary of findings

- Audits had been carried out on an ad-hoc basis rather than targeting areas where improvements were needed.
- An audit completed in 2015 identified that five out of the 22 patients were taking certain medicines to supress the immune system had not had adequate monitoring. Learning had not been implemented as on the day of our inspection we found six patients on this medicine that had not received appropriate monitoring.

**Are services caring?**

**Requires improvement**

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

- The practice was the only practice in Essex to have been recognised as a dementia friendly practice. The practice was awarded for being accessible for patients with dementia, which included the use of visual aids around the practice.
- Patients told us that staff and clinicians were respectful and considerate during difficult times in their lives.
- There were 47 patients on the learning disabilities register and 44 had received a health check in the last year.
- The practice had identified 1.4% of the practice list as being carers. The GP care advisor held regular clinics at the practice and was able to signpost carers to support in relation to benefits, grants and other means of support and assessment.
- Data from the national GP patient survey published in July 2016 showed patients rated the practice below others for several aspects of care.
- There were systems and training in place to maintain patient and information confidentiality.

**Are services responsive to people's needs?**

**Requires improvement**

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

- Results from the national GP patient survey published in July 2016 showed that patient's satisfaction with how they could access care and treatment was lower than local and national averages. Patients told us they had to wait some time for a routine appointment. Patients indicated that they could not see a preferred GP to ensure continuity of care.
- On the day of our inspection, there was an eight day wait for a routine appointment with a GP and seven day wait for a routine appointment with the nurse, although patients we spoke with said that they were always able to get an emergency appointment.

# Summary of findings

- There were measures in place which sought to address the needs of the practice population, including clinics held at the practice and online services.
- Appointments could be made to have blood tests taken at the surgery. There was a dispensary located at the Layer-de-le-Haye branch.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The advanced nurse practitioner conducted a weekly visit to a local care home which sought to ensure continuity of care.
- There were weekly clinics held at the practice by the midwife and private clinics with the community counsellor and physiotherapist. The GP care advisor signposted patients to support.

**Are services well-led?**

**Inadequate**

The practice is rated as inadequate for being well-led.

- There was a lack of oversight in relation to medicines monitoring, audit and performance.
- There were ineffective measures to identify record and manage risks. Out of date medicines were being used and there was a lack of risk assessments relating to medicines being stored. Prescription stationery was not monitored, neither were uncollected prescriptions. Recruitment procedures were inconsistent.
- Policies and procedures were incomplete and difficult to locate.
- Meeting minutes were brief and primarily consisted of agendas.
- Audits were ineffective at identifying issues relating to medicines management and monitoring patients taking high risk medicines. Learning form audits was not implemented to mitigate risks to patients.
- An action plan had not been drafted to appropriately address the issues identified in the GP survey published in July 2016.
- There was not a comprehensive action plan to improve underperformance in relation to QOF outliers.

# 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 practice is rated as inadequate for the care of older people overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- Joint injections were available for elderly patients living with osteoarthritis.
- Patients on high risk medicines were not being reviewed effectively prior to being issued with a repeat prescription to ensure that their medicines were being prescribed at a correct and safe dose.
- The advanced nurse practitioner attended at a local care home weekly to meet the needs of patients who lived there. Other representatives from care homes where patients lived told us the clinicians were helpful and responsive.
- Home visits were available for flu vaccinations and chronic disease reviews. However, the arrangements for storing vaccines were not safe.
- Patients aged 88 and above were included in the avoiding unplanned admissions register, although the practice were unable to access this register on the day of our inspection.

### People with long term conditions

**Inadequate**

The practice is rated as inadequate for the care of people with long-term conditions overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- 70% of patients with diabetes had a measured total cholesterol of 5 m/mol or less. This was lower than the local and England average of 80%.
- The practice was also identified as underperforming in relation to targets for hypertension, heart conditions and asthma.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- Patients on high risk medicines were not being reviewed effectively prior to receiving a repeat prescription.

# Summary of findings

- Patients indicated that they could not see a preferred GP to ensure continuity of care.
- The GP care advisor held weekly clinics at the practice to co-ordinate care and identify what additional support was available to people with long-term conditions.

**Families, children and young people**

**Inadequate**

The practice is rated as inadequate for the care of families, children and young people overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- Immunisation rates were in line with local averages for all standard childhood immunisations. For children under two, vaccination rates were between compared to the local average of 94% to 99%. However, the arrangements for storing vaccines were not safe.
- The midwife held weekly clinics at the practice. This promoted the ongoing sharing of information.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of abuse. However, policies did not identify the correct clinical lead.
- The percentage of women aged 25-64 whose notes record that a cervical screening test had been performed in the preceding five years was comparable to other practices.

**Working age people (including those recently retired and students)**

**Inadequate**

The practice is rated as inadequate for the care of working age people (including those recently retired and students) overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- Appointments could be made to have blood tests taken at the surgery with one of the trained phlebotomists.
- There was a late night surgery on a Thursday, whereby the practice opened at 8.00am and stayed open until 8.15pm.
- There was an eight day wait to get a routine appoint with a GP, and a seven day wait for an appointment with a nurse, although emergency appointments were available.

# Summary of findings

- Appointments could be made or cancelled in person, on-line or over the telephone and text reminders advised patients of their appointment time. Repeat medicines could be obtained online.

**People whose circumstances may make them vulnerable**

Inadequate

The practice is rated as inadequate for the care of people whose circumstances may make them vulnerable overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- There was a weekly hearing clinic for patients who had a hearing impairment; however, there was no hearing loop available.
- Leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.
- There were 47 patients on the learning disabilities register and 44 had received a health check in the last year and three had declined.
- The practice's computer system alerted GPs if a patient was also a carer.The practice had identified 1.4% of the practice list as being carers.
- The GP care advisor held weekly clinics at the practice to signpost carers to support in relation to benefits, grants and other means of support and assessment.
- There was no system to ensure that patients collected their repeat prescriptions.

**People experiencing poor mental health (including people with dementia)**

Inadequate

The practice is rated as inadequate for the care of people experiencing poor mental health (including people with dementia) overall. The provider is rated as inadequate for safe, effective and well-led, and rated as requires improvement for providing caring and responsive services. The concerns which led to this rating apply to everyone using the practice, including this population group.

- The practice has been recognised as a Dementia Friendly practice.
- Privately paying patients who were experiencing poor mental health could be referred to the community counsellor who held a weekly clinic at the practice.

# Summary of findings

- Performance for mental health related indicators were in line with the national average. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan was 90%. This was comparable to the national average of 88%.
- 78% of patients diagnosed with dementia that had their care reviewed in a face to face meeting in the last 12 months, which was in line with the national average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. Surveys were sent to patients in July to September 2015 and January to March 2016. The results were variable, with patients responding that they could get an appointment, although not with a preferred GP. 271 survey forms were distributed and 120 were returned. This represented a completion rate of 44% of the surveys distributed, and 1.8% of the total practice population.

- 73% of patients found it easy to get through to this practice by phone compared to the local average of 71% and a national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the local average of 84% and the national average of 85%.
- 68% of patients described the overall experience of this GP practice as good compared to the local average of 84% and national average of 85%.
- 62% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the local average of 75% 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 19 comment cards and responses were mixed. Ten were good, complimenting the understanding, caring approach of clinicians and the helpful, polite attitude of reception staff. However, some patients raised concerns over a lack of appointments and appointment times over-running.

We spoke with four patients during the inspection. They all told us that they could see or speak to a GP when they needed to and that were treated with dignity and respect. However, most patients told us that their appointments did not run on time and half said that they found it difficult to get through on the telephone.

We reviewed the result of the NHS Friends and Family test in the month prior to our inspection. There were 30 responses received. In these, 19 patients said they would be extremely likely or likely to recommend the practice to their friends and family. Six patients said they were neither likely nor unlikely to recommend the practice. Five patients said they would be unlikely or extremely unlikely to recommend the practice.

We met with five members of the Practice Participation Group (PPG). They told us that the patients they represented were happy with the GPs, nurses and reception staff at the surgery. They said that the recent closure of the Birch site had resulted in some negative feedback and they also told us there were some issues with getting through on the telephone, although they felt this had improved. They told us they felt very involved and valued by the practice and they gave examples of how they had been a part of the changes and improvements.

## Areas for improvement

**Action the service MUST take to improve**

- Implement processes to monitor the refrigerators storing vaccines to ensure that recommended temperatures are maintained and risks to patients are mitigated.
- Follow recognised processes in relation to the management of controlled drugs and implement effective systems to ensure that staff are following them.
- Monitor patients prescribed high risk medicines.
- Implement effective systems to ensure that prescriptions for repeat medicines are signed by the doctor before being dispensed.
- Monitor prescription stationery to ensure this handled in line with national guidance.

# Summary of findings

- Mitigate risks to patients by ensuring patients' records include a full list of medicines that they are taking.
- Implement effective processes to ensure that all medicines in use have not expired and are suitable for use.
- Update policies and procedures to reflect leads, contacts and current arrangements and ensure these are easily located.
- Mitigate the risks associated with the area where medicines are stored at the Stanway location by completing a risk assessment to ensure these are secured appropriately.
- Ensure recruitment processes are followed to ensure that staff are suitable and trained for the role for which they are employed.
- Mitigate the risks associated with staff acting as chaperones by ensuring relevant staff a disclosure and barring service check or a risk assessment is in place as to why one was not necessary.
- Improve the leadership and governance at the practice so that risks to patients are identified and mitigated, the quality of the services provided are monitored and assessed and health outcomes for patients are improved.
- Ensure atropine is available in the event of a medical emergency or assess the risk of not doing so.

**Action the service SHOULD take to improve**

- In the dispensary, ensure there is a clear process in place to monitor record and review near misses in relation to medicine errors.
- Record detailed meeting minutes.
- Take steps to improve access and respond to the issues raised in the National GP Patient Survey.
- Ensure that the learning from significant events is cascaded to all relevant staff to reduce the risk of reoccurrence.

# Dr Abiodun Obisesan

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector and supported by a GP specialist advisor, a practice manager specialist advisor and a pharmacist specialist.

## Background to Dr Abiodun Obisesan

Dr Abiodun Obisesan, also known as Winstree Medical Practice is situated in Stanway, Colchester, in Essex. There is also a branch surgery in Layer-de-la-Haye, Colchester and patients can attend either surgery for their appointments. A further branch surgery at Birch was closed earlier this year. The practice provides GP services to approximately 6,700 patients.

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

The practice population has higher number of children aged five to18 years compared to the England average and fewer patients aged 65 – 75 years. Economic deprivation levels affecting children and older people are significantly lower than the local and England average, as are unemployment levels. The life expectancy of male and female patients is higher than the local average by one year. There are slightly more patients on the practice's list that have long standing health conditions.

The practice is governed by an individual male GP. He is supported by a full-time female salaried GP, two part-time female salaried GPs and a part-time female long-term locum. There is also a nurse practitioner, a practice nurse and two healthcare assistants employed by the practice.

Administrative support consists of a part-time practice manager, a part-time assistant practice manager and a part-time office manager. There are also a number of full-time and part-time reception staff. Staff are deployed above both the main practice and the branch at Layer-de-la-Haye.

Dr Abiodun Obisesan is a dispensing practice, the dispensary being located at the branch surgery in Layer-de-la-Haye. The dispensary is available to patients who live more than 1.5 miles from a chemist.

The main practice at Stanway is open from 8.00am until 6.30pm on a Monday, Tuesday and Friday. It opens at 7am on a Wednesday to provide an early morning blood clinic for patients who require blood tests. The practice closes at 6.30pm on a Wednesday. There is a late night surgery on a Thursday, whereby the practice opens at 8.00am and stays open until 8.15pm.

The branch surgery at Layer-de-le-Haye is open every day from 8am until 1pm, closed for lunch between 1pm and 2.30pm. It reopens at 2.30pm until 6.30pm. On a Monday morning, the surgery opens at 7am to provide an early morning blood clinic for patients who need blood tests.

When the practice is closed patients can access the walk-in centre in Colchester which is open from 7am until 10pm every day. Outside of these hours, care is provided by Care UK, another healthcare provider. Patients can also call 111 for emergency GP support.

# Detailed findings

## 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 9 August 2016. During our visit we:

- Spoke with the lead GP, a salaried GP, the practice manager, practice nurse, healthcare assistant, reception manager, a member of reception staff and a secretary. We spoke with four patients who used the service and five member of the patient participation group (PPG).
- Looked at audits, policies, procedures, documents and staff files.
- 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**

There was a system in place for reporting significant events, although the systems for recording actions were not always effective.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported 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).
- Significant events were routinely discussed at a weekly clinical meeting. We saw that completed significant event forms were annexed to an agenda. There were no detailed meeting minutes to evidence the discussion that took place into the significant event so we could not be assured that any identified learning had been cascaded to relevant staff.
- Safety incidents and patient safety and medicines alerts were cascaded to the relevant individuals and discussed at clinical meetings. We saw that searches took place to identify patients who may be affected by the alerts and appropriate action was then taken.
- The practice had a system in place for recording when things went wrong with medicines that had been dispensed to patients, and these were reviewed every two months at dispensary team meetings. However, there were no processes in place to record near misses, when mistakes had been narrowly averted. After the inspection, the provider advised us that a system had since been put in place to record near misses.

**Overview of safety systems and processes**

The systems, processes and practices in place to keep patients safeguarded from abuse were sometimes inconsistent or inaccurate. For example:

- There was a safeguarding adults and a safeguarding children policy available to all staff working at the practice on the shared drive. However, the safeguarding adults policy was difficult to locate and the incorrect clinician was named as safeguarding lead on both policies. Staff were confident in describing what would constitute a safeguarding concern and all said that they would report abuse, but not all staff knew who the clinical lead for safeguarding was.
- Staff had all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to level 3.
- GPs would ask a nurse or healthcare assistant to act as chaperone if they were available, failing which they would ask another trained member of staff. However, not all staff, including the healthcare assistant, had a valid DBS check or risk assessment to consider whether a DBS check was required. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The nurse practitioner was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and a resulting action plan completed.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. The GP had oversight of the patients being seen by the healthcare assistant when she administered certain vaccinations.
- We reviewed four personnel files and found that appropriate recruitment checks had not been consistently undertaken prior to employment. For example, we found that proof of identification, references, confirmation of registration with the appropriate professional body, previous job history and the appropriate checks through the Disclosure and Barring Service were often missing.

**Medicines management**

- We checked how medicines were ordered, stored and handled at both locations of the practice. Medicines were stored in a clean and tidy manner and were only accessible to authorised staff. Medicines were purchased from approved suppliers. There were protocols about medicines management available for staff to use, which were revised following our inspection.

Medicines in the dispensary were within their expiry date but we found out of date stock in use in the treatment rooms. There was no room temperature monitoring in the medicines area of the Stanway practice to ensure medicines were kept within the recommended temperature range.

- The practice did not have in place adequate systems to manage medicines especially vaccines that required cold storage. We saw that three of the four refrigerators had repeated temperature readings outside the recommended range. Specialist refrigerators for the storage of vaccines were not always being used. Records indicated that the temperature had not been maintained at the recommended range and there was no second thermometer to check the readings. In the month of our inspection, there had been six occasions where temperatures had been recorded out of range, in July there had been 17 occasions and in June there had been five occasions. There was no indication that any action had been taken to investigate. Reception staff who were involved in the monitoring of the refrigerator had received no training regarding medicines and were unaware of the significance of the high temperature readings.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. The controlled drugs were stored securely and only authorised staff could access them. The amount of medicines stored was not being checked regularly both in the dispensary and in the treatment room. We found that there was no record of one type of controlled drug that was stored in the cupboard; all controlled drugs of this type should be recorded in controlled drug registers so that the practice can ensure secure management.
- The practice had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. Members of staff working in the dispensary had received appropriate training and received annual appraisals. Systems were in place to action any medicine recalls.
- Dispensing staff were dispensing repeat prescriptions before they were signed by a GP and these were delivered to the Stanway location to await collection. These medicines were not stored separately and there was a risk that these would be handed to patients before a GP had the chance to review and sign these prescriptions. The practice offered a delivery service for medicines for patients who found it difficult to collect from either of the practice's locations. Prescription stationery was not monitored, neither were uncollected prescriptions.
- Medicines prescribed by other healthcare professionals were not recorded in patient records and there were not adequate systems in place to ensure patients received the appropriate monitoring required with high risk medicines. There was no effective system in place to ensure that patients taking these medicines were receiving regular blood tests and monitoring. For example, on the day of our inspection we found that there were 153 patients who took medicines for their heart, 76 patients who took medicines for their thyroid function and 13 patients who took medicines to thin their blood who had not had checks completed in the required time frame. Measures were taken after the inspection to contact patients on high risk medicines to ascertain and mitigate risks.
- We found insecure prescription stationery that was not being handled in line with national guidance.

**Monitoring risks to patients**

Not all risks to patients at the premises were assessed and reviewed.

- There were procedures in place for monitoring and managing risks to patient and staff safety around the premises, although there was no risk assessment in relation to access to the stock of medicines stored in the Stanway practice. There was a health and safety policy and first aid kit available. The practice had up to date fire risk assessments and carried out regular fire drills. Electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. However, the practice could not find calibration testing certificates for one of the fridges. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (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. Many administrative staff

worked part-time so they could cover unexpected absence. In the event of a staff shortage, the practice could obtain temporary staff from an agency that had relevant checks in place, although we were informed this had not happened for some time.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training.
- Emergency medicines were available and processes were in place to check these medicines regularly. However one medicine (atropine) that is recommended for practices that are carrying out minor surgery or coil fittings was not available. The practice assured us that they would review their emergency medicines so that Atropine was available after our inspection.
- There were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

The practice had a continuity plan in place for major incidents such as power failure or building damage. However, although the plan referred to a contacts list, this was not completed.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

- GPs met weekly to discuss individual and wider clinical issues and nurses could also attend. In addition to this, nurses met three monthly and practice meetings took place monthly. Minutes were brief and mainly consisted of an agenda. Clinicians told us these meetings were used as an opportunity to discuss current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines, but were unable to provide evidence of these discussions nor records of any activity that that followed as a result. However, examples were given of current issues discussed, for example in relation to paediatric referrals.
- The practice sought to monitor that these guidelines were followed through audit, although this was not effective at identifying and actioning issues of concern.

**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 that the practice gained 91% of the total number of points available. This was comparable to the practice average across England of 94.2% and 91% in the locality.

Data from 2014/2015 showed that the practice was an outlier for four indicators. This was the most up to date, verified data available at the time of our inspection:

- 70% of patients with diabetes had a total cholesterol of 5 mmol/l or less. This was lower than the local average of 80% and England average of 81%. However, 2015/2016 data indicated improvement with diabetes care, which was now in line with local and England averages. We saw evidence that clinicians from the practice attended regular update meetings for diabetic care providers.
- 73% of patients with hypertension had a last blood pressure reading of 150/90mmHg or less. This was lower than the local and England average of 84%.
- 63% of patients with asthma had an asthma review that includes an assessment of asthma control using the 3 RCP questions. This was lower than the local and England average of 75%. We raised this with the lead GP who informed us that they had difficulty ensuring that commuters attended for these checks. They hoped the data would improve by introducing telephone check-ups, but there was no robust plan to secure improvements.
- 79% of patients with atrial fibrillation with CHADS2 score of 1 were treated with anticoagulation drug therapy or an antiplatelet therapy. This was lower than the local and England average of 98%. We found that performance had improved through a system of audit since the previous year.

We compared verified QOF data for 2014/2015 with unverified data for 2015/2016. The unverified data indicated that there had been improvements. Whereas in 2014/2015, the practice achieved 506 points out of a total of 559, unverified data for 2015/2016 showed an improvement at an achievement of 528 points.

There was some evidence of quality improvement including clinical audit, although this was not effective at identifying and managing risks to patients. The practice had not audited some areas of QOF that presented as an outlier, and risks that were identified at previous audit were not effectively mitigated:

- The practice carried out an audit in July 2015 of patients who were taking certain medicines to supress the immune system. This identified that five out of the 22 patients had not had adequate monitoring and these patients were subsequently called in for monitoring. However, on the day of our inspection, 13 months after the initial audit, we found that there were six patients on this medicine that had not received appropriate monitoring and therefore, learning from audits was not consistently implemented.
- There had been three completed clinical audits completed in the past two years. These considered whether NICE guidelines were being adhered to at the practice, for example in relation to patients with atrial fibrillation taking appropriate medicines. In some instances, audits identified issues relevant to the

Inadequate

# Are services effective?

## (for example, treatment is effective)

practice population and improvements were made and monitored. However, as there was no clear understanding of performance, audits were not carried out in all areas where improvements were needed.

**Effective staffing**

- Staff received training that included safeguarding, fire safety awareness, infection control, basic life support and information governance.
- All staff had an annual appraisal with their line manager. They told us that they found this a useful means of reviewing their performance and that they felt confident discussing any issues or concerns.
- The practice evidenced some role-specific training, for example wound-care management and immunisations.

**Coordinating patient care and information sharing**

A midwife, a private counsellor and a private physiotherapist held weekly clinics at the practice which sought to promote referral and information sharing when a need was identified. A GP care co-ordinator also worked at the practice two to three times a week. Their role was to advise patients on non-medical issues such as benefits, grants and referrals to other providers, for example occupational therapy.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a three monthly basis.

**Consent to care and treatment**

- Clinical staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw evidence to confirm that patients gave their consent before procedures took place.
- Non-clinical staff were not certain when children were able to give consent, although we found that appropriate procedures were followed when children requested appointments.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support. For example:

- Patients experiencing stress or anxiety could be referred to the private counsellor who held a weekly clinic at the practice. Further, those receiving end of life care, those at risk of developing a long-term condition and those requiring advice on their diet and smoking were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82% and local average of 83%. Further, the amount of patients aged 60-69 screened for bowel cancer within 6 months was 64% which was comparable to the CCG average of 60% and England average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 96% to 100% and five year olds from 96% to 97%.

Requires improvement

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

- Chairs in the waiting area were positioned away from the reception desk, towards a television which sought to avoid discussions being overheard.
- If patients wished to discuss a private or sensitive matter, receptionists would direct them to an unused treatment room to discuss their concerns.
- Staff had all received training in information governance so that sensitive information was handled appropriately.

We spoke with four patients who all told us that they were treated with dignity and respect when they visited the practice. They said that their confidentiality was respected and most said that they felt involved in their care. Comment cards highlighted that staff were respectful and considerate to patients during difficult times in their lives.

However, results from the national GP patient survey published in July 2016 showed patients did not always feel they were treated with compassion, dignity and respect as responses for this area of the survey were on the whole, below local and national averages. For example:

- 80% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 78% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 92% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 85% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and the national average of 87%.

**Care planning and involvement in decisions about care and treatment**

Results from the national GP patient survey showed patients had some concerns about their involvement when making decisions about their care and treatment. Results were below local and national averages. For example:

- 78% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85% and the national average of 86%.
- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 85%.

We explored the results of the GP survey further with the practice manager. They explained that there had been a number of changes at the practice, including closing the Birch branch surgery and changes to GPs. There were no other plans in place to improve performance.

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

- Community hearing checks took place at the practice, for practice patients and patients from other surgeries. However, we were informed that there was no hearing loop available for patients who were deaf.
- Staff told us that translation services were available for patients who did not have English as a first language.
- The system for calling patients to their appointments was visual as well as audible, so that patients who were blind or hard of hearing knew when their appointment was being called.

**Patient and carer support to cope emotionally with care and treatment**

The practice is the only practice in Essex to have been recognised as a dementia friendly practice. This involved ensuring the premises were suitable for patients with dementia, as well as putting systems in place to facilitate timely diagnoses. The patient participation group hosted a coffee morning at the surgery with the Alzheimer's Society to educate and support patients and their families about living with dementia.

Requires improvement

# Are services caring?

The practice website provided information about how to access services in the community. Further, 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.

There were 47 patients on the learning disabilities register and 44 had received a health check in the last year and three had declined. We spoke with representatives from local care homes where patients lived and they told us that there was mutual respect and a good working relationship with the practice.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 1.4% of the practice list as being carers. As the practice population had changed since the merger, the practice proactively went about identifying patients who were also carers. They began a campaign, displaying posters advertising carers to complete forms to identify themselves as carers. This campaign was with the involvement of the GP care advisor who held regular clinics at the practice. The GP care advisor is able to signpost carers to support in relation to benefits, grants and other means of support and assessment. The practice identifies carers as such on their systems, and receptionists are advised to allocate carers a double appointment if they need this.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

There were measures in place which sought to address the needs of the practice population. These included:-

- Appointments could be made to have blood tests taken at the surgery with one of the trained phlebotomists. This service was available from 7am on a Monday morning at the Winstree Road practice, and at 7am on a Friday morning at the Layer-de-la-Haye practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The advanced nurse practitioner conducted a weekly visit to a local care home to provide regular support and continuity of care. Representatives from local care homes told us that they were able to access a GP or nurse in a timely manner.
- There were weekly clinics held at the practice by the midwife, GP care advisor and private clinics held by the physiotherapist and counsellor.
- Minor surgery was carried out the surgery which included the removal of some cysts, moles and ingrowing toenails.
- 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 as well as those only available privately.
- There were facilities for the disabled and translation services available. A weekly community hearing clinic took place for practice patients and those from other practices.
- The practice offered text message reminders of appointments when patients provided their mobile telephone number.
- Appointments could be booked online for the advanced nurse practitioner.
- There was a dispensary located at the Layer-de-la-Haye branch for patients who lived more than 1.5 miles from a pharmacist.

**Access to the service**

The main practice at Stanway was open from 8.00am until 6.30pm on a Monday, Tuesday and Friday. It opened at 7am on a Wednesday to provide an early morning blood clinic for patients who need blood tests. The practice closed at 6.30pm on a Wednesday. There was a late night on a Thursday, whereby the practice opened at 8.00am and stayed open until 8.15pm.

The branch surgery at Layer-de-le-Haye was open every day from 8am until 1pm, closed for lunch between 1.00pm and 2.30pm. It reopened at 2.30pm until 6.30pm. On a Monday morning, the surgery opened at 7am to provide an early morning phlebotomy clinic for patients who needed blood tests.

Patients were advised to telephone the relevant practice for appointments for that day and consultations could take place in person or on the telephone. Appointments could also be booked in advance.

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

- 38% of patients with a preferred GP usually get to see or speak to that GP. This was lower than the local average of 61% and the national average of 59%.
- 69% of patients were satisfied with the practice's opening hours. This was lower than the local and national average of 76%.
- 50% of patients usually wait 15 minutes or less after their appointment time to be seen which was lower than the local average of 61% and the national average of 65%.

The practice had made some changes to the appointment system this year. These took place after the results of the GP survey were published. This involved making fewer appointments pre-bookable and more appointments available on the day. On the day of our inspection, there was an eight day wait for a routine appointment with a GP and seven day wait for a routine appointment with the nurse. Patients we spoke with said that they were always able to get an emergency appointment.

Feedback on comment cards relating to access was still variable, with patients commenting on the day of our inspection that GPs frequently over-ran and so they had to wait for a long time to be seen. Comment cards indicated there continued to be difficulty getting through on the phone, despite the phone system being changed in May 2016.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

**Listening and learning from concerns and complaints**

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy was available at the reception desk. There was information on the practice website about where the complaints policy could be located.
- The practice manager handled all complaints in the practice. These were investigated with the relevant member of staff or clinician and an open, honest response was provided.

We saw that verbal or written complaints were recorded, investigated and a response was given within the timescales indicated in the practice's policy. Complaints were shared with staff so that lessons were learnt to prevent these from happening again.

# 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 vision and strategy of the practice was impeded by a lack of governance and oversight by the provider which meant that risks to patients were often unnoticed or overlooked. In their statement of purpose, the practice advocated good health and high quality, evidence-based care in a non-discriminatory fashion to all members of the practice population. Whilst the practice provided holistic, caring services in some instances, we found that there was a lack of effective systems which meant that the care provided was often unsafe, ineffective and not well-led.

Following the recent closure of the Birch branch and changes to the GPs working at the practice, the provider continued to look at ways of improving the service and meeting the needs of the practice population. This included considering remote consultations, working with other providers in the locality to utilise resources efficiently and effectively and changes to the management structure. However, as at the date of our inspection, improvements were yet to take effect; patients continued to raise issues with accessing appointments, and risks to patients were found.

**Governance arrangements**

The practice was governed by a lead GP, with support from the clinical and administrative team.

- Understanding of performance was not comprehensive and staff were unsure where to find required information, such as admission avoidance registers. We saw evidence to suggest that QOF may improve in some areas in the future, but there was no robust plan to action and respond to all outliers. In some instances, challenges were accepted rather than met, for example this was evident in relation to attendance for health checks: it was hoped that uptake would be improved by telephone consultations although there was no robust plan of action to meet the issue.
- There was a programme of continuous clinical audit to monitor quality and to make improvements. However, although one clinical audit had identified issues with monitoring patients taking a certain medicine, learning had not been effective as we still found the issue with this during the course of our inspection, along with others.
- There were ineffective measures to identify, record and manage risks at the practice. We found out of date medicines being used, a lack of risk assessments relating to medicines being stored and incomplete policies and risk assessments. Prescription stationery was not monitored, neither were uncollected prescriptions. Recruitment procedures were inconsistent as not all required information was requested.
- The staffing structure was supported by a system of organisational meetings so that staff were aware of the issues and information that concerned them. Although minutes were brief and mainly consisted of agendas, staff told us of how they used these meetings to inform their day-to-day practice.

**Leadership and culture**

The lead GP had identified some areas for improvement, for example, the need for additional support in the exercise of the managerial function so that additional time could be spent on policies, procedures and administration, which required improvement. However, not all issues had been identified and we found there was ineffective oversight of medicines monitoring and management, risks to patients, performance and audit.

Staff were aware of their own roles and responsibilities and felt confident approaching clinicians with anything they were unsure of. Whereas policies and procedures were not always clear in terms of contacts and lead roles, staff gave examples of how they had sought advice from clinicians when they had queries.

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

The practice had an active and informed patient participation group who held events and met regularly with a view to educating patients and obtaining their feedback. Meetings were attended by the practice manager which sought to ensure a meaningful discussion. The practice population group told us they felt involved and informed by the practice, and gave examples of how they had influenced changes at the practice, for example by contributing to the notice boards in the waiting area and advising of improvements required at the premises.

The national GP patient survey published in July 2016 indicated that patients had concerns about access, waiting too long to be seen and with the GP giving them enough

# Are services well-led?

Inadequate

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

time, amongst other issues. Many of these concerns were re-iterated by patients on the day of our inspection. Again, we found that the practice was accepting of this feedback rather than actively putting together a strategy to improve performance, giving reasons as to why they believed the feedback was as such rather than providing a decisive response as to the action to be taken. It was hoped a change to the appointment system and telephone system would improve things, but feedback we received on the day of the inspection did not suggest this was to be the case.

We saw some positive examples of the practice acting on feedback, for example, we were told how regular meetings had been set up with a local care home which had improved communication and further, how the practice had worked to become a dementia friendly practice to advance the support and communication for patients living with dementia and their families. However, action on feedback was often inconsistent, disjointed or insubstantial and did not effectively address issues raised.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed<br>**Recruitment procedures were not operated effectively to ensure that persons were employed of good character.**<br>**Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014** |

This section is primarily information for the provider

# Enforcement actions

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>The provider did not have effective systems or processes to assess, monitor and mitigate the risks to the health, safety and welfare of patients, in particular in relation to medicines (including vaccines that require cold storage), controlled drugs, the expiry dates of medicines, prescription stationery, uncollected prescriptions and patients who were prescribed medicines that require monitoring.<br>Audits and action plans were not completed or ineffective in relation to identified outliers and poor patient feedback.<br>Risk assessments were not completed relating to medicines stored at the main location, the requirement of DBS checks for chaperones and the practice of unsigned prescriptions being dispensed prior to GP signature.<br>Policies were incomplete or inaccurate, including safeguarding, business continuity plan and Control of Substances Hazardous to Health.<br>Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 |