Dr Sprake & Partners

Quality Report

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Date of inspection visit: 13 September 2016
Date of publication: 04/11/2016

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Sprake & Partners on 13 September 2016. Overall the practice is rated as good.

Our key findings were as follows:

- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Nationally reported data showed that outcomes for patients with long-term conditions were consistently better than national averages. The practice had achieved at least 99% of the total points available in all but one of the 19 quality and outcomes framework (QOF) clinical indicators:
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- 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 were able to get an appointment with a GP when they needed one, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure in place and staff felt supported by management. The practice proactively sought feedback from staff and patients, which they acted on.
- Managers promoted a culture of continuous reflection and learning. Clinical education meetings were held twice weekly. One of the GP partners and the practice manager had completed a strategic leadership skills course.
- There were very high levels of staff satisfaction. There was a stable team; the majority of staff had worked at the practice for many years. Staff told us they were proud to work at the practice and many referred to the practice as a fantastic place to work.

We saw several areas of outstanding practice including:

- Innovative training processes were in place, this included members of the practice's patient participation group (PPG) carrying out 'simulated

Summary of findings

surgeries' with the trainee GPs. There were comprehensive debriefs following the surgeries with the PPG patients, trainee GPs and their trainers to ensure all learning was captured. The practice was keen to promote general practice as a career choice and as such, had invited a number of sixth form students to work in the practice on a two day placement.

- Clinicians worked closely with patients and their families to prepare care plans and help prevent unnecessary admissions to hospital. In the previous year, the practice had the lowest non-elective (emergency) admission rate across the clinical commissioning group (CCG), 293 per 1,000 population, compared to the average of 413.
- One of the doctors was a GP with a special interest (GPwSI) in musculo-skeletal services. As a result, the practice was able to reduce referrals to secondary care by treating patients within the practice. The practice's referral rate to orthopaedics outpatient services was the lowest across the CCG (31.5 per 1,000 population, compared to the average of 47.7). Other neighbouring practices also used the service provided by the GP and their referral rates were also well below average (37.4 and 35.5 per 1,000 population).

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.

The nationally reported data we looked at as part of our preparation for this inspection did not identify any risks relating to safety. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. There was an open culture where all safety concerns raised were valued as integral to learning and improvement. Risks to patients were assessed and well managed.

There was evidence of good medicines management. Good infection control arrangements were in place and the practice was clean and hygienic. Effective staff recruitment practices were followed and there were enough staff to keep patients safe. Disclosure and Barring Service (DBS) checks had been completed for all staff that required them.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.

Data showed that the practice was performing highly when compared to practices nationally. The practice used the Quality and Outcomes Framework (QOF) as one method of monitoring its effectiveness. The latest publicly available data from 2014/15 showed the practice had achieved 99% of the total number of points available, which was above the England average of 95%. The data showed that outcomes for patients with long-term conditions were consistently better than national averages. The practice had achieved at least 99% of the total points available in all but one of the 19 clinical indicators.

The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. Clinicians worked closely with patients and their families to prepare care plans and help prevent unnecessary admissions to hospital. In the previous year, the practice had the lowest non-elective (emergency) admission rate across the CCG, 293 per 1,000 population, compared to the average of 413.

Summary of findings

The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Innovative training processes were in place, this included members of the practice's patient participation group (PPG) carrying out 'simulated surgeries' with the trainee GPs.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients said they were treated with compassion, dignity and respect and they felt involved in decisions about their care and treatment. Information for patients about the services available was available. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Results from the National GP Patient Survey, published in July 2016, showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was above average for their satisfaction scores on consultations with doctors and nurses. For example, of those who responded: 98% said they had confidence and trust in the last GP they saw, compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%; 99% said they had confidence and trust in the last nurse they saw, compared to the CCG average of 98% and the national average of 97%.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality. For example, there were good arrangements in place to support patients with learning disabilities; reviews were carried out by the same GP and organised by the same administrator for several years.

Results from the National GP Patient Survey, published in July 2016, showed that patients' satisfaction with how they could access care and treatment was above national averages, but below local averages. For example: 83% of patients were able to get an appointment when they needed, compared to the CCG average of 86% and the national average of 85% and 75% of patients described

Summary of findings

their experience of making an appointment as good, compared to the CCG average of 77% and the national average of 73%. Patients we spoke with on the day were able to get appointments when they needed them.

However, the survey showed that some patients felt they waited too long to be called in for their appointment; 39% of patients said they usually waited more than 15 minutes after their appointment time, compared to the CCG average of 21% and the national average of 27%.

Managers were aware of these results and had taken action; for example, reviewing GPs' working sessions and building in blocks of time between appointments to allow them to catch up.

Are services well-led?

Good

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

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear, documented vision to deliver high quality care and promote good outcomes for patients. There was a systematic approach to working with other organisations to improve care outcomes and obtain best value for money.

There was a well-defined leadership structure in place with designated staff in lead roles. There was a high level of constructive engagement with staff and a high level of staff satisfaction. Staff spoke very highly of managers; several staff had worked at the practice for many years. Team working within the practice between clinical and non-clinical staff was good.

The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had implemented a number of innovative systems.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. For example, all patients over the age of 75 had a named GP. Patients at high risk of hospital admission and those in vulnerable circumstances had care plans.
- Weekly multi-disciplinary team meetings with the community nursing team were held to discuss at risk patients who had recently been discharged from hospital and care planning for those at high risk of admission to hospital.
- The practice was responsive to the needs of older people and offered home visits and urgent appointments for those with enhanced needs.
- All patients over the age of 90 were contacted prior to the annual 'flu vaccination day' to check if they wanted to attend the practice or preferred a home visit for immunisation.
- A palliative care register was maintained and the practice offered immunisations for pneumonia and shingles to older people.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of admission to hospital were identified as a priority.
- Longer appointments and home visits were available when needed. The practice's electronic system was used to flag when patients were due for review. This helped to ensure the staff with responsibility for inviting people in for review managed this effectively.
- Patients had regular reviews to check with health and medicines needs were being met.
- For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- National indicators showed that outcomes for patients with long-term conditions were consistently better than national averages. The practice had achieved at least 99% of the total points available in all but one of the 19 quality and outcomes

Summary of findings

framework (QOF) clinical indicators. For example, performance for COPD (chronic obstructive pulmonary disease) related indicators was better than the national average (100% compared to 96% nationally).

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- The practice had identified the needs of families, children and young people, and put plans in place to meet them.
- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- Appointments were available outside of school hours and staff arranged on the day appointments for unwell children.
- There were monthly child health meetings with practice staff and health visitors.
- The practice's uptake for the cervical screening programme was 84.4%, which was above the clinical commissioning group (CCG) average of 83.1% and the national average of 81.8%.
- Pregnant women were able to access an antenatal clinic provided by healthcare staff attached to the practice.

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 and flexible. Extended hours surgeries were offered on every Tuesday and Thursday evening until 8pm for patients who could not attend during normal opening hours.
- The practice offered appointments throughout the whole day and pre-bookable telephone consultations were also available.
- Appointments were available with a healthcare assistant from 7.30am two mornings per week.

Summary of findings

- The practice offered a full range of health promotion and screening which reflected the needs for this age group. Patients could order repeat prescriptions and book appointments on-line.
- Additional services were provided such as health checks for the over 40s and travel vaccinations. The practice was a pilot site for NHS health checks before they were rolled out nationally.

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.
- There were good arrangements in place to support patients with learning disabilities; annual health checks were carried out by the same GP and organised by the same administrator for several years. This continuity of care allowed staff to build up relationships with patients and their carers and families. The practice was involved in a national project 'Getting it right - from the start' to improve the patient experience for those with learning disabilities.
- Staff, teams and services were committed to working collaboratively to ensure patients with complex needs were supported to receive co-ordinated care. For example, multi-disciplinary team (MDT) meetings took place on a weekly basis. In-house training sessions had been provided by a national charity and the local community learning disabilities liaison nurse.
- 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.
- Good arrangements were in place to support patients who were carers. The practice had systems in place for identifying carers and ensuring that they were offered a health check and referred for a carer's assessment.

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).

Summary of findings

- The practice worked closely with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. Care plans were in place for patients with dementia.
- Patients experiencing poor mental health were sign posted to various support groups and third sector organisations.
- A counsellor was available at the practice three sessions per week.
- The practice kept a register of patients with mental health needs which was used to ensure they received relevant checks and tests. Appointments were made with the same GP wherever possible.
- Staff had developed close links with the community matrons for mental health and wellbeing; they were able to provide further support for patients.

Summary of findings

What people who use the service say

We spoke with seven patients during our inspection. We spoke with people from different age groups, who had varying levels of contact and had been registered with the practice for different lengths of time.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We reviewed 26 comment cards. Respondents used phrases such as couldn't have had better care, really caring, provide the best of care and excellent. They described staff as pleasant, knowledgeable, helpful and understanding.

Patients were very complimentary about the practice, the staff who worked there and the quality of service and care provided. They told us the staff were very caring and helpful. They also told us they were treated with respect and dignity at all times and they found the premises to be clean and tidy. Patients were happy with the appointments system, although some felt they waited too long to be called in for their appointment.

The National GP Patient Survey results published in July 2016 showed the practice was generally performing in line with local and national averages, although waiting times at the practice appeared high. There were 108 responses (from 235 sent out); a response rate of 46%. This represented 1.2% of the practice's patient list. Of those who responded:

- 87% said their overall experience was good or very good, compared with a CCG average of 88% and a national average of 85%.
- 77% found it easy to get through to this surgery by phone, compared with a CCG average of 79% and a national average of 73%.
- 91% found the receptionists at this surgery helpful, compared with a CCG average of 90% and a national average of 87%.
- 83% were able to get an appointment to see or speak to someone the last time they tried, compared with a CCG average of 86% and a national average of 85%.
- 94% said the last appointment they got was convenient, compared with a CCG average of 93% and a national average of 92%.
- 75% described their experience of making an appointment as good, compared with a CCG average of 77% and a national average of 73%.
- 39% usually waited more than 15 minutes after their appointment time to be seen, compared with a CCG average of 21% and a national average of 27%.
- 39% felt they had to wait too long to be seen, compared with a CCG average of 28% and a national average of 34%.

Outstanding practice

Innovative training processes were in place, this included members of the practice's patient participation group (PPG) carrying out 'simulated surgeries' with the trainee GPs. There were comprehensive debriefs following the surgeries with the PPG patients, trainee GPs and their trainers to ensure all learning was captured. The practice was keen to promote general practice as a career choice and as such, had invited a number of sixth form students to work in the practice on a two day placement.

Clinicians worked closely with patients and their families to prepare care plans and help prevent unnecessary admissions to hospital. In the previous year, the practice had the lowest non-elective (emergency) admission rate across the clinical commissioning group (CCG), 293 per 1,000 population, compared to the average of 413.

One of the doctors was a GP with a special interest (GPwSI) in musculo-skeletal services. As a result, the practice was able to reduce referrals to secondary care by treating patients within the practice. The practice's referral rate to orthopaedics outpatient services was the lowest across the CCG (31.5 per 1,000 population,

compared to the average of 47.7). Other neighbouring practices also used the service provided by the GP and their referral rates were also well below average (37.4 and 35.5 per 1,000 population).

Dr Sprake & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC Lead Inspector. The team included a GP specialist advisor.

Background to Dr Sprake & Partners

Dr Sprake & Partners (also known as Lane End Surgery) is registered with the Care Quality Commission to provide primary care services. It is located in Benton, Tyne and Wear.

The practice provides services to around 8,700 patients from one location: 2 Manor Walk, Newcastle upon Tyne, Tyne and Wear, NE7 7XX. We visited this address as part of the inspection. The practice has three GP partners (two female and one male), three salaried GPs (two female and one male), two practice nurses (both female), two healthcare assistants, a practice manager, and 12 staff who carry out reception and administrative duties.

The practice is part of North Tyneside clinical commissioning group (CCG). The age profile of the practice population is broadly in line with CCG and national averages. Information taken from Public Health England placed the area in which the practice is located in the third less deprived decile. In general, people living in more deprived areas tend to have greater need for health services.

The practice is a teaching and training practice and two of the GPs are accredited GP trainers. At the time of the inspection there were two trainee GPs working at the practice.

The practice is located in a converted two storey building. All patient facilities are on the ground floor. There is on street parking near to the practice, disabled parking spaces behind the building, a disabled WC, wheelchair and step-free access.

Opening hours are between 8am and 6pm on Mondays. Wednesday and Fridays, and between 8am and 8pm on Tuesdays and Thursdays. Patients can book appointments in person, on-line or by telephone. Appointments were available at the following times:

- Monday - 8.30am to 11.30am; then from 2.30pm to 5.30pm
- Tuesday – 8.30am to 11.30am; from 2.30pm to 5.30pm; then from 6.30pm to 8pm
- Wednesday – 8.30am to 11.30am; then from 2.30pm to 5.30pm
- Thursday – 8.30am to 11.30am; from 2.30pm to 5.30pm; then from 6.30pm to 8pm
- Friday – 8.30am to 11.30am; then from 2.30pm to 5.30pm

A duty doctor is available each afternoon until 6.30pm.

The practice provides services to patients of all ages based on a General Medical Services (GMS) contract agreement for general practice.

The service for patients requiring urgent medical attention out of hours is provided by the NHS 111 service and Vocare, which is also known locally as Northern Doctors Urgent Care.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

Detailed findings

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

As part of the inspection process, we contacted a number of key stakeholders and reviewed the information they gave to us. This included the local clinical commissioning group (CCG).

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.

We carried out an announced visit on 13 September 2016. We spoke with seven patients and 11 members of staff from the practice. We spoke with and interviewed three GPs, a trainee GP, a practice nurse, the practice manager, a healthcare assistant and four staff carrying out reception and administrative duties. All of the GP partners made themselves available to us on the day of the inspection. We observed how staff received patients as they arrived at or telephoned the practice and how staff spoke with them. We reviewed 26 CQC comment cards where patients and members of the public had shared their views and experiences of the service. We also looked at records the practice maintained in relation to the provision of services.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- There was a genuinely open culture within the practice in which all safety concerns were highly valued as integral to learning and improvement. All staff we spoke with told us about the value of reporting significant events and fully understood their role in this, as well as their role in assisting investigations where appropriate.
- Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the Duty of Candour (the Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- Incidents were also reported on the local cross primary and secondary care Safeguard Incident and Risk Management System (SIRMS).
- The practice carried out a thorough analysis of the significant events.

Staff told us they were encouraged to report incidents; both minor and more significant issues were reported and recorded. Lessons were shared to make sure action was taken to improve safety in the practice, for example, following one incident (a successful resuscitation), steps were taken to make sure all emergency medicines and equipment were held on a trolley which could be easily accessed by staff when needed.

We discussed the process for dealing with safety alerts with the practice manager and some of the clinical staff. Safety alerts inform the practice of problems with equipment or medicines or give guidance on clinical practice. Alerts were disseminated by the practice manager to the lead GP for safety alerts (each year a different GP acted as the nominated lead). The lead GP or nurse then decided what action should be taken to ensure continuing patient safety, and mitigate risks. The alerts were passed on to relevant staff and discussed at the clinical governance meetings.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three, and the nurses to level two.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead; they liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Regular infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Regular medicines audits were carried out

with the support of the local clinical commissioning group (CCG) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). The practice had a system for production of Patient Specific Directions to enable Health Care Assistants to administer vaccinations (only if they had received specific training and only when a doctor or nurse was on the premises).

- Recruitment checks were carried out and the three files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate DBS checks.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the staff common room. The practice had an up to date fire risk assessment and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (legionella is a type of bacteria found in the environment which can contaminate water systems in buildings and can be potentially fatal).
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to ensure all clinical staff were kept up to date. Staff had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet patients' needs.
- The practice monitored that these guidelines were followed through risk assessments and audits.

Management, monitoring and improving outcomes for people

Staff were actively engaged in activities to monitor and improve quality and outcomes. The practice participated in the Quality and Outcomes Framework (QOF). The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long term conditions and for the implementation of preventative measures. The results are published annually. The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

The latest publicly available data from 2014/15 showed the practice had achieved 99% of the total number of points available, which was above the England average of 95%.

At 8.4%, the clinical exception reporting rate was below the England average of 9.2% (the QOF scheme includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review, or where medicines cannot be prescribed due to a contraindication or side-effect).

The data showed that outcomes for patients with long-term conditions were consistently better than national averages. The practice had achieved at least 99% of the total points available in all but one of the 19 clinical indicators:

- Performance for COPD (chronic obstructive pulmonary disease) related indicators was better than the national average (100% compared to 96% nationally). For example, the percentage of patients with COPD who had had a review, undertaken by a healthcare professional, in the preceding 12 months was 91%, compared to the national average of 89.8%.
- Performance for mental health related indicators was above the national average (100% compared to 92.8% nationally). For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a record of blood pressure in the preceding 12 months was 95.1%, compared to the national average of 89.5%.
- Performance for stroke and transient ischaemic attack related indicators was better than the national average (100% compared to 96.6% nationally). For example, the percentage of patients with stroke or TIA who had had influenza immunisation was 98.6%, compared to the national average of 94%).

The QOF data showed the practice had performed exceptionally well in obtaining 100% of the total points available to them for delivering care and treatment aimed at improving public health. This was above the national average of 95.7%.

The practice provided details of their QOF results for the most recent year; these unverified figures, showed that performance had further improved and the practice had achieved an overall score of 99.1% of the total points.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. We saw a number of clinical audits had recently been carried out. The results and any necessary actions were discussed at the clinical team meetings. This included an audit to check that records showed when patients prescribed a type of anticoagulant medicine (anticoagulation medicines work to prevent blood clotting) should taking the medicine. An initial audit was carried out which showed that 16 out of 17 patients had 'stop dates' marked on their records. Action was taken and advice was sought from a specialist. A further audit cycle was carried out and this showed an improvement, in that all patients had stop dates marked in their records.

Opportunities to participate in benchmarking and peer review were proactively pursued. Findings were used by the practice to improve services.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Information about patient outcomes was used to make improvements such as;

- One of the doctors was a GP with a special interest (GPwSI) in musculo-skeletal services. As a result, the practice was able to reduce referrals to secondary care by treating patients within the practice. The practice's referral rate to orthopaedics outpatient services was the lowest across the CCG (31.5 per 1,000 population, compared to the average of 47.7). Other neighbouring practices also used the service provided by the GP and their referral rates were also well below average (37.4 and 35.5 per 1,000 population).
- Clinicians worked closely with patients and their families to prepare care plans and help prevent unnecessary admissions to hospital. In the previous year, the practice had the lowest non-elective (emergency) admission rate across the CCG, 293 per 1,000 population, compared to the average of 413.

Effective staffing

The continuing development of staff skills, competence and knowledge was recognised as being integral to high quality care. Staff had the skills, knowledge and experience to deliver effective care and treatment and were proactively supported to acquire new skills.

- The practice had a long track record as a training practice. Two of the GPs were accredited GP trainers; one also held a senior post at the local medical school. At the time of the inspection there were two trainee GPs in post.
- Innovative training processes were in place, this included members of the practice's patient participation group (PPG) carrying out 'simulated surgeries' with the trainee GPs. There were comprehensive debriefs following the surgeries with the PPG patients, trainees and their trainers to ensure all learning was captured.
- In addition to supporting trainee GPs, the practice also worked closely with the local university and taught first to final year medical students. There was a whole team approach to teaching; which promoted effective one to one observation and supported feedback, not only from the GPs, but the wider clinical team as well. Students were involved in carrying out clinical audits, under the supervision of the GP partners.
- The practice was keen to promote general practice as a career choice and as such, had invited a number of sixth form students to work in the practice on a two day placement.
- The GP trainers were very experienced and had worked with both trainee GPs and medical students who had previously either taken time away from their studies, or who required additional support to complete their training programmes.
- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updates for relevant staff. For example, for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- Managers promoted a culture of continuous reflection and learning. Clinical education meetings were held twice weekly. One of the GP partners and the practice manager had completed a strategic leadership skills course.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example, when people were referred to other services.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Staff, teams and services were committed to working collaboratively to ensure patients with complex needs were supported to receive co-ordinated care. For example, multi-disciplinary team (MDT) meetings took place on a weekly basis. We saw evidence of several cases where clinicians were able to intervene and provide timely care and support to patients, for example, those involved in safeguarding cases.

Staff had developed close links with the community matrons for mental health and wellbeing; they were able to provide further support for patients experiencing poor mental health.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

Patients who may be in need of extra support were identified by the practice. For example:

- Patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- A dietician and smoking cessation advice was available on the premises.

The practice's uptake for the cervical screening programme was 84.4%, which was above the CCG average of 83.1% and the national average of 81.8%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were comprehensive systems in place to encourage patients with learning disabilities to attend screening appointments. For example, a series of easy read leaflets about the screening tests had been developed and staff had undertaken further training. An audit to determine the effectiveness of these arrangements was in progress.

Childhood immunisation rates for the vaccinations given were above CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 98.8% to 100% (compared to the CCG averages of between 97.5% and 98.8%) and for five year olds ranged from 95.1% to 98.8% (compared to the CCG averages of between 92.2% and 98.4%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. The practice was a pilot site for NHS health checks before they were rolled out nationally. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect.

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

All of the 26 patient CQC comment cards we received were positive about the service experienced. We spoke with seven patients during our inspection. Patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the National GP Patient Survey, published in July 2016, showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was above average for their satisfaction scores on consultations with doctors and nurses. For example, of those who responded:

- 98% said they had confidence and trust in the last GP they saw, compared to the clinical commissioning group (CCG) average of 96% and the national average of 95%.
- 90% said the last GP they spoke to was good at treating them with care and concern, compared to the CCG average of 89% and the national average of 85%.
- 99% said they had confidence and trust in the last nurse they saw, compared to the CCG average of 98% and the national average of 97%.
- 92% said the last nurse they spoke to was good at treating them with care and concern, the same as the CCG average and above the national average of 91%.
- 91% said they found the receptionists at the practice helpful, compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views.

Results from the July 2016 National GP Patient Survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example, of those who responded:

- 91% said the GP was good at listening to them, compared to the CCG average of 90% and the national average of 89%.
- 89% said the GP gave them enough time, the same as the CCG average and the above the national average of 87%.
- 87% said the last GP they saw was good at explaining tests and treatments, compared to the CCG average of 89% and the national average of 86%.
- 83% said the last GP they saw was good at involving them in decisions about their care, compared to the CCG average of 85% and the national average of 82%.
- 95% said the last nurse they spoke to was good listening to them, compared to the CCG and national average of 91%.
- 96% said the nurse gave them enough time, compared to the CCG average of 93% and the national average of 92%.
- 91% said the nurse was good at explaining tests and treatments, the same as the CCG average of 91% and above the national average of 90%.

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

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. For example, there were leaflets with information about a local 'positive women's group', a stroke information service and a local carers group.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all patients who were also carers; 225 patients (2.6% of the practice list) had been identified as carers. They were referred for social services support if appropriate. Written information was available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw several examples where GPs had visited families on evenings and at weekends to provide support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Services were planned and delivered to take into account the needs of different patient groups and to help ensure flexibility, choice and continuity of care. For example;

- The practice was open every Tuesday and Thursday evening until 8pm for patients who could not attend during normal opening hours.
- There were longer appointments available for people with a learning disability and those who needed an interpreter.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, a hearing loop and translation services available.
- The practice held regular clinics to provide childhood immunisations and minor surgery.
- Smoking cessation support was provided by the practice.
- There was a practice based retinal screening clinic.
- The practice held an annual 'flu day' on a Saturday morning for patients to receive their immunisations. All patients over the age of 90 were contacted prior to the day to check if they wanted to attend the practice or preferred a home visit for immunisation.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality. There were good arrangements in place to support patients with learning disabilities; reviews were carried out by the same GP and had been organised by the same administrator for several years. This continuity of care allowed staff to build up relationships with patients and their carers and families. The practice was involved in a national project 'Getting it right - from the start'. A team, including a person with learning disabilities, visited the practice, looked at the premises and spoke with staff. They provided a support plan for the practice. This was positive and also highlighted areas for improvement, including developing more easy read leaflets. The practice had taken action to address this and had invited the team to deliver whole practice education sessions.

GPs provided support to patients with physical and learning disabilities who lived in a local residential home. There was a named GP who liaised with the staff at the home and carried out annual reviews for patients in their own environment, with their families and carers. Staff knew patients well and supported them to decide on and prepare emergency health care plans. One of these patients was also a member of the practice's patient participation group.

Access to the service

The practice was open between 8am and 6pm on Mondays. Wednesday and Fridays, and between 8am and 8pm on Tuesdays and Thursdays. Appointments were available at the following times:

- Monday - 8.30am to 11.30am; then from 2.30pm to 5.30pm
- Tuesday – 8.30am to 11.30am; from 2.30pm to 5.30pm; then from 6.30pm to 8pm
- Wednesday – 8.30am to 11.30am; then from 2.30pm to 5.30pm
- Thursday – 8.30am to 11.30am; from 2.30pm to 5.30pm; then from 6.30pm to 8pm
- Friday – 8.30am to 11.30am; then from 2.30pm to 5.30pm

Extended hours surgeries were offered every Tuesday and Thursday evening. In addition to pre-bookable appointments with GPs that could be booked up to two weeks in advance (three weeks for nurse appointments), urgent on the day appointments were also available for all patients that needed them. Staff told us that even if there were no appointments left, patients would not be turned away. GPs worked later to ensure all urgent needs were addressed; they told us they would prefer to see their own patients rather than send them to a walk in centre.

Results from the National GP Patient Survey, published in July 2016, showed that patients' satisfaction with how they could access care and treatment was in line with national averages, but below local averages. Patients we spoke with on the day were able to get appointments when they needed them. For example:

- 73% of patients were satisfied with the practice's opening hours, compared to the CCG average of 78% and the national average of 76%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 83% of patients were able to get an appointment when they needed, compared to the CCG average of 86% and the national average of 85%.
- 77% of patients said they could get through easily to the surgery by phone, compared to the CCG average of 79% and the national average of 73%.
- 75% of patients described their experience of making an appointment as good, compared to the CCG average of 77% and the national average of 73%.

However, results in relation to waiting times at the practice were below average;

- 39% of patients said they usually waited more than 15 minutes after their appointment time, compared to the CCG average of 21% and the national average of 27%.
- 39% of patients felt they had to wait too long after their appointment time to be seen, compared to the CCG average of 28% and the national average of 34%.

Managers were aware of these results and had taken action; for example, reviewing GPs' working sessions and building in blocks of time between appointments to allow them to catch up.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Information was available to help patients understand the complaints system. Leaflets detailing the process were available in the waiting room and there was information on the practice's website.
- Patients we spoke with were aware of the process to follow if they wished to make a complaint.
- We saw several examples where the practice had supported patients who were concerned about other services but had approached the practice with this information. The practice was mindful of not commenting on other services but were sensitive to patients and gave them time to talk through their issues. For example, following one complaint managers liaised with other services (with the patient's consent) and discussed the concerns, they were then able to report back to the patient on the action that had been taken.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. The practice displayed openness and transparency when dealing with complaints.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, following a complaint about the use of an interpreter and travel vaccinations, information about accessible information standards was given to staff and discussed at a team meeting and a leaflet about the travel health service was developed.

Managers had comprehensive arrangements in place to check that actions taken had been effective. For example, the practice manager reviewed patient records for any further issues and to check patients were satisfied with the practice's response.

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, documented vision to deliver high quality care and promote good outcomes for patients. The values and vision statement had been devised to cover patients, the practice team and the wider community.

- The practice had a mission statement, this was "Lane End is a GP surgery that believe in the highest quality patient-orientated care. We aim to involve patients and their families in their own health decisions and work as a friendly team in a professional and mutually supportive manner. We teach and train the GPs of the future with an ethos of vocation and patient-centredness, and work enthusiastically with our community partners to deliver excellent and cost-effective care to patients in the wider locality".
- Staff knew, understood and shared the practice's values.

There was a systematic approach to working with other organisations to improve care outcomes and obtain best value for money. For example, one of the doctors was a GP with a special interest (GPwSI) in musculo-skeletal services. As a result, the practice was able to reduce referrals to secondary care by treating patients within the practice. Other neighbouring practices also used the service provided by the GP and their referral rates were also well below average.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- Managers had a comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership, openness and transparency

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the Duty of Candour. (The Duty of Candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support and training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There were very high levels of staff satisfaction. There was a stable team; the majority of staff had worked at the practice for many years. Staff told us they were proud to work at the practice and many referred to the practice as a fantastic place to work.

There was a clear leadership structure in place and effective team working arrangements.

- Staff told us that regular team meetings were held.
- Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. They said they felt confident in doing so and were supported if they did.
- Staff said they felt respected, valued and supported.
- A key part of the practice's strategy was 'to actively seek everyone's contribution and suggestions to improve services to patients'. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged everyone to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. They had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. There was constructive challenge from patients; for example, members of the PPG took part in 'dummy' consultations as part of the trainee GPs training. Feedback from all those involved was very positive.

Following patient feedback that they sometimes found it difficult to book follow-up appointments with the GP they had just seen, the practice had implemented a 'pink slip' system. Patients were encouraged to book follow-up appointments with any of the GPs, and were reassured that the medical records enabled all GPs to access and understand their previous history and any treatment plans in place. However, managers were aware that this would not be appropriate in all cases. Therefore, where it was felt it was clinically necessary for the same GP to carry out the follow-up review the patient was given a pink slip to give to the reception staff. The staff were then aware that they needed to book an appointment with the same GP.

The practice had also gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they were encouraged to raise concerns and would not hesitate to give feedback to colleagues and management.

Continuous improvement

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The GP partners had lead roles in other organisations, for example, one was a medical tutor, an associate sub-dean at a university and the regional lead in the clinical network for diabetes; these roles helped to identify new ways of working. One of the GP partners was involved in the development of the primary care forward plan for the local area. The practice manager was a member of the finance committee which supported the CCG's financial recovery.

Managers promoted a culture of continuous reflection and learning. Clinical education meetings were held twice weekly. One of the GP partners and the practice manager had completed a strategic leadership skills course.

One of the practice nurse had 25% of their time dedicated to development of clinical systems, education of practice staff and patients with long term conditions

The practice had developed a safety alert system; this innovation was shared with other local practices.

The practice was keen to promote general practice as a career choice and as such, had invited a number of sixth form students to work in the practice on a two day placement.