# Haughton Thornley Medical Centres

## Quality Report

Thornley House Medical Centre,
Thornley Street,
Hyde
SK14 1JY
Haughton Vale Medical Centre,
Tatton Rd
Denton
M34 7PL
Tel: 0161 367 7910
Website: www.htmc.co.uk

Date of inspection visit: 6 December 2017
Date of publication: 29/01/2018

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

**This practice is rated as Outstanding overall.**
(Previous inspection April 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Outstanding

Are services well-led? - Outstanding

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Outstanding

People experiencing poor mental health (including people with dementia) - Outstanding

We carried out an announced comprehensive inspection at Haughton Thornley Medical Centres on 6 December 2017 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw several areas of outstanding practice including:

- The practice and PPG were proactive in encouraging patients to sign up to have full online access to their medical records. We saw to date the practice have 62% of patients signed up for access. The practice were in the process of evaluating the impact and monitoring usage to assess the benefits to patients and the practice.
- The PPG in partnership with Hyde Community Action ran an ESOL course (English for Speakers of Other Languages) with a health theme for 16 female patients

in which they taught them how to access a GP and other health services, how to sign up for online services, medical records access and how to use "My Medication Passport". Evaluations of this project showed, by the end of the course, 100% of the women reported increased confidence, knowledge, awareness of online access to health records, healthy eating, exercise, pharmacy and other local services and they shared the information with their family and friends.There was a waiting list of 60 patients for future courses.

- The practice secured funding in 2015 for the Hyde Healthy Living project which was to benefit all patients over 75 years of age across the neighborhood including those registered with other practices. Although the formal funding for the project ended in August 2017 the practice had maintained the social prescribing, additional GP time, and the pharmacist and were working with the local Health and Well-being team to co-ordinate future reviews. Evaluation of the programme to date showed 102 patients and their carers benefitted from the programme and their goals were monitored and outcomes measured using a nationally recognized evaluation tool. We saw from the evaluation, following intervention 53% said they felt more positive, 56% were managing their symptoms. Outcomes for individuals included a review of benefits received, disability badges issued, stair lifts and mobility aids being fitted to help prevent falls and support to attend social events. Hyde Healthy Living Project was awarded the BMJ Primary care team of the year 2016.
- Following on from the Healthy Hyde project have integrated social prescribing pathways and templates into the clinical system allowing staff to quickly refer patients for additional support in the community where required, for example to Age UK and the community response team. Data provided by the practice showed 180 social referrals were made by the practice, meaning a quicker more streamlined system for patients

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

# 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 |
| **People with long term conditions** | Good |
| **Families, children and young people** | Good |
| **Working age people (including those recently retired and students)** | Good |
| **People whose circumstances may make them vulnerable** | Outstanding |
| **People experiencing poor mental health (including people with dementia)** | Outstanding |

# Haughton Thornley Medical Centres

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a practice nurse specialist adviser.

## Background to Haughton Thornley Medical Centres

Haughton Thornley Medical Centres is the registered provider and provides primary care services to its registered list of 11826 patients. The practice delivers commissioned services under the General Medical Services (GMS) contract and is a member of Tameside and Glossop Clinical Commissioning Group (CCG).

The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities. The practice offers direct enhanced services that include meningitis provision, the childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia, influenza and pneumococcal immunisations, learning disabilities, minor surgery and rotavirus and shingles immunisation.

Regulated activities are delivered to the patient population from the following addresses:

Thornley House Medical Centre,

Thornley Street,

Hyde

SK14 1JY

Haughton Vale Medical Centre,

Tatton Rd

Denton

M34 7PL

The practice has a website that contains comprehensive information about what they do to support their patient population and the in house and online services offered: www.htmc.co.uk.

The age profile of the practice population is broadly in line with the CCG averages. Information taken from Public Health England placed the area in which the practice is located in the third most deprived (from a possible range of between 1 and 10). In general, people living in more deprived areas tend to have greater need for health services. We noted 11% of patients were Bangladeshi or British Bangladeshi of which approximately 8% English was not their first language.

Good

# Are services safe?

## Our findings

**We rated the practice, and all of the population groups, as good for providing safe services.**

### Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had risk assessed the need for chaperones to have received a DBS check and had concluded that it was not required.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

### Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for staff, including temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- Following the flooding of both sites during 2016, clear risk assessments were carried out for the temporary accommodation required and safety of staff and patients using the existing buildings during renovation and repairs.

### Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- For patients at the end of life the practice used Electronic Palliative Care Co-ordination Systems (EPaCCS) which places the patients' wishes at the centre of their care such as preferred place of death. EPaCCS enabled them to work together with other health and social care providers and out of hours services by sharing and having access to key information about patients ensuing coordinated joined up care for patients and their families. We noted 88% of patients were able to have care provided in their place of choice, for example at home or in a hospice.
- Referral letters included all of the necessary information and referrals were peer reviewed and discussed as part of clinical meetings.

### Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Good

# Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

## Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

## Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts, for example following an alert from Medicines and Healthcare products Regulatory Authority (MHRA) in relation to the prescribing of Sodium Valproate, the practice incorporated pop up alerts into the clinical computer system to ensure safe prescribing.

A practice business continuity plan was in place and utilised effectively at both sites following floods during 2016 leaving Haughton Vale Medical Centre unsuitable for patients to access for several months.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**We rated the practice as good for providing effective services overall and across all population group.**

### Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (01/07/2015 to 30/06/2016) were comparable to other Practices in England.
- The number of antibacterial prescription items prescribed (01/07/2015 to 30/06/2016) were comparable to other practices in England and the percentage of antibiotic items prescribed that are Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) were also comparable to other practices in England.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months that included an assessment of asthma control using the three Royal College of Physicians (RCP) questions was 85.5% (CCG 76%, National 71%).
- The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 95% (CCG and National 83%).
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) (diagnosed on or after 1 April 2011) in whom the diagnosis had been confirmed by post bronchodilator spirometry between 3 months before and 12 months after entering on to the register was 89% (CCG 90.5%, National 89%).
- The percentage of patients with COPD who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 97% (CCG and National 90%)
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 87% (CCG and National 83%).
- The percentage of patients with atrial fibrillation in whom stroke risk had been assessed using the CHA2DS2-VASc score risk stratification scoring system in the preceding 12 months (excluding those patients with a previous CHADS2 or CHA2DS2-VASc score of 2 or more) was 99% (CCG 98%, National 97%).
- The practice worked closely with the 'Be Well Team' to support patients identified as pre-diabetic to make healthy lifestyle choices and to date had 50 patients actively involved in the programme.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above the target percentage of 90% or above in three areas:
  - Percentage of children aged 2 with pneumococcal conjugate booster vaccine 92%
  - Percentage of children aged 2 with Haemophilus influenzae type b and Meningitis C booster vaccine 93%

Good

# Are services effective?

## (for example, treatment is effective)

- Percentage of children aged 2 with Measles, Mumps and Rubella vaccine 93%
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's uptake for cervical screening was 82%, which was above the 80% coverage target for the national screening programme. To improve uptake the practice wrote to patients in need of cervical screening and had seen an increased uptake in year as a result.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- The practice offered all aspects of family planning, including contraceptive implants and coils

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had alerts within patient's records which also indicated patients with carers.

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

- 86% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is comparable than the national average of 84%.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the national average. However we noted higher than average exception reporting of 21%, 8% above the national average. Speaking with the GPs they were reviewing exception reporting and if there was anything further they could do for patients to prevent unnecessary exception reporting in the future.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 94%; CCG 88%; national 91%)
- The practice had a locality mental health service on site which patients could access, alongside patients from other practices in the area.

### Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The most recent published Quality Outcome Framework (QOF) results (2016/17) were 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall clinical exception reporting rate was 11% compared with a national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The practice used information about care and treatment to make improvements. Monitoring and reviewing QOF and prescribing data as part of clinical meetings and using quality evaluation and quality improvement tools to monitor outcomes for patients.
- The practice was actively involved in quality improvement activity. Where appropriate, the practice initiated local projects across the locality for example the Hyde Healthy Living project. The practice also took part in local and national improvement initiatives such as the Atrial Fibrillation (AF) initiative.
- The practice had adopted a process of continuous quality improvement and evaluation, led by the practice manager and supported by a foundation year doctor who had a specific interest in quality improvement (QI).

Good

# Are services effective?

## (for example, treatment is effective)

We were provided with a range of quality improvement work and key performance indicators set by the practice team as part of the QI programme, for example reviewing the volume of documents received by GPs and identifying ways of safely disseminating to other staff to reduce GPs workload.

- The practice were taking part in a Greater Manchester wide Atrial Fibrillation (AF) initiative after a PPG member brought the project to the attention of the practice and helped secure funding to purchase the devices required for the practice to take part. The device works with a mobile phone App and takes an electrocardiogram (ECG) when patients place their fingers on the electrodes and results are displayed instantly. The device helps to identify patients with AF but also helps patients to manage their condition and is loaned out to patients from the practice as part of the scheme. The practice have established internal quality measures in addition to the scheme with the goal of increasing the number of patients diagnosed with AF and prevent strokes. To date the practice had done 13 tests using the device and had identified five patients with atrial fibrillation.
- The practice were also working with other practices locally to create a cross practice clinical peer support group to enable clinicians to discuss (with consent) patient care and treatment.

### Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

### Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

### Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The percentage of new cancer cases (among patients registered at the practice) who were referred using the urgent two week wait referral pathway (practice 48%) was comparable to other practices in the CCG and nationally.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

### Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

Good

# Are services effective?

## (for example, treatment is effective)

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Good

# Are services caring?

## Our findings

**We rated the practice, and all of the population groups, as good for caring.**

### Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs. Staff and the PPG had a number of initiatives to ensure equality and access to care and treatment, for example the PPG in partnership with Hyde Community Action ran an ESOL course (English for Speakers of Other Languages) with a health theme for 16 female patients in which they taught them how to access a GP and other health services, how to sign up for online services, medical records access and how to use "My Medication Passport". There was a waiting list of 60 patients for future courses.
- The practice gave patients timely support and information and had been trained as care navigators.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. The reception area at both sites had also been renovated to improve confidentiality at reception.
- All of the 37 patient Care Quality Commission comment cards we received were positive about the service experienced across both sites. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 366 surveys were sent out and 120 were returned. This represented about 1% of the practice population. The practice were average for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 84% of patients who responded said the GP gave them enough time; CCG - 87%; national average - 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.
- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 86%; national average - 86%.
- 90% of patients who responded said the nurse was good at listening to them; (CCG) - 94%; national average - 91%.
- 91% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 99% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 92%; national average - 91%.
- 81% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

### Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. The practice wherever possible also ensured reviews and consultation for vulnerable patients were carried out by the same GP to establish a relationship and understanding of patients additional needs.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment. This was supported by a suite of referral templates readily available to staff to easily refer patients for additional services and support in the community and secondary care.

Good

# Are services caring?

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 256 patients as carers (2% of the practice list). We saw information for carers was readily available in the waiting area which was updated by the local carers centre and on the practice website. The practice also had templates in place to directly refer patients who required additional support in the community for example to Age UK.

- Staff told us that if families had experienced bereavement, the GP best known to the family 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. The practice also made contact with other health providers such as hospital to ensure any appointments would be cancelled and correspondence linked to the patient concerned would not be sent.
- For patients at the end of life the practice used Electronic Palliative Care Co-ordination Systems (EPaCCS) which places the patients' wishes at the centre of their care such as preferred place of death. EPaCCS enabled them to work together with other health and social care providers and out of hours services by sharing and having access to key information about patients ensuing coordinated joined up care for patients and their families. We noted 88% of patients were able to have care provided in their place of choice, for example at home or in a hospice. One GP was also working with colleagues locally to develop a co-ordinated approach to improve the end of life care for children.

Results from the national GP patient survey 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:

- 82% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 88% and the national average of 86%.
- 78% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 82%; national average - 82%.
- 90% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 91%; national average - 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 87%; national average - 85%.

### Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**We rated the practice, and all of the population groups, as outstanding for providing responsive services across all population groups.**

### Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended opening hours and seven day access via a local hub, online services such as repeat prescription requests, advanced booking of appointments, and advice services for common ailments.
- The practice provided 15 minute appointments as standard and where required double appointments. Extended appointments were also provided for holistic long term condition reviews.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- One GP offered dry needling which is a treatment similar to acupuncture to provide pain relief and assist injury rehabilitation to patients where required as an alternative or in addition to medication.
- The practice and PPG were proactive in encouraging patients to sign up to have full online access to their medical records. We saw to date the practice had 62% of patients signed up for this which included 67% of Bengali patients, 77% of patients prescribed methotrexate and 47% of patients on the gold standards framework. The practice were featured in the September 2017 Health edition of "Which" magazine relating to their work giving patients full online access to their GP records and members of the PPG have spoken at national conferences sharing their experience. The practice were in the process of evaluating the impact and monitoring usage to assess the benefits to patients and the practice.
- Following on from taking part in the Healthy Hyde project the practice had integrated social prescribing pathways and templates into the clinical system allowing staff to quickly refer patients for additional support in the community where required, for example to Age UK and the community response team. Data provided by the practice showed 180 social referrals were made, meaning a quicker more streamlined system for patients.
- The practice was able to provide minor surgery on-site for patients and an ultra sound clinic was provided to prevent patient having to travel for these services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice secured funding in 2015 for the Hyde Healthy Living project which was to benefit all patients over 75 years of age across the neighbourhood including those registered with other practices and although the formal funding for the project ended in August 2017 the practice had maintained the social prescribing, additional GP time, the pharmacist and were working with the local Health and Well-being team to co-ordinate future reviews. Evaluation of the programme to date showed 102 patients and their carers benefitted from the programme and their goals were monitored and outcomes measured using a nationally recognised evaluation tool. We saw from the evaluation, following intervention 53% said they felt more positive, 56% were managing their symptoms. Outcomes for individuals included a review of benefits received, disability badges issued, stair lifts and mobility aids being fitted to help prevent falls and support to attend social events. Hyde Healthy Living Project was awarded the BMJ Primary care team of the year 2016.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were

reviewed at one appointment. The practice requested relevant blood tests were performed in advance to ensure all clinical information was available to complete reviews. The multi reviews were also provided for housebound patients within their own home. Consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The PPG and practice worked together to put education events on for patients with long-term conditions in the community. Events held have included diabetes and future events were planned in relation to asthma.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group 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 opening hours and Saturday appointments.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Local services such as ultra sound and minor surgery were provided on site to prevent patients having to travel.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had an ethos of continuity of care for vulnerable patients and those with learning disabilities and allowed patients to choose their preferred GP, details were added to the patient's record to ensure wherever possible appointments were booked with the appropriate clinicians. We were provided with numerous example of how the clinicians and patient relationships developed to enable people to feel safe and engage with clinicians to receive care and treatment, for example, one GP would create a safe environment for a patient with learning disabilities by playing music and dancing with them to enable them to carry out reviews.
- The practice were a foodbank collection point facilitated by the PPG and where needed referred patients to the foodbank.
- The practice worked closely with the local community substance misuse team to provide a shared care service on-site. Two GPs had a special interest in substance misuse and had additional qualifications in this specialist area. The practice also registered patients who lived in a local alcohol rehabilitation unit.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice has dedicated staff who managed the timely reviews of mental health and dementia patients, by monitoring the registers and contacting the patients and making appointments at a time which is convenient with the patient with the GP who is known to them.
- The practice worked closely with one member of the PPG who was also a dementia friend trainer to become a Dementia friendly practice, they provided training for staff and PPG members and helped make the public areas more dementia friendly.
- The practice will be facilitating MIND to provide services on site for the patients.

### Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages. This was supported by observations on the day of inspection and completed comment cards. 366 surveys were sent out and 120 were returned. This represented about 1% of the practice population.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 76% and the national average of 76%.
- 62% of patients who responded said they could get through easily to the practice by phone; CCG – 69%; national average - 71%.
- 74% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 82%; national average - 84%.
- 76% of patients who responded said their last appointment was convenient; CCG - 78%; national average - 81%.
- 66% of patients who responded described their experience of making an appointment as good; CCG - 69%; national average - 73%. The practice were looking to improve results and were encourage patients to utalise the online appointment system.

The practice used a range of methods to gather patient feedback which included internal surveys, questionaiires and the friends and family test. For example in Nov/Dec 2016, 50 patients were asked for feedback on telephone consultations. We noted from the report when patients were asked for their satisfaction levels, 92% stated good to excellent. Feedback was monitored and reviewed thoughtout the year by the practice team and actions identified to make inprovements.

### Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 18 verbal and written complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care.

# Are services well-led?

Outstanding ☆

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

## Our findings

**We rated the practice as outstanding for providing a well-led service.**

### Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

### Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities and this extended beyond the practice the Hyde neighbourhood as a whole.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. There was a strong culture of improving outcomes for patients across the practice and this was reflected in their aims and objective.
- Staff were aware of and involved in the development and monitoring of the vision, they understood the values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region and where possible new initiatives developed within the practice were shared across the locality to improve outcomes for people across Hyde. For example one GP was the neighbourhood lead and we saw where funding for a new initiative was sought for the whole locality as well as for the practice.
- The practice planned its services to meet the needs of the practice population for example understanding the needs of the Bangladeshi patient population and aiming to be a dementia friendly practice.
- The practice monitored progress against delivery of the strategy and had a quality improvement programme in place.

### Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients. We saw the staff, partners and PPG had a shared purpose, to deliver positive outcomes for patients and encourage self-care.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals and a timetable was in place for future appraisals. Staff were supported to meet the requirements of professional revalidation where necessary.
- The practice was a training practice and had four GP trainers who supported foundation year doctors and other trainee GPs. The practice was also looking at providing training for nurses in the future.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

# Are services well-led?

Outstanding ☆

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

### Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.
- One GP was leading on the development of clinical pathways within the locality which could be utilised not only in the practice but would benefit practices and patients across the local area. Examples included atrial fibrillation case finding in clinical settings and diagnosis and management of polycystic ovarian syndrome. The practice were also working with local colleagues to look at adapting the local end of life pathway to include specific guidance for children at the end of life as this was not currently in place.

### Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Audits included a nurse prescribing audit, minor surgery audit and an audit of intrauterine contraception insertion.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

### Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- The practice had adopted a process of continuous quality improvement and evaluation, led by the practice manager and supported by a foundation year doctor who had a specific interest in quality improvement (QI). We were provided with a range of quality improvement work and key performance indicators set by the practice team as part of the QI programme. All quality improvement programmes had clearly defined aims and objectives, with means of measuring the outcomes embedded within the plans, for example: To increase the number of patients diagnosed with atrial fibrillation in the practice by 15 patients by March 2019. To date the practice has done 13 tests using the device and had identified five patients with Atrial fibrillation.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice had a range of methods to gather patient feedback. In addition to the National GP survey data, friends and family and responding to comments on NHS choices the practice also carried out satisfaction surveys with patients for example, of the 134 completed minor surgery questionnaires in 2016, 128 rated the service overall as excellent. The practice also used a company to carry out independent evaluations, for example feedback on telephone consultations and face to face consultations with nurses and GPs.
- The practice kept a combined action log from the various methods of feedback which showed the action taken and outcomes in relation to patient feedback.

# Are services well-led?

Outstanding ☆

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

- Feedback from staff was gathered via regular meetings but the practice also used 360 degree feedback in which all staff including managers received confidential, anonymous feedback from the people who work around them.
- The practice used information technology systems to monitor and improve the quality of care. We saw for example where patients presented with rashes or skin conditions, with consent the GPs would take photographs and share with colleagues within the locality with a dermatology specialist to seek second opinions and guidance on the best cause of treatment, preventing wherever possible patients from having to be referred to secondary care. The practice were working with other practices/colleagues locally to utilise technology to be able to seek opinions, share learning and guidance from other clinicians who may have specialisms for example diabetes, again with the aim of being able to treat patients without the need for referrals.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

### Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture.
- There was an active patient participation group (PPG) who met regularly and had a number of sub groups looking at specific areas for example, dementia, food bank and IT. The PPG also had a detailed section on the practice website which provided patients with a wealth of information. They were awarded PPG of the year in 2016 by the National Association of Patient Participation. Not only were the PPG proactive in the practice they also worked across the locality and engaged with the CCG. Examples of initiatives included:
  - Promotion and distribution of "My Medication Passports"
  - Working with Hyde Community Action who support the women within the local Asian Community, running ESOL courses with a focus on health. The first course for 16 women enabled them to sign up for online services, medical records access and how to use "My Medication Passport". They also learned how to use the library and help other members of their family. There is a waiting list for future courses.
    - Evaluations of this project showed, by the end of the course, 100% of the women reported increased confidence, knowledge, awareness of online access to health records, healthy eating, exercise, pharmacy and other local services and they shared the information with their family and friends.
    - Over 67% of the women said that without the help from this project they would not have been able to register with the local services, understand the services and confidently access them.
    - Six months on, after the end of the pilot, over 92% of the women reported increased confidence in their ability to speak everyday English language as well as making their own appointments at their GP practice.
  - The PPG were proactive in promoting and support people to have online access to their medical records and members of the PPG have spoken at national conferences and interviewed on the local radio.
  - The PPG supported by the practice run health promotion events in the local community during National self-care week.
  - Setting up education sessions for patients within the practice and wider community, examples have included dementia awareness, asthma in children and CPR.
  - Facilitating a food bank drop off point within the practice
- The service was transparent, collaborative and open with stakeholders about performance. Partners and managers were active members of the locality group where they shared learning and new initiatives with colleagues.
- GPs held monthly paediatric liaison meetings with local consultants as a means of shared learning and meeting the needs of vulnerable children.
- The practice website was well maintained and contained not only information about the service

# Are services well-led?

Outstanding ☆

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

provided but a wealth of self care and health promotion information with links to local and national support organisations. We noted there was an area dedicated to mental health in light of the recent Manchester arena bombing.

### Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example:

- The continued quality improvement programme which engaged staff at all levels
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had secured funding for the neighbourhood which included establishing on site counselling for patients and developing an IT system to share learning between practices and seek advice and guidance from peers securely.
- The practice are working with community partners to introduce a new tool to help patients recognise and develop their own strengths and abilities.to manage their medical condition. The Patient Activation Measure (PAM) helps clinicians provide more specific patient centred care. The tool which they are aiming to introduce in 2018 will help clinicians to measure the skills, knowledge and confidence patients have in managing their own condition and enables clinicians to work with patients to be more confident in self management.