Dr H W Ng & Partner

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 carried out an announced comprehensive inspection at Dr H W Ng & Partner on 27 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be safe, effective, well-led, caring and responsive to patients' needs. It was also good for providing services for the following population groups; older people, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable, people with long term conditions and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- The practice was clean and hygienic.
- 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.
- The practice worked effectively with other providers.
- 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 available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- 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.

We saw one area of outstanding practice:

- The practice excelled in its proactive approach to the ongoing health surveillance of people with long term conditions, particularly those with diabetes.

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

Importantly the provider should

- Ensure that flooring in clinical areas meets the specifications as recommended by the Department of Health guidance on infection control in health care premises.
- Ensure that an automated external defibrillator is available for use in accordance with recommendations set out in the guidance issued by the Resuscitation Council.
- Carry out an assessment of the practice water supply in relation to the risk of water-borne infections such as legionella.

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 safe and is rated as 'good'.

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Staff were trained to identify and respond to potential abuse. Medicines, including vaccines, were stored appropriately and were safe to use. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. The practice was clean and hygienic and had an up to date infection control policy. Staff could deal effectively with medical emergencies. There was a plan in place to ensure the practice continued to operate in the event of a major incident.

Are services effective?

Good

The practice is effective and is rated as 'good'.

Data showed patient outcomes were at or above average for the locality, particularly for those with diabetes. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure effective treatment for patients who were at the end of their life and for those who were frail or at risk. The practice worked effectively with other providers such as hospitals, out-or-hours service and social services, and shared information in order to do so.

Are services caring?

Good

The practice is caring and is rated as 'good'.

Survey data showed that patients rated the practice similar to others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is responsive to people's needs and is rated as good.

The practice reviewed the needs of its local population and engaged with NHS England Area Team and the Clinical Commissioning Group to ensure it was providing a service that met the needs of its population. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. National survey data showed that the practice performed better than average for opening hours and appointments. The practice had good facilities and was well equipped to treat patients and meet their needs, including those who were disabled or those who spoke languages other than English. The practice had a large number of Chinese speaking patients from across the CCG area. 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 well-led and is rated as good.

There was a clear vision and philosophy of care that was shared by all staff. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and ensured staff were told when these were updated. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. There was a strong learning culture in the practice with clear arrangements for appraisal, training and clinical supervision.

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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and monitored the care of patients who were particularly frail, through multi-disciplinary team meetings. The practice also carried out a range of enhanced services, for example, in dementia and end-of-life care where the national data indicated a better than average performance. The practice was responsive to the needs of older people, and offered appointments at a time that suited them, double appointments for those with enhanced needs and home visits for those who could not attend the surgery. Older people who did not attend appointments were followed up with a call to ascertain their welfare.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice excelled in its proactive approach to the ongoing health surveillance of people with long term conditions, particularly those with diabetes. This was reflected in the nationally held data which showed that the practice was consistently performing significantly better than other practices in the CCG area. For example, we noted significantly higher than expected rates for health surveillance (such as blood pressure, cholesterol monitoring and feet checks) and treatment for this group of patients.

The practice had a rigorous approach to clinical audit of the treatments of long term conditions, such as ongoing audits into prescribing for diabetes, asthma and anti-coagulation medicine. These had resulted in adjusted treatments and measurable improvements for identified individual patients.

The practice actively took part in research to promote the health of people with long term conditions, such as the longitudinal 'Million Women Study' into various factors affecting women's health and also a study into a common rheumatic disorder.

Nursing staff were trained in all aspects of chronic disease management and were supported through proactive and effective clinical supervision. Patients at risk of hospital admission were identified as a priority and their care was managed proactively through individually tailored care plans. Longer appointments and home visits were available when needed.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates were at 100% for most standard childhood immunisations and above 97% for the measles, mumps and rubella vaccine. Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments, including double appointments were available outside of school hours and the premises were suitable for children and babies. The practice collaborated with community midwives, health visitors and school nurses. Chlamydia and cervical screening were offered at the practice. Cervical screening rates were higher than expected for this area.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care 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. For example, extended hours were offered once each week as well as telephone consultations. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments where necessary. The practice had a large number of patients from the Chinese speaking community in the CCG area. 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). All patients who experienced poor mental health had individually tailored care plans. People with 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 carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.	

Summary of findings

What people who use the service say

We spoke with three patients on the day of our inspection. Everyone we spoke with reported that they were treated with kindness, respect and dignity by all the staff at the practice and that they were provided with plenty of information about their care and treatment. They also reported that they could easily get an appointment and that the practice was responsive to their needs.

We collected 22 comment cards that had been left for us by patients in advance of our visit. Only wholly positive experiences of patients were reported on the comment cards with none of the cards indicating any negative or critical views. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2014 National Patient Survey. We noted that 77% or patients stated they would recommend the practice with 87% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally and similar to the average for this Clinical Commissioning Group (CCG). 93% of patients reported that the reception staff were helpful and a 98% satisfaction rate for patients who thought they were treated with care and concern by the nursing staff. This was higher than the CCG average.

Generally, patient satisfaction with appointments and accessibility was similar to other practices, except that 98% of patients felt it easy to get though on the telephone – among the best nationally.

Areas for improvement

Action the service SHOULD take to improve

Take steps to ensure that flooring in clinical areas meets the specifications for such flooring as recommended by the Department of Health guidance on infection control in health care premises.

Take steps to ensure that an automated external defibrillator is available in order to meet the recommendations of guidance issued by the Resuscitation Council.

Carry out an assessment of the practice water supply in relation to the risk of water-borne infections such as legionella.

Outstanding practice

The practice excelled in its proactive approach to the ongoing health surveillance of people with long term conditions, particularly those with diabetes. This was reflected in the nationally held data which showed that the practice was consistently performing better than other practices in the CCG area.

Dr H W Ng & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by a GP and a practice manager specialist adviser

Background to Dr H W Ng & Partner

Dr H W Ng & Partner, also known as Scott Park Surgery, is a community general practice that provides primary medical care for around 2,700 patients who live in the Eastwood area to the North of Southend-on-Sea in Essex. According to Public Health England, the patient population is predominantly white British with a slightly higher than average percentage of patients aged over 49 years as compared with the rest of England. There is a less than average percentage of patients in the age range 20 to 39 years and a lower percentage of patients aged under 9 years.

Dr H W Ng & Partner has one principal GP with occasional sessions each week by an established locum doctor. The practice manager is also a partner in the practice. There are two practice nurses who run a variety of appointments for people with long term conditions.

There is a practice manager and a team of non-clinical, administrative and reception staff who all work part-time, sharing a range of roles.

The practice provides a range of clinics and services, which are detailed in this report, and operates generally between the hours of 8 am and 6.30pm, Monday to Friday with additional hours till 7.15pm on every Monday evening. Outside of these hours, primary medical services are accessed through the NHS 111 service.

Why we carried out this inspection

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

This provider had not been inspected before and that was why we included them in this round of inspections in the Southend Clinical Commissioning Group (CCG) area.

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

We conduct our inspections of primary medical services, such as Dr H W Ng & Partner, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the service.

Detailed findings

We carried out an announced visit on 27 November 2014. During our visit we spoke with the principal GP, the practice manager, a member of the nursing team and administration staff.

We spoke with three patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed 22 CQC comment cards completed by patients using the service prior to the day of our visit day where they shared their views and experiences.

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

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

We also look at how well services are provided for specific groups of people and what care is expected for them. Those population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Good

Are services safe?

Our findings

Safe track record

We found evidence that Dr H W Ng & Partner was consistently safe over time. The practice had clear and simple policies and procedures in place relating to escalating safety incidents such as significant events, allegations or suspicions of abuse, complaints and safety alerts. These were supported by an open and transparent culture among the staff about keeping people safe. Staff were aware of their responsibilities and showed a good understanding of the procedures.

We looked at a summary of 12 of these incidents for the three years preceding our visit. Any action that was required to ensure patients were safe was initiated quickly and robustly. For instance, we learned of one incident from December 2012 where a person was suddenly taken ill whilst visiting the practice and was immediately seen by the GP. The patient subsequently recovered after treatment. The incident led to a number of steps being taken to reduce any risk to patient safety from a future occurrence, one of which was the procurement and maintenance of a supply of 'butterfly' needles to facilitate the administration of emergency medicine. The records relating to this and other more recent events showed the practice had consistently applied rigorous standards to their review of, and response to, matters affecting patient safety.

Learning and improvement from safety incidents

The practice learned and improved their processes as a result of their system for reporting, recording, analysing and learning from significant events, incidents and accidents, complaints and other untoward events; a process known as significant event analysis (SEA). For example, we looked at the two most recent SEA that had taken place in the year prior to our inspection, one of which related to medicines and the other to repeat prescribing. Both of these records showed that a thorough analysis of the event had taken place, that action had been taken to address errors and that both the practice and individual staff members had learned from the experience.

All staff were empowered to report incidents and events and could determine whether an event was deemed to be significant and thus required further investigation. Staff reported any concerns or events on a template form that was available on the practice computer system for addition to the agenda of the quarterly practice meetings. At such meetings, staff were involved in the discussion about the incident, agreeing the actions to be taken and formulating lessons learned, although any immediate action or learning was passed on straightaway by the practice manager.

We noted that safety alerts issued by the NHS were responded to immediately by the practice and held in a 'clinical information folder' on the practice computer system to be shared with staff.

Reliable safety systems and processes including safeguarding

The practice had policies and systems in place to manage and review risks to vulnerable children, young people and vulnerable adults. These procedures were accessible to all the staff on the practice computer system. Staff fully understood and consistently implemented these procedures.

The principal GP was the named lead for safeguarding adults and children and the staff were aware that they could escalate their concerns through him. All staff had received training in keeping people safe and recognising abuse that was appropriate to their role. This included the GPs, the managing partner and the nurses who were trained to the recommended, more advanced level.

Staff we spoke with knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities about documenting safeguarding concerns and how to contact the relevant agencies during and out-of-hours.

The lead GP and the managing partner shared the role of 'Caldicott Guardian', someone who is responsible for ensuring the confidentiality of patient's personal information. As such, they took an active role in local safeguarding meetings and facilitated the flow of information to other agencies about patients who might be at risk.

The practice computer system was equipped with a facility to alert staff to any patients who might be vulnerable, such as children subject of a child protection plan or children who were in the care of the local authority.

Good

Are services safe?

The practice had a chaperone policy in place. A chaperone is a person who is present during an intimate or sensitive consultation to ensure that the patient is safe during the examination. Nursing and other staff who carried out this role had received training to do so.

Medicines management

We spoke with a practice nurse and checked medicines stored in the treatment rooms and in both refrigerators. Medicines were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that temperature sensitive medicines, such as childhood immunisations and flu or travel vaccines, were kept at the required temperatures. Refrigerator temperatures were monitored twice daily using the minimum, maximum and actual measurements allowing the staff to be assured that they remained safe to use. Vaccines were rotated in the refrigerator so that they were used in date order.

Medicine stocks were monitored by the practice nurse who ensured that the practice was adequately stocked with the medicines it required. For example, all vaccines were checked weekly and all medicines for use in an emergency checked monthly to ensure they remained 'in date' and safe to use. Emergency medicines were kept in a box and in the GP's bag. The practice did not stock any medicines categorised as controlled drugs.

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

There was a safe system in place for managing repeat prescriptions. Prescriptions could be ordered by hand, by post or by using the practice's online system. We saw that there was a safe system in place for receiving, checking, authorising and re-issuing prescriptions. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

The practice was clean and tidy on the day of our inspection. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness. The practice was cleaned according to a cleaning schedule, with daily and weekly tasks. Cleaning was monitored by the use of a log that was signed by one of the nurses. Clinical waste, including used sharp instruments, was disposed of properly and held in a locked bin for weekly collection.

An recently updated infection control policy and supporting procedures were in place, such as those that provided instructions for dealing with a needle stick injury, guidance on hand-washing and a single-use instrument policy. These were available for staff to refer to on the practice computer system and enabled them to implement measures to control the risks of a healthcare associated infection. All staff had completed online infection control training.

The practice was well equipped to support staff to observe good infection control techniques. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Notices about hand-hygiene techniques were displayed in treatment rooms and toilets. Hand-washing sinks with hand gel and hand towel dispensers were available in treatment rooms.

One of the practice nurses had the lead responsibility for infection control and retained hard copies of all policies, schedules and audits in a dedicated folder. One of the nurse's responsibilities was to carry out an infection control audit and to deal with any shortfalls identified. We saw that a self-assessment checklist had been used to carry out this audit in August 2014 and that this was repeated in November 2014. We noted that issues relating to the cleaning of the ladies toilet and the need to replace one of the treatment room bins had been identified in the earlier audit. These had been put right by the time of the second audit, showing that the audit had been effective.

Whilst the practice was clean and tidy, we noted that the flooring in a room set aside for use as a treatment room was fitted with a simple vinyl floorcovering and standard painted skirting board. In addition, the flooring in the GP's room was carpeted. We acknowledge that the risk of infection through spillage was reduced as the practice did not carry out minor surgery and that there was an appropriate spillage protocol in place. However, these types of floor covering do not meet the specifications for flooring in clinical areas as recommended by the Department of Health guidance on infection control in health care premises.

Good

Are services safe?

We also found that the practice had not carried out a risk assessment of its water supply in relation to water-borne infections such as legionella.

Equipment

Staff we spoke with told us they had appropriate equipment to enable them to carry out their work. We saw that all items of equipment, for example the electro-cardiogram (ECG) machine and spirometer (a lung capacity testing machine) were calibrated, properly maintained and cleaned before and after each use. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

The practice was a purpose built building and so the layout and facilities were appropriate to the size of the patient list and the staff establishment.

Staffing and recruitment

We found evidence that there were sufficient numbers of appropriately skilled staff on duty at all times to ensure patients were treated safely. For instance, the nurses had been trained in the management of long term conditions.

The practice had a clear overview of the needs of its patient population and had put in place an appropriate amount of scheduled appointments with sufficient appropriately skilled staff. The practice manager reviewed the take-up of the appointments daily to ensure that enough staff were available to cover.

Whilst the staff worked to a rota, we found that there was flexibility built in and a willingness by the staff to cover in times of sickness and leave. Staff members we spoke with told us that they were able to manage their workload within their allotted hours.

The practice had a robust recruitment policy that was sent to us in advance of our inspection. We looked at five staff records and saw that all staff who were employed had been subject to appropriate references and checks to ensure they were safe to work with vulnerable people. This included references being taken up for all staff and criminal records checks for all clinical staff. We also learned that the identity of new staff was verified before they were offered employment and that the recruitment interview process was designed to examine the suitability of candidates for all roles.

Criminal records checks were not carried out on non-clinical staff who might perform the role of chaperone; however, they had been trained to carry out this role. Subsequent to the inspection, we discussed with the practice manager the potential risks of such staff not being subject of a criminal records check. We saw that the practice had assessed this and were satisfied that there was no risk. We were assured that non-clinical chaperones were used infrequently and that this was only ever when in the consultation room at the same time as the GP.

Monitoring safety and responding to risk

We saw that the practice had procedures in place to deal with potential medical emergencies. All staff had received training in basic life support and received update training annually. This included training on cardio-pulmonary resuscitation and on recognising anaphylactic shock associated with an allergic reaction to vaccines.

Staff did not have access to an automated external defibrillator, a device used to restart the heart in a medical emergency, which is a recommended item of equipment according to guidance issued by the resuscitation council. There was also no emergency oxygen in place although this was acquired immediately following out inspection.

The practice carried a stock of medicines in the reception for use in the event of a medical emergency. These included medicines for use with people experiencing a diabetic emergency or anaphylactic shock. The emergency medicines were checked fortnightly to ensure they were within their expiry dates along with checks on the equipment.

Staff at all levels could share immediate concerns about risks to individual patients with a clinician. Staff we spoke with said they were confident they could recognise patients who might have acute needs requiring a clinician's input as a priority. For example, we learned of one such incident, recorded as a significant event, of a patient suddenly taking ill in the waiting area. The patient was attended to by the GP immediately, treated with appropriate medicine and was admitted to hospital via emergency ambulance.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness, significant adverse weather or other unforeseen incident. The plan included relevant contact information

Good

Are services safe?

for local services and commissioners to enable rapid contact to be made with relevant organisations. The document was kept under review and hard copies were located off-site.

The practice manager told us that the plan was also kept in an 'emergency box' that had been made up to ensure the safe running of a clinic if the practice premises were not in use. This box was also kept off-site and included various forms, treatment cards, stationery, disposable gloves, aprons, hand wash gel, sample containers and other items that could be up-lifted and taken to any location in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. This included the use of best practice and clinical guidance described by the National Institute for Health and Care Excellence (NICE) and local guidance emanating from local commissioners of health services such as the Clinical Commissioning Group (CCG).

For example, the principal GP was a board member of the local CCG and also the CCG prescribing lead. This ensured that they were abreast of all changes in guidance and alerts relating to the use of medicines, not only for the practice but also for the local area. Any changes to guidance or any information about advances in particular treatment, was cascaded to relevant staff during quarterly staff meetings, or as and when it was required. This ensured that all staff would benefit from the most recent updates and their understanding enhanced through discussion. For example, we learned of a patient whose treatment plan had been changed as a result of published research and that this had had a noticeable beneficial outcome.

Furthermore, the GP was also a member of a local 'time to learn' group of around 15 GPs from smaller, one or two partner practices. This group met monthly, sometimes with a guest clinical speaker, to exchange ideas, discuss changes in guidance and to peer review referrals made.

We saw that the practice identified patients who were most at risk of repeated or unscheduled attendances at the hospital admissions through the accident and emergency department (A&E). The practice managed their care through individually tailored, proactive care plans. These plans were reviewed at monthly multi-disciplinary team (MDT) meetings held with social services staff and the community nursing team. The monitoring data available to us showed that the practice was consistently performing very well and below the average for the CCG area for patients attending A&E.

Patients approaching the end of their life were also subject of individual care plans and these too were reviewed at three monthly MDT meetings involving the community nursing team and the Macmillan service.

During our inspection we saw no evidence of discrimination in decision making about care and treatment decisions. Moreover, as the principal GP and the practice manager spoke three different Chinese dialects between them, we saw that the practice had a large number of registered Chinese speaking patients from across the CCG area, not just the local community.

Management, monitoring and improving outcomes for people

The practice was diligent in monitoring their performance to ensure patients achieved the best possible outcomes. The practice actively ran regular searches using their computer system and the quality and outcomes framework (QOF) to help them to manage their performance in the diagnosis and treatment of common chronic conditions and to assess their quality and productivity. The QOF is the national data management tool generated from patients' records that provides performance information about primary medical services. This enabled the practice to take a proactive approach to recalling patients for their regular long term condition reviews. In addition to reviews carried out by the practice nurses, the principal GP monitored those patients whose condition was worsening, particularly diabetic patients who were experiencing deteriorating control of their condition.

To support this, the practice also ran a programme of clinical audits. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness.

For example, we looked at a completed audit cycle that had examined the practice performance for prescribing newer diabetic medicines to ensure their compliance with NICE guidelines. As a result of the initial audit in 2013 we saw that a number of patients had had their medicine adjusted in line with the guidance. The audit was repeated the following year and this had resulted in further adjustments in treatment. The audit has helped the practice to achieve the very high indicators of diabetic management as reported in the QOF data. For example, we noted significantly higher than expected rates for health surveillance (such as blood pressure, cholesterol monitoring and feet checks) and treatment for this group of patients as compared with the rest of the CCG area and we consider that this is an area where the practice excelled.

Good

Are services effective?

(for example, treatment is effective)

In addition to the audits on diabetes, the practice had also carried out initial audits on asthma prescribing and on the use of a particular anticoagulation medicine. In each case, an identified number of individual patients had had their treatment adjusted as a result of the findings of the audits. Both of these initial audits had concluded just prior to our inspection and were due to be followed up the next year to assess the effectiveness of the treatment changes.

As well as these audits, the practice had also contributed to national or academic studies. Such studies included the longitudinal 'Million Women Study' into various factors affecting women's health and also a study into a common rheumatic disorder.

Effective staffing

We looked at records and spoke with staff and found that both clinical and non-clinical staff were appropriately trained and supported to carry out their roles effectively. For example, nursing staff had been trained in immunisations, asthma, diabetes and other long term conditions. Other training that had been offered to non-clinical staff included conflict resolution and improving the patient experience.

All staff had been trained in the use of the practice's computer system and in other topics that were generally regarded as being 'key'. Such training included basic life support, equality and diversity, fire safety, health and safety, infection control information governance and safeguarding. Staff had the opportunity to take part in 'time to learn' meetings every three months.

We looked at five staff files and found them to be comprehensive and up to date. We saw that staff received an annual appraisal during which they were given the opportunity to give feedback about their role and receive feedback about their performance. Training needs were identified during appraisal meetings. Staff told us they felt supported by their appraisal system and felt they had received enough training to carry out their roles. Staff also felt supported by the open door policy and were able to escalate concerns or discuss any problems as and when they arose.

We saw that the principal GP and the nurses had undergone relevant continuing professional development and appraisal to ensure they maintained their registration with the General Medical Council and the Nursing and Midwifery Council respectively. Clinical supervision of the nurses took place as and when this was required. The nurses approached the principal GP who allocated time for extended discussions on issues they were dealing with and to enhance their learning. Steps were also taken to ensure that the regular locum GP used by the practice was also registered to perform as a GP.

Working with colleagues and other services

We found that the practice engaged regularly with other health care providers in the area such as the district nursing team (with whom there was almost daily contact), health visitors, the emergency department of the local hospital and the local ambulance service. All records of contact that patients had with other providers, including blood and other tests such as x-rays, were received electronically then reviewed by the GP and followed up straightaway. Those patients who were at most risk from unscheduled hospital admissions were contacted immediately by the principal GP following any discharge from hospital after such an unplanned admission.

As reported above, the evolving needs of every patient receiving end-of-life care was reviewed at a three monthly MDT meetings involving the community nursing team and the Macmillan service. As patients neared the very end-of-life, information from their care plans and any documents that related to their decisions about resuscitation were sent to the ambulance service and the out-of-hours service to ensure that specific wishes about their death could be met. Other patients most at risk, including older people who were frail were subject of monthly MDT meetings that also involved the social services. There was direct contact with the social workers between meetings in order to facilitate appropriate action in any crisis situation.

In some cases the practice carried out health checks for patients with learning disabilities that belonged to other practices.

Information Sharing

The practice used an established electronic patient records management system (known as EMIS) to provide staff with sufficient information about patients. All staff were trained in its use. The system carried personal care and health records and was set up to enable alerts to be communicated about particular patients such as information about children known to be at risk frail, older patients.

Good

Are services effective?

(for example, treatment is effective)

The system also enabled correspondence from other health care providers, such hospital discharge letters or blood and other test results, to be received and held electronically to reduce the need for paper held records. The practice system was also the gateway to the 'choose and book' system which facilitated the management of referrals on to other services such as the hospital outpatients. This system was readily available and accessible to all staff.

The practice had begun to use the electronic Summary Care Record which enabled faster access to key clinical information about patients for healthcare staff when treating patients in an emergency or out of normal hours. The practice told us they had planned to 'go-live' with the electronic prescribing system early the following year.

Consent to care and treatment

We found that patients' consent to care and treatment was always sought in line with legislation and guidance. This consent was either implied, in respect of most consultations and assessments or was explicitly documented for specific procedures such as an injection. In every case, the GP or the nurse provided sufficient information to the patient to enable them to understand their treatment before proceeding. Patients we spoke with on the day of our visit told us that they were always provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

We also saw that the practice applied well-established criteria used to assess the competence of young people under 16 to make decisions in their own right about their care and treatment without the agreement of someone with parental responsibility. There was also specific information about this process on the practice web-site and in the practice information leaflet. In such cases the young person would be offered an appointment to see the GP whom would assess the person's competence to make such decisions before proceeding.

We also saw that the provisions of the Mental Capacity Act 2005 were used appropriately. Assessments of patients thought to have limited capacity to consent were carried out diligently and with the involvement of key people known to those patients. This was particularly relevant for patients who had a learning disability or who lived with dementia. We noted, for example that a guide to assessing patients' capacity was on the back of the consulting room door and the GP talked us through the assessment process.

Health promotion and prevention

All new patients were required to make an appointment for a consultation with a practice nurse for a health check when they registered with the practice. Any new patients with repeat prescription medicines were seen by the GP to assess the ongoing need for the medicine. This enabled the GP to focus on particular areas of health concern when they saw them for their first appointment. The practice asked patients to complete a new registration form which included information about their lifestyle and social factors. The GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice also used the flu clinics as an opportunity to support and educate patients. Patients were also offered any outstanding health checks required and offered additional vaccines, such as shingles and the pneumococcal vaccine. We also learned that the practice nurses visited patients in their own homes to administer the flu or other vaccines to those who were frail or otherwise housebound.

The practice nurses managed the health and treatment plans of people with long term conditions such as diabetes, asthma and heart disease. No specific scheduled clinics were offered for this but the patient list size enabled people with these conditions to be seen as part of the nursing team's routine appointments schedule. We found that there was a culture amongst the GP and the nursing team to use their contact with patients to take a holistic view of patients' mental, physical health and wellbeing; for example, by offering chlamydia screening to younger patients and offering smoking cessation advice to smokers. We saw from statistical information, for example, that the practice had performed higher than most other practices nationally in relation to offering smoking advice to patients. Furthermore, the practice also had recorded significantly higher numbers of women who had received a cervical screening test in the last five years as compared to the rest of the country.

The practice had numerous ways of identifying patients who needed additional support, and were proactive in offering additional help. For example, the practice kept a

Good

Are services effective?

(for example, treatment is effective)

register of all patients with learning disabilities and all such patients in this group had received an annual physical health check. The practice nurses and the principal GP also offered NHS health checks for patients aged 40 to 74 years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for childhood immunisations was significantly higher than other practices in this CCG area, with the take-up rate at 100% for most vaccines, and 97% for measles, mumps and rubella combined vaccine. The practice also proactively followed up patients who did not attend.

The practice waiting area contained a very large amount of health promotion and ill-health prevention literature, either on display or in leaflet form on a large central unit. This was also the case with the practice web-site that was exceptionally informative with links and signposts to other services such as a carers' forum and social services. The practice web-site also had specific information advising patients about different aspects of self-care such as healthy living guidance, 'the family medicine chest', childhood ailments and holiday health. We considered that this reflected a proactive culture among the practice team to take every opportunity to improve the health of its patient population.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with three patients on the day of our inspection. All of the patients we spoke with reported that their GP and the nurses were courteous, considerate and compassionate. Patients also told us that all the reception staff were polite and had a pleasant manner with patients. This was borne out during our observations in the reception area when we listened to reception staff speaking with patients over the telephone and observed their interaction with patients at the desk.

A notice was posted in the reception area which stated that patients could ask reception staff if they needed to speak quietly in private. Reception staff told us they could take patients to a side room to speak confidentially in such circumstances. We also noted that staff spoke quietly and discreetly with patients at the reception desk and that telephone calls were answered out of the hearing of patients in the waiting area. There was a large notice in the reception area which reminded staff of the practice's 'Ethics Code'. This notice stressed the need for confidentiality and the benefits of fostering good relationships with patients.

We saw that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However, disposable curtains were not provided in consulting rooms and treatment rooms. We saw that the layout of the building and the signs that directed patients to their treatment room ensured that the risk of them entering a room whilst another examination was going on was reduced. The practice nurse told us that they assured privacy of patients they might be examining intimately by asking permission to lock the door during such an examination and that they would leave the room whilst patients got dressed or undressed. In this way, the practice had taken steps to ensure patients' dignity was respected in the absence of curtains or other screening.

We saw that there was a chaperone policy in operation and this was prominently displayed in reception and on the practice web-site. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. A female patient we spoke with confirmed that she knew about the chaperone policy and had previously been offered a chaperone during an examination by a male doctor.

We looked at the opinions of patients reported on the NHS Choices web-site. Four of those were reported within the 12 months prior to our inspection visit and showed some positive and some negative experiences. We reviewed 22 comment cards that had been collected in the reception area from patients in advance of our visit. None of the comment cards indicated any negative or critical opinions and all of the cards reported wholly positive experiences of patients. Most of the cards referred to patients' experiences as being very good or excellent. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We looked at data from the 2014 National Patient Survey, carried out on behalf of the NHS and reported on the NHS Choices web-site. We noted that 77% or patients stated they would recommend the practice with 87% stating that they felt the practice was good or very good; these were among the middle range of ratings nationally and similar to the average for this Clinical Commissioning Group (CCG). 93% of patients reported that the reception staff were helpful. This was also higher than the national average. The survey showed a 98% satisfaction rate for patients who thought they were treated with care and concern by the nursing staff, higher than the CCG average. However, this satisfaction rate was 76% in relation to patients' experiences of the doctor and this was lower than the CCG average.

We saw that the practice's patient participation group (PPG) had carried out a 'Friends and Family' survey at the end of 2013. A PPG is a group made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. The survey showed that 94% of patients had said they would be likely or highly likely to recommend the practice to a family member. Many of the reasons given by patients were related to the friendliness of the staff and doctors and the care, compassion and attention they were treated with.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

We found that patients were involved in decisions about their treatment. The National GP Patient Survey 2014 showed that, on average, 84% of patients felt the GP was good at giving them enough time, good at listening to them and good at explaining test results to them. The survey showed that 75% of patients felt that the GP was good at involving them in decisions about their care. These satisfaction rates were similar to the average for both the local CCG area and for England in general. The corresponding figures for the nursing staff were higher than the national average with 99% reporting that the nurses gave them enough time, listened to them and explained test results, whilst 93% felt the nurses involved them in care decisions.

Our interviews with patients on the day of our visit showed that they were very satisfied with their level of involvement and that they felt they were in control of the care and treatment. Patients said that their diagnoses were explained well by their GP and that they had opportunities to ask questions to enable them to make informed decisions. Further, a significant number of the 22 comment cards we reviewed reported that patients felt listened to.

Where it was evident that patients had limited capacity to understand their care and treatment planning, we saw that the practice took steps to involve the families and those close to patients in decisions. This was particularly the case with the relatives or carers of older people who were a significant part of the patient population. From our interviews with patients we learned of a specific example where this had been effective.

We found that patients who were referred onwards to hospital or other services were involved in the process. We saw that patients could make a choice about where and when to receive follow-up treatment from hospital providers by the use of the 'choose and book' system.

The practice had access to translating and interpreting services for patients who had limited understanding of English to enable them to fully understand their care and treatment. In addition, the doctor and the practice manager spoke three different Chinese dialects to enable Chinese speaking patients across the CCG area to understand their treatment.

Patient / carer support to cope emotionally with care and treatment

Patients and others close to them received the support they needed to cope emotionally with their care and treatment, particularly those that were recently bereaved. For example, staff we spoke with told us they were always made aware of the names of the patients who had recently deceased. This ensured that relatives of patients who had died were greeted appropriately and enquiries made to establish whether they required any additional support.

Furthermore, relatives of patients who had died were called by the practice and offered a visit by the practice nurse in order to assess their emotional and support needs and to offer a referral to local counselling or bereavement support services if necessary.

The care plans of patients who were most at risk of unscheduled hospital admissions were discussed at monthly multi-disciplinary team (MDT) meetings involving the social services department and the community nursing team. The care plans of patients who were receiving end-of-life care were also discussed at three-monthly MDT meetings that involved the Macmillan service. This ensured that the practice could regularly and actively monitor the evolving health and support needs of these groups of patients.

The practice actively took steps to identify patients who were carers. This group of patients were provided with information about local services providing practical and emotional support and referrals to these services were actively managed by the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved. The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as children who were known to be at risk of harm.

The practice understood the needs of its patients with long term conditions. For example, we saw the quality and outcomes framework (QOF) data showed that the practice was performing better than other practices in the area in relation to the monitoring and management of patients with diabetes.

The practice had a well-established recall system for patients with long term conditions such as asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of printed information about healthy living and opportunistic smoking cessation advice.

As we have reported above, the practice had identified those patients who were at risk of unplanned admission to hospital and had tailored, individual care plans to meet their needs co-ordinated through monthly multi-disciplinary team (MDT) meetings. This enabled the practice to actively monitor and treat those patients to mitigate the risk of attendance at A&E. The practice also held three-monthly MDT meetings for those patients who were receiving end-of-life care.

The practice made use of a monthly local community newsletter that was circulated to homes and businesses in the area to communicate topical information about its services. For example, the practice had published information about the availability of the shingles vaccine, the formation of the practice's patient participation group and the NHS' Care Data Programme, a national patient information initiative designed to help the NHS determine the country's future health needs.

Tackle inequity and promote equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, in addition to patients with long term conditions, the practice held registers for particular groups of patients that received regular or scheduled treatment in accordance with the practice's contractual arrangements. In this way, patients with learning disabilities, patients with dementia and those with poor mental health were identified and so that their physical health needs could be monitored alongside their psychological well-being. Longer appointments were available for these groups of patients to enable their consultations to be more effective.

We also saw that the practice was largely configured in a way that enabled patients in wheelchairs to access their GP with the exception that the front door was particularly heavy and there was no other means, such as a bell, of alerting staff inside the building if a patient required assistance to get in. There was level access throughout with widened doorways and an accessible toilet.

We saw that the practice web-site had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care. We saw that interpreters were arranged in advance and that extended appointments were booked to facilitate this on the infrequent occasions this occurred.

Patients who were short term visitors to the area, such as members of the travelling community, could access care where this was immediately necessary by registering as a temporary resident. However, as the practice served a relatively stable population these instances were very few.

The practice manager and the principal GP spoke three Chinese dialects between them and so this practice patient population included a large number of the Chinese speaking residents of Southend. Furthermore, we noted that the practice staff had received in-house equality and diversity training during 2014.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

The practice is located in an area which has a higher than average proportion of working age people over 40 years of age and a significantly higher than average older population. In order to meet the needs of this group of patients the practice opened for late consultation appointments until 7.15pm every Monday.

Some appointments were released for booking in advance with the remainder being made available on the day for emergency patients. Patients who wished to be seen in an emergency were offered an appointment slot towards the end of surgery opening times and we learned that the practice sometimes over-ran if more patients required to be seen in an emergency. Telephone consultations were also offered to all patients at the end of normal surgery hours where the GP would make a decision as to whether the patient needed to come in to be seen or treated through telephone advice.

The practice was very flexible in its arrangements for seeing older patients, offering appointments at a time that suited them, even if all appointments for the day had gone. For example, during our inspection we saw that an older, frail couple had attended at the wrong time and arrived after the morning session was closed. We also saw that longer or back-to-back appointments were available for patients with more complex needs or where patients had more than one ailment.

The principal GP and the practice nurse also carried out home visits to patients who were unable to get to the practice. For example, the practice nurse carried out home visits to provide immunisations and used those visits as opportunities to assess other health needs at the same time.

Patients could book appointments over the telephone, in person or by registering to use an online facility governed by the practice's electronic patient record system. The practice web-site contained detailed information about how to book appointments. Call-handling was carried out as a 'back-office' function and during busy times additional staff answered the telephones to ensure patients did not have to wait longer than necessary for their call to be answered.

The 2014 National GP Patient Survey results showed that patient satisfaction with the practice's opening hours was among the top 25% in the country whilst patients' satisfaction with their experience of making an appointment was at 82%, similar to other practices nationally. The survey also showed that 98% of patients said they found it easy to get through on the telephone, also among the best. On the day of our inspection, all three of the patients we spoke with said that they were happy with the appointment booking system and that they appreciated being able to make an emergency appointment on the day. Comment cards we received were also positive about the appointment system with several patients particularly commenting about good appointment availability.

Listening to and learning from concerns and complaints

The practice listened to concerns and responded to complaints to improve the quality of care. The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. The practice manager was responsible for handling all complaints in the practice. There was information on the practice website, in leaflet form in the reception area and in a notice on the notice board advising patients of the complaints procedure. All three of the patients we spoke with said they had never had cause to complain and told us they would know how to complain if necessary.

We looked at the complaints received in the last twelve months and saw that these were satisfactorily handled and dealt with in a timely way. The practice reviewed complaints on an ongoing basis and reviewed these regularly at team meetings. We noted that no themes had been identified over the previous year; however lessons learnt from individual complaints had been acted upon. We saw an example where, following a complaint, the practice had reviewed its process for checking repeat prescriptions.

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 principal GP told us that their aim was to provide high quality care at the right place and that they believed ill patients should never find difficulty in finding high quality care. This was a vision that was reflected in the practice's statement of purpose they had submitted to the CQC as part of their registration responsibilities with the principal aim stated as 'To ensure our population experiences effective, and appropriate personalized care and treatment'. The practice web-site also carried a practice charter which was focused on the needs of the patient.

It was evident from our interviews with the GP, the practice manager and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that put outcomes for patients first. Throughout our visit we saw a consistent, kind, caring and compassionate approach to patients that supported this aim.

We saw that future strategic plans of the practice included its participation in plans for a federation of GPs for the CCG area and consideration of taking on a GP partner to ensure succession planning.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. The principal GP told us that they took personal responsibility to ensure that the practice ran smoothly and continued to provide a good service. All of the key functions of the practice were shared between the principal GP and the practice manager who was also a partner in the practice. Both the principal GP and the practice manager explained that this enabled decisions to be made quickly and efficiently and ensured the practice was adaptable.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The practice also actively used feedback from complaints, concerns and the findings of significant event analyses (SEA), clinical audits and referral peer reviews to understand and manage any risks to their service. We looked at a number of examples of each of these as previously reported above.

Decision making and communication across the workforce was structured around key, scheduled meetings. Business meetings took place weekly or more frequently and staff had the opportunity to take part in 'time to learn' meetings every three months.

We noted that the practice an expected range of policies and protocols that governed how they carried out their business. All staff had signed to say they had read and understood them. Any updates were communicated by email to staff who were required to check daily and acknowledge receipt. We also saw that screen messages were placed on the practice computer system to alert staff of any important information. For example, safety alerts issued by the NHS and information about any risks to patients were held on the system in a 'clinical information folder' to be shared with staff.

Leadership, openness and transparency

We found that the leadership style and culture reflected the practice vision of putting patients first. The principal GP and the practice manager were open, highly visible and approachable and we learned that an 'open-door' policy existed for all staff to raise issues whenever they wished.

As well as the clear formal meeting structure the practice operated an inclusive approach to staff involvement and decision making, which encouraged staff to contribute their views. For example, information about the practice's performance was shared with staff, such as data from the QOF, the findings of audits and results from patient surveys. This ensured staff had an interest in the success of the practice and in delivering the practice vision.

We spoke with staff about this approach and they told us they felt valued and able to contribute. Staff were positive in their attitudes and presented as a happy workforce. We felt this to be evidence of the effectiveness of the open and candid approach adopted by the practice.

Seeking and acting on feedback from patients, public and staff

As well as enabling staff to contribute their feedback, we also found that the practice engaged actively with its

Are services well-led?

Good

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

patient population to help to drive improvements in services. The practice was participating in the 'Friends and Family' test and had a comments and suggestions box in the waiting area.

The practice also had an active patient participation group (PPG). Such groups are made up of patient's representatives and staff with the purpose of consulting and providing feedback in order to improve quality and standards. We looked at the profile of the PPG for this practice and saw that it was generally representative of the patient population in the older age ranges with both men and women and a consistent membership of around six.

The PPG met quarterly and reported their activity through the notes of the meetings and a newsletter distributed in reception and on the practice website. The PPG also produced an annual report that set out its achievements in the previous year, such as the findings of surveys it had carried out.

We did not speak with members of the PPG during our inspection. However, it was evident from the notes of the PPG meetings that the group was both supportive and challenging when required. For example, we saw that the meeting records had a standing agenda item entitled 'Improvement of Patient Service' where plans and proposals for improvements were debated and agreed. Such improvements included, for example, the implementation of the practice's online appointment system as a result of a survey about online access carried out by the PPG the previous year.

Management lead through learning & improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to nursing and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through three monthly, internal 'time to learn' sessions.

The principal GP ensured he protected himself from clinical isolation by actively participating in an external local 'time to learn' group for GPs from similar small practices as reported earlier. This learning approach was reflected in the investment in clinical supervision of the nurses for which the GP allocated extended discussion time.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. All staff were encouraged to escalate issues that might result in improvements or better ways of working. It was clear to us that everyone who worked at the practice found the open door policy and the inclusive leadership style to be of great benefit. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.