Dr Joseph Arayomi

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We conducted a comprehensive announced inspection on 13 March 2015.

Specifically, we found the practice to be good for providing effective, caring, responsive and well-led services. It was also good for providing services for the older people, people with long-term conditions, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances, and people experiencing poor mental health (including people with dementia). It required improvement for providing safe services.

Our key findings were as follows:

- Staff understood and their responsibilities to raise concerns, and to report incidents. Information about safety was recorded, monitored, appropriately reviewed, addressed and shared with staff during meetings.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was readily available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However, there was an area of practice where the provider needed to make improvements.

The provider should:

- Implement a system for reporting and investigating incidents of a less serious nature and near misses as part of improving safety within the practice.
- Carry out regular checks to ensure that cleaning tasks are completed to a satisfactory standard.

Summary of findings

- Improve records including minutes form internal and external meetings so that they reflect discussions, actions and any learning outcomes.

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?

Good

The practice is rated as good for providing safe services. Staff understood their responsibilities to raise concerns, and to report incidents and near misses and we saw that significant events were reported and investigated. Lessons were learned and communicated widely to support improvement. However incidents of a less serious nature and near misses were not routinely reported or investigated as part of improving safety. Risks to patients were assessed however and well managed. There were enough staff working at the practice to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were above average for the locality and where there were areas for improvement the practice was proactive in dealing with these. Staff referred to guidance from National Institute for Health and Care Excellence. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and where further training needs had been identified there were plans to meet these needs. There was evidence of appraisals and identifying training and development for all staff. Staff worked with multidisciplinary teams to ensure that patients received effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from patient surveys showed that patients rated the practice higher than others for several aspects of care, such as how GPs and nurses explained their care to them, involving them in making decisions and listening to them. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to follow. We also saw that staff treated patients with kindness and respect, and maintained confidentiality. We received positive remarks on the comment cards we left for patients to complete about their care at the practice. The patients we spoke with during the inspection were also positive about the care they received.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS England Area Team and the local Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. CCGs are groups of general practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services. The practice had a flexible appointments system with extended hours (mornings and evening appointments available on specific days). The majority of patients said they could make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy and staff knew their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

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

Good

This practice is rated as good for the care of older people. Patients over the age of 75 had a named GP to ensure the continuity of care delivered. The GPs carried out visits to patient's homes if they were unable to travel to the practice for appointments. Staff worked proactively to ensure that patients received annual health checks and seasonal flu vaccinations.

The practice identified people with caring responsibilities and those who required additional support which was recorded on their patient record. Patients with caring responsibilities were invited to register as carers so that they could be offered support and advice about the range of agencies and benefits available to them

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health. Appointments were available with the practice nurse for annual health checks and reviews for long term conditions such as diabetes and respiratory conditions including asthma and chronic obstructive pulmonary disease (COPD). When needed, longer appointments and home visits were available. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

People whose health prevented them from being able to attend the surgery received the same service from one of the practice nurses who arranged visits to them in their home.

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Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Appointments could be booked in person by telephone or via the online booking system. Appointments were flexible and extended hours were available with early morning and late evening appointments available on specific days.

Summary of findings

Information and advice was available to promote health to women before, during and after pregnancy. The practice monitored the physical and developmental progress of babies and young children. There were arrangements for identifying and monitoring children who were at risk of abuse or neglect.

Records showed that looked after children (such as those in foster care / under the care of the Local Authority), those subject to child protection orders and children living in disadvantaged circumstances were discussed and any issues shared and followed up at monthly multi-disciplinary meetings. GPs and nurses monitored children and young people who had a high number of A&E attendances or those who failed to attend appointments for immunisations and shared information appropriately. Staff were trained to recognise and deal with acutely ill babies and children and to take appropriate action.

There was information available to inform mothers about all childhood immunisations, what they are, and at what age the child should have them as well as other checks for new-born babies. Staff proactively followed up patients who failed to attend appointments for scheduled immunisation and vaccination programmes. The practice performed better than the local average for uptake in childhood immunisations and vaccinations.

Information and advice on sexual health and contraception was provided during GP and nurse appointments. The practice provided clinics for long acting reversible contraceptives such as contraceptive implants and intrauterine devices (IUD coils) and took referrals from other GP practices.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Appointments could be booked online, in person or by telephone. Appointments could be booked in advance.

Information about annual health checks for patients aged between 40 and 74 years was available within the practice and on their website. Nurse led clinics were provided for well patient health checks. The practice provided travel advice and vaccination through appointments with the practice nurse team. Information on the

Summary of findings

various vaccinations available including diphtheria, tetanus, polio, and hepatitis A was available on the practice website. When patients required referral to specialist services referrals were made in a timely way.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of patients who had learning disabilities. All patients with learning disabilities were invited to attend for an annual health check. The practice regularly worked with multidisciplinary teams in the case management of vulnerable people. The practice had arrangements to sign-post vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice provided dementia screening services and referrals were made to specialist services as required.

The practice had arrangements to sign-post patients experiencing poor mental health to various support groups and third sector organisations including MIND. Patients were referred to local counselling sessions where appropriate and patients were provided with information how to self-refer should they wish to receive counselling.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 72 CQC comment cards patients had completed. The responses received were overwhelmingly positive about the care and treatment they received and the kindness of staff at the practice. Patients who completed comment cards reported that the practice offered flexible appointments and that they could always see a GP on the same day for urgent carer and treatment. Approximately 30% of patients who completed comment cards to us that they often had to wait long periods to see the GP when they attended appointments and that GP's regularly 'ran late'.

We also spoke with three patients who spoke positively about their experience of being patients at the practice. They told us that on occasions they did have to wait to be seen, however they felt that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful.

Data available from the NHS England GP patient survey carried out in 2014 showed that the practice scored in the mid to upper range nationally for satisfaction with the practice, with many patients reporting satisfaction with the way they were treated by staff, involved in decision making and feeling listened to. Patients also we spoke with reported difficulties in accessing appointments.

We reviewed the results of the NHS Friends and Family test. We saw that the practice consistently scored highly in terms of the number of patients who were extremely likely of likely to recommend the practice to friend and family. The practice was ranked 5th out of 272 practices across Essex in terms of their proactive approach in implementing the Friend and Family Test.

Areas for improvement

Action the service SHOULD take to improve

- Implement a system for reporting and investigating incidents and near misses as part of improving safety within the practice.
- Carry out regular checks to ensure that cleaning tasks are completed to a satisfactory standard.
- Improve records including minutes form internal and external meetings so that they reflect discussions, actions and any learning outcomes.

Dr Joseph Arayomi

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor.

Background to Dr Joseph Arayomi

Dr Arayomi practice is located in a residential area of Basildon. The practice provides services for approximately 1,700 patients living in the Pitsea area.

The practice is managed by a single handed GP. The practice employs one part time salaried GP, one practice nurse one healthcare assistant, and four reception staff. Practice management duties were covered by a practice manager who is supported by a senior administrator.

The practice is open between 8am to 7.30pm on Mondays and 8am to 6.30pm on other weekdays. Early morning appointments from 08.20 am are available on Tuesdays. GP and nurse appointments are available from 9am to 12.30pm, and 4.30pm to 6.30pm (available up to 7.30pm on Mondays). Routine appointments may be booked online via the practice website.

Dr Joseph Arayomi had opted out of providing out-of-hours services (evenings and weekends). These services were provided by SEEDS (South Essex Emergency Doctors Service) a local out-of-hours service and details of how to contact the service was available within the practice, on the practice website and in a recorded telephone message.

Why we carried out this inspection

We inspected Dr Arayomi as part of our comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions

Detailed findings

- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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 13 March 2015. During our visit we spoke with the GP, practice nurse, reception staff and the practice manager. We also spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety including incidents, comments, complaints and national patient safety alerts. The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns. They told us that the procedures within the practice worked well. However records we viewed and discussions with the GP and practice manager confirmed that incidents of a less serious nature and near misses were not recorded or used to review safety within the practice.

There were systems for dealing with the alerts received from the Medicines and Healthcare products Regulatory Agency (MHRA). The alerts had safety and risk information regarding medication and equipment, often resulting in the withdrawal of medication from use and return to the manufacturer. We saw that all MHRA alerts received by the practice had been actioned and completed. There were also arrangements for reviewing and acting on National Patient Safety Agency (NPSA) alerts. These are alerts that are issued to help reduce risks to patients who receive NHS care and to improve safety. Staff told us that information was shared through email notifications and practice meetings.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Through discussions with staff and a review of records we saw that significant events were fully investigated to determine where improvements could be made and to identify learning opportunities to prevent recurrences. We looked at the records in relation to the two significant events reported within the previous twelve months. We found that both had been investigated, acted upon and reviewed to help prevent any recurrence. We found that other events or incidents of a less serious nature such as near misses were not routinely reported or investigated as part of the process for learning and improving safety within the practice.

We were told that incidents and significant events were discussed with staff at regular meetings and where areas for improvements were identified these were reviewed to help ensure that learning was imbedded into the practice. Staff, including receptionists, administrators and nursing staff, told us the practice had an open and transparent culture for dealing with incidents when things went wrong. They told us that they were supported and encouraged to raise concerns and to report any areas where they felt patient care or safety could be improved

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable families, children, young people and adults. Safeguarding policies and procedures were available to staff, which included details of how and to whom concerns should be reported. Practice training records made available to us showed that the GP and nursing staff had received relevant role specific training on safeguarding adults and children. Training was planned in the near future for administrative and reception staff who had not yet undertaken this training. Staff we spoke with were able to demonstrate that they understood their responsibilities to keep patients safe and they knew the correct procedures for reporting concerns. The practice had a designated lead for safeguarding vulnerable adults and children who had oversight for safeguarding and acted as a resource for the practice. From training records viewed showed that the lead had undertaken appropriate safeguarding training. Staff we spoke with were aware of the lead and who they could speak to if they had any safeguarding concerns.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended or failed to attend appointments; for example looked after for children (children under the care of the local authority / in foster care) or those children who were subject to child protection plans, elderly patients and those who had learning disabilities. Vulnerable families, adults and children were discussed monthly / six weekly multidisciplinary team meetings, which were attended by health visitors, district nurses and other health and social care professionals as required. We looked at the records from these meetings and found that information was shared with the relevant agencies, reviewed, followed up, and appropriate referrals were made as required.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is

a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The chaperone policy described the clinician's responsibilities for determining when a chaperone would be needed. The policy covered chaperoning a patient in their own home. The policy advised that where a chaperone was deemed appropriate but unavailable consultations should be rescheduled unless in emergency situations where to do so would adversely impact on the health of the patient.

Chaperone duties were undertaken by the practice nurse and the senior administrator / healthcare assistant who confirmed that they had not undertaken chaperone training. We were told that chaperone training was scheduled for all relevant staff the week following our inspection and records we saw confirmed this. Staff we spoke with were aware of their roles and responsibilities when acting as a chaperone during patient consultations. Patients we spoke with were aware that they could request a chaperone during their consultation, if they chose to.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on the practice electronic system which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines Management

There were arrangements for secure storage of medicines, including vaccines, emergency medicines and medical oxygen. Medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines, including those for use in a medical emergency and these were found to be in date. However we found that that medicines other than vaccines were stored in the refrigerator, which is contrary to guidance for the safe and effective storage of vaccines. A new fridge was purchased to store other medicines shortly after our inspection visit.

The practice followed national guidelines around medicines prescribing and repeat prescriptions. We reviewed information we held about the practice in respect of medicines prescribing. We found that the practice prescribing for antibiotics, sedatives and non-steroidal anti-inflammatory medicines were similar to the national average and in line with prescribing guidelines.

The practice nurse administered immunisations and vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of directives and evidence that nurses had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. The practice had arrangements for reviewing patients with long term conditions on a six to twelve monthly basis to ensure that the medicines they were prescribed were appropriate and that risks were identified and managed. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Information about the arrangements for obtaining repeat prescriptions was made available to patients in printed leaflets and posters. Patients could order repeat prescriptions in person, by fax, post or via the practice online prescription system. Through discussion with staff including the GPs we found that there were arrangements for ensuring that patients' therapeutic blood levels were routinely monitored to ensure that medicines were prescribed safely and effectively. Staff told us that they proactively followed up on patients to advise them to contact the practice for blood test results.

Patients we spoke with told us they were given information about any prescribed medicines such as side-effects and any contra-indications. They told us that that the repeat prescription service worked well and they had their medicines in good time.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. The practice had suitable procedures for protecting patients against the risks of infections. Hand sanitising gels were available for patient and staff use. These were located at the entrance, reception area and throughout the practice as were posters promoting good hand hygiene. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Good

Are services safe?

The practice provided information and advice to patients around the Ebola virus. Written information was displayed at the practice reception and a message provided information to patients when they telephoned the practice. This advised patients of the actions they should take if they had concerns or had recently travelled to West Africa.

A contract cleaning company was employed to clean the premises in which the practice was located. We saw there were cleaning schedules in place for general areas. The practice nurse and practice manager reported that there had been some concerns about the effectiveness of cleaning by the company. We saw that the practice had cleaning checklists, however these checks had not been routinely carried out and the practice nurse told us that they would be more proactive in checking that cleaning tasks were carried out by the cleaning company. The practice nurse told us that they were responsible for cleaning the treatment room and clinical areas between patient consultations.

The practice had in place infection control policies and procedures for staff to follow, which enabled them to plan and implement measures for the control of infection. These included procedures for dealing with bodily fluids, handling and disposing of surgical instruments and dealing with needle stick injuries. From a review of records and through discussion with the practice manager we found that clinical staff had undertaken infection control training. All staff working within the practice had received hand hygiene training and instructions. We saw that clinical staff (GPs, nurse and healthcare assistant) had undergone screening for Hepatitis B vaccination and immunity. People who are likely to come into contact with blood products, or are at increased risk of needle-stick injuries should receive these vaccinations to minimise risks of blood borne infections. Staff were provided with appropriate personal protective equipment including gloves and aprons and guidance for their use.

The practice nurse acted as the clinical lead for infection control and had undertaken further training to enable them to provide advice on the practice infection control policy. A number of infection control audits had been carried out in 2014 and 2015. These audits tested the effectiveness of infection control policies and practices. The audits covered premises, environment, hand washing and managing clinical waste. The results of the audits seen indicated that the infection control procedures were effective.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. Staff told us that medical equipment including blood pressure monitoring devices, scales, thermometers were periodically checked and calibrated to ensure accurate results for patients and records we viewed confirmed this.

We observed that a number of portable electrical equipment had not been PAT tested, some since 2007. PAT testing is an examination of electrical appliances and equipment to ensure that they are safe to use. The practice manager told us that this was due to an oversight and We received confirmation that these checks had been carried out following our inspection.

Staffing & Recruitment

The practice had policies and procedures for recruiting new staff to help ensure that they were suitable to work in a healthcare setting. The practice recruitment policy set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the records for three members of staff and these contained evidence that interviews had been conducted and employment references had been obtained prior to employment. Records we viewed showed that GPs and the practice nurse had criminal records checks carried out by the Disclosure and Barring Service (DBS). We saw that there were arrangements in place to carry out criminal records checks for all staff working at the practice. There were procedures in place for managing under-performance or any other disciplinary issues.

Staff told us there were usually enough staff to maintain the smooth running of the practice and to ensure that patients were kept safe. Staffing levels were regularly reviewed to ensure that there was appropriate cover to deal with day-to-day appointments and home visits. There were arrangements in place provide GP locum cover where needed. Staff told us that they would work extra hours to cover when colleagues were off work due to planned leave or unplanned absence due to illness.

Monitoring Safety & Responding to Risk

Good

Are services safe?

The practice had a health and safety policy, which staff were aware of. We saw that a health and safety risk assessment had been carried out to help identify risks to staff and patients.

The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they aware of these procedures. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described an incident where they dealt with a patient who was experiencing a mental health issue. Staff could demonstrate how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health issue or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were procedures in place for staff to refer to when dealing with emergency situations. We saw records showing GPs and the practice nurse had received training in basic life support. Other non-clinical staff who had not undertaken this training told us that they would alert the GP or practice nurse in the event of a medical emergency. Training was planned for all non-clinical staff in the near future.

Emergency medicines and oxygen were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis (allergic reactions) and hypoglycaemia (low blood sugar). Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had a business continuity plan to deal with a range of emergencies that may impact on the daily operation of the practice. The plan identified key members of staff and their roles and responsibilities in identifying and managing risks to the provision of service from the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained details of the relevant people to contact in the event of any incident, which may disrupt the running of the day-to-day operation of the practice.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. Fire exits and the fire evacuation procedure were clearly signposted within the practice. Through discussions with staff and a review of records we found that staff had not undertaken fire safety training and fire evacuation drills were not carried out. However we saw evidence tat staff training was planned in the near future.

We found that fire fighting equipment including fire extinguishers were situated throughout the premises and the waiting area, which was shared with a neighbouring GP practice. We found that fire extinguishing equipment had not been tested since 2013. It was unclear that there were any joint arrangements between both GP practices to ensure that fire fighting equipment was checked and maintained annually to ensure that they were safe and fit for use if required. Following our inspection we were provided with evidence that fire extinguishing equipment had been tested and fire evacuation drills were planned for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nursing staff we spoke with could clearly outline their rationale for the delivery of patient care and treatment. Staff were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. Information and new guidance were made available in information folders and shared with staff during regular meetings so as to ensure that practices were in line with current guidelines to deliver safe patient care and treatments. We found the GPs were utilising clinical templates to provide thorough and consistent assessments of patient needs. Information we held about the practice showed us that the practice's performance in assessing and treating patients with long term conditions such as diabetes, heart disease, asthma and chronic obstructive pulmonary disease (COPD) were higher than or in line with national averages.

The practice GP took a lead role in specialist clinical areas such as family planning and female reproductive health and the practice nurse supported this work. The practice nurse carried out reviews for patients with long term conditions and carried out well man and well woman checks through pre-booked appointments. This helped the GPs to treat patients with more complex medical conditions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, child protection alerts management and medicines management.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate on-going quality improvement and effective care. Clinical audits are ways in which the delivery of patient treatment and care is reviewed and assessed to identify areas of good practice and areas where practices can be improved. We looked at the records for one completed clinical audit, which had been carried out around the use of emergency contraception. Patients who had been prescribed emergency contraception were reviewed to check that appropriate guidance had been followed and they had been offered screening for sexually transmitted diseases such as Chlamydia and patients offered long acting reversible contraceptives. The audit was repeated and the results demonstrated that prescribing practices were in line with current National Institute for Health and Care Excellence (NICE) guidelines, in the best interests of patients and cost effectiveness.

We looked at the data and information we held about the practice. This included information taken from the Quality Outcomes Framework (QOF) system; part of the General Medical Services (GMS) contract for general practices where practices are rewarded for the provision of quality care. The practice's overall QOF score for the clinical indicators was in line with the local and national average, demonstrating that they were providing effective assessments and treatments for patients with a range of conditions such as diabetes, dementia, learning disabilities and mental health disorders. We saw evidence that where the practice scored below the national average that staff were proactive in making the necessary improvements.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Staff described the process for ensuring that repeat prescriptions were checked and reviewed and the processes for alerting the GPs if they had any concerns about repeat prescriptions. The computerised system flagged up relevant medicines alerts when the GP went to prescribe medicines. We were shown evidence to confirm that following the receipt of an alert the GPs reviewed the use of the medicine in question, prescribed alternatives or, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs and reviewed their treatments appropriately.

Effective staffing

The practice employed staff who were appropriately skilled and qualified to perform their roles. Newly appointed staff undertook a period of induction, which was tailored to their roles and responsibilities and took into account their skills

and experience. We looked at employment files, appraisals and training records for four members of staff. We saw evidence that clinical staff were appropriately qualified and trained, and where appropriate, had current professional registration with the Nursing and Midwifery Council (NMC) and General Medical Council (GMC). We saw clinical staff undertook relevant training and reflective practice to enable them to maintain continuous professional development to meet the revalidation requirements for their professional registration.

Individual staff performance was assessed and training and development needs were identified through an annual appraisal system. Staff did not have personal development plans that detailed their planned learning and development objectives. However staff told us that where they had identified training needs that these had been provided for. The practice manager told us that staff training had proved a challenge as all of the staff worked part time. They showed us evidence that all staff had been signed up with personal online learning accounts and that personal development plans would be introduced as part of on-going staff training and development. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. The practice also had systems in place for identifying and managing staff performance should they fail to meet expected standards.

The practice had dedicated leads for overseeing areas such as safeguarding, infection control, palliative care, family planning and female reproductive health. The practice nurse had undertaken specific training in health promotion and the treatment of minor illness such as, acute asthma, smoking cessation and sexual health screening. The nurse provided services including well person checks, long term condition reviews, family planning and cervical screening. This enabled the GPs to focus on more complex problems and conditions.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs including those with more complex needs. There were clear procedures for receiving and managing written and electronic communications in relation to patient's care and treatment. Correspondence including test and X ray results, letters including hospital discharge, out of hour's providers and the NHS 111 summaries were reviewed and actioned on the day they were received.

The practice held two monthly multidisciplinary team meetings to discuss patients with complex needs including those with end of life care needs, vulnerable families and children on the at risk register. These meetings were attended by district nurses, social workers and palliative care nurses where decisions about care planning were documented in a shared care record. We looked at the records for the last four meetings and found that information was not recorded in detail to reflect discussions and actions taken and shared to ensure that patients received coordinated care, treatment and support. Information was recorded in patients records.

Information Sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by staff to coordinate, document and manage patients' care.. Staff told us that information was accessible to help them make decisions and to plan and deliver effective care and treatment.

There was a system for making sure test results and other important communications about patients were dealt with. The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care. We saw that treatment records for patients who had used the 'out-of-hours' service, overnight or at weekends were reviewed the following morning so as to ensure that patients received appropriate treatment.

The practice maintained registers for patients with life limiting illnesses, those receiving palliative care and treatments, and patients with learning disabilities. GPs and nurses at the practice worked closely with Macmillan nurses and other agencies who support people with life limiting illnesses. They held two monthly palliative care meeting to ensure that care and support was delivered in a co-ordinated way so that patients received care and treatment that met their changing needs.

Staff were alert to the importance of patient confidentiality and the need to obtain appropriate consent. They gave us an example of a situation where a receptionist had checked a request with a GP before sharing any information with a third party.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

The practice had policies and procedures in place for obtaining patient's consent to care and treatment. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of the practices' consent policies and procedures and told us that they obtained patients consent before carrying out physical examinations or providing treatments. Clinical staff we spoke with were aware of parental responsibilities for children and they told us that they obtained parental consent before administering child immunisations and vaccines.

The clinicians demonstrated an understanding of legal requirements when treating children. They understood Gillick competency. This is used to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Staff we spoke with were aware of the Mental Capacity Act 2005 as it relates to the treatment of people who lack capacity to make certain decisions. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so, by ensuring that any decisions made on their behalf are in the person's best interests.

Health Promotion & Prevention

There was a limited range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, which was shared with a neighbouring GP practice. This made it somewhat confusing as to which practice information provided related to. We saw information about mental health, domestic violence advice and support that was prominently displayed in waiting areas with helpline numbers and service details. Information available included advice on diet, smoking cessation and alcohol consumption was available in consulting and treatment rooms. The practice website held a comprehensive range of information about health promotion and disease prevention as well as links and signposting to other relevant support services.

All newly registered patients were offered routine medical check-up appointments with a health care assistant or nurse. Patients between 40 and 74 years old who had not needed to attend the practice for three years and those over 75 years who had not attended the practice for a period of 12 months were encouraged to book an appointment for a general health check-up. Nurse led pre-booked appointments were available for health promotion and disease prevention. Treatment and advice was provided including sexual health, family planning and menopausal advice, heart disease prevention, diabetic and asthma.

The practice's performance for health checks and screening was consistently high. Staff used routine appointments to carry out health checks for patients who had learning disabilities and those with mental health conditions to help promote health and identify any deterioration in a patient's health. The practices' performance for uptake of seasonal flu vaccinations for patients 75 years and over and for cervical cytology screening (smear tests) for women aged between 25 years and 65 years was above the local and national averages.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Information about the range of immunisation and vaccination programmes for children and adults were well signposted throughout the practice and on the website. Data we looked at before the inspection showed that the practice was performing above the average of other practices in the area for take up of childhood immunisations.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 72 CQC comment cards that patients had completed prior to our inspection and spoke in person with four patients. The response from patients was overwhelmingly positive with all patients reporting that staff at the practice were helpful and good at listening to them. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. The majority of patients said they felt the practice provided consistent and excellent care and treatment.

We reviewed the most recent information available from the national patient survey, which was carried out in 2014. This showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. For example the practice scored highly for patients who were satisfied with how treatments were explained to them and how they were treated by staff.

Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Reception staff told us that where patients wished to speak privately to a receptionist, they were offered the opportunity to be seen in another room. During the inspection we spent time in the practice reception area. This gave us the chance to see and hear how staff interacted patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients. The layout of the waiting area was not conducive to promoting confidentiality in conversations between reception staff and patients. Staff told us that should patients wish they could discuss matters of a personal or confidential nature in private.

There were signs in the waiting areas and consulting rooms explaining that patients could request a chaperone during examinations. Patients we spoke with told us that they knew that they could have a chaperone during their consultation should they wish to do so. Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice had a range of anti-discrimination policies and procedures and staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The practice had policies and procedures in place for obtaining patient's consent to care and treatment where people were able to give this. The procedures included information about people's right to withdraw consent. GPs and nurses we spoke with had a clear understanding of 'Gillick' competence in relation to the involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care.

The 2014 patient national GP survey information we reviewed showed that patients' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, approximately 77% of practice respondents said the GP was good at explaining treatment and results and 73% said that the GP involved them in decisions about their care and treatment. Over 90% of patients who completed the surveys were happy with how they were treated, listened to and involved in the care and treatment provided by nursing staff.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us the GPs were extremely conscientious and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we

Good

Are services caring?

received was also overwhelmingly positive and the vast majority of the 72 patients who responded told us that they were happy with their involvement in their care and treatment.

The practice identified vulnerable patients and kept a register. The practice monitored the emergency admissions, readmissions, unplanned admissions and discharges from hospital for patients with long term conditions, older people, those living in care homes and vulnerable at risk patients. This monitoring identified patients most likely to have an unplanned admission to hospital. Where patients were identified as vulnerable care plans were implemented, which were discussed and reviewed at multidisciplinary team meetings to help ensure that patients had appropriate support systems in place to help reduced unplanned admissions to hospital.

Staff told us that the majority of patients registered at the practice were English speaking. They told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception area informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The practice had policies and procedures in place for identifying and supporting patients who voluntarily spent time looking after friends, relatives, partners or others, who needed help to live at home due to illness or disability. Patients who were carers for others were identified as part of the new patient registration and carers were provided with information and support to access local services and benefits designed to assist carers.

The practice had arrangements for obtaining patients' wishes for the care and treatment they received as they approached the end of their lives. Patients' wishes in respect of their preferred place to receive end of life care were discussed and doctors worked with other health care professionals and organisations to help ensure that patients' wishes were acted upon. Information was available about the support available to patients who were terminally ill and their carers and families.

Staff told us families who had suffered bereavement were called by the GP and condolences cards were sent to bereaved families. There was a variety of written information available to advise patients and direct them to the local and nationally available support and help organisations who deal with emotional issues such as bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with dementia, mental health conditions, learning disabilities and those with life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients. We saw that When patients required referral to specialist services referrals were made in a timely way.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice understood and responded to the different needs of patients from different ethnic backgrounds and those who may be vulnerable due to social or economic circumstances. The practice manager told us that the majority of patients were English speaking. There were arrangements for accessing translation services for patients whose first language was not English.

Patients who needed extra support because of their complex needs were allocated a longer time for their appointments. We saw specific tailored care plans to meet their needs for patients with learning disabilities and for those affected by dementia as well as those with long term medical conditions.

Access to the service

The practice was open between 8am to 7.30pm on Mondays and 8am to 6.30pm on other weekdays. Flexible appointments and extended hours were available. Early morning appointments from 08.20 am are available on Tuesdays. GP and nurse appointments were available from 9am to 12.30pm, and 4.30pm to 6.30pm (available up to 7.30pm on Mondays). Routine appointments could be booked in advance in person, by telephone or using the practice online booking system. The practice offered emergency appointments daily to deal with urgent medical problems and to see unwell children. Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits and telephone consultations were made available as required.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

The majority of the 72 patients who completed a CQC comment card said that they were satisfied with the arrangements for accessing appointments. Patients commented that appointments were flexible to meet their needs. Approximately 30% of patients who completed comment cared reported that they had to wait a long time to see the GP. Staff reported that this was in part due to GPs spending extra time with patients during consultations. Patients comments also reflected that GPs spent time listening to them and meeting their needs.

We reviewed the national GP patient survey data (2014) and saw that the practice was rated as 'among the best' practices nationally for scores relating to practice opening times, patients experiences of accessing appointments and getting through to speak with someone on the telephone. 92% of patients who participated in the survey reported satisfaction with how easy it was to get an appointment and 86% said that they were happy with the ease of getting through to speak with someone on the telephone.

The practice was located in a single storey building, which was shared with three other GP practices The waiting area was shared with one of the three GPs who shared the premises and staff reported that it could become very cramped during busy periods. Disabled access toilets and baby changing facilities were available.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and included details of the timelines for investigating and responding to complaints and concerns

Good

Are services responsive to people's needs?

(for example, to feedback?)

raised. There was a designated responsible person (the practice manager) who handled all complaints in the practice. Information describing how to raise concerns or make complaints was available to patients to patients in the practice information leaflet, which was available at the practice reception area. Patients were advised what they could do if they remained dissatisfied with the outcome of the complaint or the way in which the practice handled their concerns. The complaints information made reference to escalating complaints to the Parliamentary and Health Services Ombudsman, a free and independent service set up to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

Doctors, nurses and administrative told us that the practice had an open culture where they felt safe and able to raise concerns. They told us learning from complaints and when things went wrong was shared through meetings and email notifications. From complaints records and the minutes of staff meetings we saw that complaints were discussed as was learning from incidents and improving patients' experiences.

We looked at the records for complaints that had been recorded and investigated by the practice within the previous 12 months. We saw that three complaints had been recorded and these had been investigated and responded to appropriately and in line with the practice policy and procedure for handling complaints. Through a review of records and discussion with staff we found that there were no arrangements for recording how verbal complaints were dealt with and responded to.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff we spoke with were aware of the vision and values for the practice. The practice team shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect.

The practice was active in focusing on outcomes in primary care. We saw that the practice had recognised where they could improve outcomes for patients and had made changes accordingly through reviews, and listening to staff and patients.

Governance Arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear, up to date and accessible to staff. Staff told us that they were aware of their roles and responsibilities within the team. A number of key staff had lead roles, these included infection control, palliative care and safeguarding. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication.

There were clear policies and procedures in place, which underpinned clinical and non-clinical practices. We saw evidence that processes and procedures were working and in practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. We saw examples of a completed audits carried out to review and monitor the assessment, diagnosis, care and treatment of patients with dementia and those who had been diagnosed with cancer demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

Leadership, openness and transparency

All staff we spoke with told us that the GP and practice management team were approachable. They told us that they were encouraged to share new ideas about how to improve the services they provided and that the practice was well managed. They told us that there was an open and transparent culture within the practice and that both staff and patients were encouraged to make comments and suggestions about how the practice was managed, what worked well and where improvements could be made.

There was good communication between clinical and non-clinical staff. The practice held regular meetings and met more frequently where required to discuss any issues or changes within the practice. Staff at the practice worked on a part time basis and communications were usually shared by email communications to help ensure that staff had appropriate, up to date and relevant information.

Practice seeks and acts on feedback from users, public and staff

The practice had a Patient Participation Group (PPG) and meetings were held jointly with the patient group from each of the three neighbouring GP practices. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. We did not speak with any members of the patient group during our inspection. The practice manager told us that the recent meetings had been primarily been taken up with discussions about the proposed plans for new premises. The practice gathered the views of patients through the NHS Friends and Family Test. The results of these indicated that patients were generally highly satisfied with the care and treatment that they received. The practice was ranked 5th out of 272 practices across Essex in terms of their proactive approach in implementing the Friend and Family Test.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff in the staff handbook.

Management lead through learning & improvement

The practice had management systems in place which enabled learning and improved performance. We spoke with a range of staff who confirmed that they received

Are services well-led?

Good

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

annual appraisals where their learning and development needs were identified and planned. Staff told us that the practice constantly strived to learn and to improve patient's experience and to deliver high quality patient care. We saw that there were improvements needed to ensure that learning from incidents, significant and serious events and complaints took place.

Records showed that some clinical audits were carried out as part of their quality improvement process to improve the service and patient care. One complete audit cycle showed that changes had been made to improve the quality of the service, and to ensure that patients received safe care and treatment.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which identified role specific training and development needs. All staff had been provided with online learning accounts through which they could access a range of training and learning resources.