Lockside Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
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

We carried out an announced comprehensive inspection at Lockside Medical Centre on 27 July 2016. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example a team lead by a GP working with patients over 75 years and the introduction of an holistic annual review programme for patients with long term health conditions.
- Data showed patient outcomes were above those locally and nationally, including unplanned hospital admissions.
- Feedback from patients about their care was consistently and strongly positive.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. The practice valued continuity of care for patients and working as a team had improved continuity of care. Data from the GP national survey published in July 2016 showed that 83% of patients stated they were able to see their usual GP compared to the CCG average (60%) and national average (59%).
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients.
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. The practice embraced new ways of working including online access and email consultations.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice embedded quality improvement into all areas of work. The strategy and supporting objectives were clear, owned by all the staff, monitored regularly, challenged, while remaining achievable.

We saw areas of outstanding practice, including:

- There was a holistic approach to assessing, planning and delivering care and treatment to people who use services. For over three years the practice have adopted a process of continuous quality improvement and small cycles of change, a process which exceeds a clinical audit system by embedding and sustaining outcomes. We saw the detail and wide range of interventions being monitored clearly displayed on a performance board for all staff. We were provided with a wide range of quality improvement work and key performance indicators set by the practice team, for example: the length of stay project, continuity of care, telephone access and safe prescribing of medicines such as antibiotics.
- The practice employed a team including a GP for 3.5 sessions a week to provide care for those patients over 75 years. The GP was supported by a HCA and patient support worker. The care included a weekly review of patients within residential/nursing homes, a hospital in reach service, visiting patients on discharge from hospital and carrying out regular reviews of housebound patients. Additionally the patient support worker also provided holistic care and support to those patients over 75 who were not in residential/ nursing homes but who had one or more chronic disease. Data showed that following the introduction of the scheme the practice had a lower than the local average rate of unplanned hospital admissions and shorter length of stay in hospital.
- The practice had established a programme of work to reduce the length of stay patients experienced following an unplanned hospital admission. The practice was looking to see if GP intervention could improve discharge rates. This was achieved by monitoring a daily list of patients in hospital, a GP contacted clinicians on the ward to share patient history and knowledge of those patients. GPs would then offer to support continued assessment and re-enablement in the community. As a result the practice liaised with the hospital discharge lead and had direct contact with ward discharge facilitators to aid communication and enabled, where possible, early discharge. The practice identified a number of barriers to the work in the initial phase but had established successful lines of communication and had several examples of successful early discharges. Early indicators showed as a result of the work, on average the number of bed days used by Lockside patients had reduced and was lower in comparison with neighbourhood practices.

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.

- There were systems in place for reporting and recording significant events
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Our findings at inspection showed that 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. For example, performance for diabetes related indicators were above the CCG and national average at 99.97%. (9.3% above the CCG average and 10.8% above the England average.) We also saw evidence the practice had lower than the local average of unplanned hospital admissions.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

- We observed a strong patient-centred culture
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this.
- Data showed that patients rated the practice above others for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice valued continuity of care for patients. Data from the GP national survey published in July 2016 showed that 83% of patients stated they were able to see their usual GP compared to the CCG average (60%) and national average (59%).
- Information for patients about services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs.
- There were innovative approaches to providing integrated patient-centred care. For example:
  - adding additional surgeries to meet needs,
  - providing a range of extended services in house and
  - providing additional support to those patients over 75 years of age and patients with long term health conditions.
- Patients could access appointments and services in a way and at a time that suited them. This included an unlimited access to GP appointments when clinically indicated.
- Telephone and email consultations were readily available as well as home visits, including the phlebotomy service, to house bound patients.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients.
- 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. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding 

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

Summary of findings

- The practice had a clear vision with quality and safety as its top priority. Quality improvement plans were developed to deliver this vision, with all staff involved. Performance was closely monitored.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients and it had a very engaged patient participation group which influenced practice development.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population. Patients wherever possible were booked appointments with their usual GP to ensure continuity of care. Evidence from the practice showed continuity of care had improved as a result.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Nursing and residential homes had an allocated GP and nurse, whenever possible these staff responded to patients' needs within the home to ensure continuity of care.
- The practice employed a team including a GP for 3.5 sessions a week to provide care for those patients over 75 years. The GP was supported by a HCA and patient support worker. The care included a weekly review of patients within residential/nursing homes, a hospital in reach service, visiting patients on discharge from hospital and carrying out regular reviews of housebound patients. Additionally the patient support worker also provided holistic care and support to those patients over 75 who were not in residential/nursing homes but who had one or more chronic disease. Evidence from the work the over 75s team showed positive feedback from patients and their families, improved outcomes for patients and better use of community services. Data showed that following the introduction of the scheme the practice had a lower than the local average rate of unplanned hospital admissions and shorter length of stay in hospital. Evidence also showed for those patients at the end of life the care the scheme enabled more patients to have care in their place of choosing, for example, at home or in a hospice.
- The practice embraced the Gold Standards framework for end of life care. This included supporting patients' choice to receive end of life care at home.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.

Summary of findings

- Longer appointments and home visits were available when needed.
- The practice introduced a holistic annual review programme following a successful pilot in April 2016 for patients with long term health conditions. These reviews were scheduled annually around a patient's birthday where patients were invited for a 40 minute appointment. A long term conditions clinical template had been devised to ensure a holistic review. The patients were provided with a detailed follow up letter which incorporated results and action plans discussed during the consultation, with the aim of empowering patients to take a lead on their own care.
- Patients with COPD and asthma had self-management plans and access to medication at home for acute exacerbations and were directed to a structured education programme. The practice offered referral to Self-Management UK who provide 6 week support courses for patients with long term conditions.

Families, children and young people

Outstanding

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

- 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 the premises were suitable for children and babies.
- We saw good examples of joint working with midwives and health visitors. A midwife held antenatal clinics weekly.
- A contraceptive service including the fitting of contraceptive coils and implants was available for patients.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working- age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.

Summary of findings

- Appointments were available outside of normal working hours, with one evening surgery and three early morning GP surgeries. There are also two early morning blood clinics.
- Telephone and email consultations were available for patients who were unable to attend the practice.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs of this age group.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding 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.
- The practice Learning Disability Lead liaised with the local Specialist Needs Nurse to ensure the register of patients with learning disabilities was accurate and helped to signpost patients and their carers should they require additional support.
- Vulnerable patients were identifiable with alerts noted on the secure computer system to ensure staff were alerted to needs.
- Annual reviews were provided for patients with learning disabilities, using a nationally recognised tool.
- The practice was proactive in monitoring those patients identified as vulnerable or at risk. This included, monitoring A&E attendances, monitoring missed appointments from those known to be vulnerable and working with other services to ensure, where appropriate, information was shared to keep patients safe.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- It had told vulnerable patients about how to access various support groups and voluntary organisations.
- The practice provided primary care to residents of a local supported home which helped residents to tackle the issues that may prevent someone from sustaining independent living. The practice worked with support staff at the home to ensure that residents, registered with the practice, needs were met.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- 85% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months.
- 100% of patients with poor mental health had a comprehensive care plan documented in the record agreed between individuals, their family and/or carers as appropriate. Exception reporting was comparable to the CCG average.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- It carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. The practice promoted self-referral to the local “Healthy Minds” service.
- It had a system in place to follow up patients who may have been experiencing poor mental health and had attended accident and emergency.
- Staff had a good understanding of how to support people with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2016 showed the practice had mixed results compared to the local and national averages. There were 106 responses and a response rate of 29%, representing 2.4% of the practice population.

- 90% find it easy to get through to this surgery by phone compared with a CCG average of 72% and a national average of 73%.
- 97% find the receptionists at this surgery helpful compared with a CCG average of 85% and a national average of 87%.
- 84% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 82% and a national average of 85%.
- 88% describe their experience of making an appointment as good compared with a CCG average of 72% and a national average of 73%.
- 90% would recommend this surgery to someone new to the area compared with a CCG average of 75% and a national average of 78%

The practice invited patients to complete the NHS Friends and Family test (FFT) either when attending the surgery or online. The FFT gives every patient the opportunity to feed back on the quality of care they have received. Results from the 284 responses received between April and June 2016 for example showed 94% would be 'extremely likely' or 'likely' and 6% 'unlikely or extremely unlikely' to recommend Lockside Medical Centre to friends or family.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 20 comment cards which were all positive about the standard of care received and included individual praise for clinical and non clinical staff. The eight patients we spoke with were complimentary of the staff, care and treatment they received.

Lockside Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist advisor and an expert by experience.

Background to Lockside Medical Centre

Lockside Medical Centre provides primary medical services in Stalybridge, Tameside from Monday to Friday. The surgery is open:

Monday 9:00am to 12:30pm and 1:30pm to 6:00pm

Tuesday 8:00am to 12:30pm and 1:30pm - 8:30pm

Wednesday 9:00am to 12:30pm and 1:30pm to 6:00pm

Thursday 9:00am to 12:30pm and 1:30pm to 6:00pm

Friday 9:00am to 12:30pm and 1:30pm to 6:00pm

Appointments are from 9:00am to 11:30am and 3:00pm to 5:30pm Monday to Friday. Extended appointments are available Tuesdays from 8:00am and evenings until 8:00pm. The practice also participates in a local extended hours scheme in which patients are able to access GP appointments at a local hub evenings and weekends.

Stalybridge is situated within the geographical area of Tameside and Glossop Clinical Commissioning Group (CCG).

The practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Lockside Medical Centre is responsible for providing care to 7464 patients.

The practice consists of five GP partners and one salaried GP, three of whom are female. The practice employ a pharmacist, practice nurses, one of whom is a nurse prescriber, health care assistant, patient advisors and phlebotomists. The practice is supported by a practice manager, assistant practice manager, patient advisor manager, information systems manager, receptionists, administrators and cleaners.

The practice was a training practice and had two GP trainees at the time of our inspection.

When the practice is closed patients are directed to the out of hours service Go-To-Doc via 111.

Why we carried out this inspection

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

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?

Detailed findings

- 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)

Before visiting, we reviewed a range of information about the practice. We asked the practice to give us information in advance of the site visit and asked other organisations to share their information about the service.

We carried out an announced visit on the 27 July 2016. We reviewed information provided on the day by the practice and observed how patients were being cared for.

We spoke with eight patients, three members of the patient participation group and nine members of staff, including GPs, practice manager, nurse, patient advisors, reception and administration staff.

We reviewed 20 Care Quality Commission comment cards where patients and members of the public had shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events and clinical events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available for consistency. The practice carried out an analysis of complaints and significant events to identify any patterns or trends and these were discussed during practice meetings and partner meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. All significant events and incidents were written up and presented at practice meetings, following which action plans were implemented. We noted significant events were reviewed to ensure actions implemented were effective.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance, local CCG and NHS England. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

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 adults and children from abuse that reflected relevant legislation and local requirements and 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 named GP lead for safeguarding adults and children. The lead attended local safeguarding meetings and attended where and when possible case conferences and always provided reports where necessary for other agencies. GPs were trained to child protection or child safeguarding level 3. The practice held safeguarding meetings with a health visitor and social worker on a quarterly basis in which patients at risk both children and adults were discussed. All patients of concern were discussed at weekly partner meetings and any actions as a result were documented and followed up by the most appropriate member of staff. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that a chaperone was available, if required. All staff who acted as chaperones were trained for the role, and had received a disclosure and barring check (DBS). (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). Speaking with staff we noted an inconsistency in approach to chaperoning, in that not all those staff acting as chaperones would stand within the curtain. We raised this with the practice who told us they would update the policy and ensure in the future all those acting as chaperones would be a position to observe procedures. In line with good practice the practice will also ensure chaperones record in patients notes they were present during the examination.
- There were procedures in place for monitoring and managing risks to patients and staff safety. There was a health and safety policy available. The practice carried out regular fire risk assessments. All of the electrical equipment was checked to ensure it was safe to use and clinical equipment was checked and calibrated to ensure it was working properly.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and checks were carried out which included hand hygiene procedures with staff. We saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored.

Good

Are services safe?

- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. The practice had developed a range of clinical protocols for nursing staff to follow to enable them to administer for example immunisations and travel vaccinations. We noted on the day of the inspection not all up to date Patient Group Directions (PGDs) were readily accessible to the practice nurse along with the internal agreed protocols. PGDs allow nurses to administer medicines in line with legislation. Following the inspection were provided with evidence of that all relevant up to date PGDs were accessible and had been signed. We were told the practice would ensure a more robust system going forward to ensure the up to date PGDs were readily available for the nurse to refer alongside the protocols.
- Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- Staff recruitment checks were carried out and the three files we reviewed showed recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Arrangements were in place for planning and monitoring the number of staff 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 to meet patients' needs. The practice were also training reception staff to become health care assistants and phlebotomists to take on extended roles in the future, the time involved with training was supported by the appointment of an apprentice receptionist.

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 annual basic life support training and there were emergency medicines available. 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 fit for use.

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 assessed needs and delivered care 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 keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and discussion during practice meetings. We noted new guidance and policies were standing agenda items for the clinical meetings.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 100% of the total number of points available, with 6.7% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets and were in line or above the national average in a number of clinical outcomes. Data from 2014/15 showed;

- Performance for diabetes related indicators were above the CCG and national average at 99.97%. (9.3% above the CCG average and 10.8% above the England average.)
- The percentage of patients with hypertension having regular blood pressure tests were above the CCG and national average at 100% (2% above the CCG average, 2.2% above the England average.)
- Performance for chronic obstructive pulmonary disease (COPD) related indicators were above the CCG and national average at 100% (3.2% above the CCG average, 4% above the England average.)

There was a holistic approach to assessing, planning and delivering care and treatment to people who use services. For over three years the practice had adopted a process of continuous quality improvement and small cycles of change, a process which exceeds a clinical audit system by embedding and sustaining outcomes. We saw the detail and wide range of interventions being monitored clearly displayed on a performance board for all staff. We were provided with a wide range of quality improvement work and key performance indicators set by the practice team, for example:

- The practice had established a programme of work to reduce the length of stay patients experienced following an unplanned hospital admission. The practice was looking to see if GP intervention could improve discharge rates. The project was established in October 2015 with an overall aim was to reduce the number of patients who stayed in Tameside hospital longer than seven days following an unplanned hospital admission by 50% by October 2016. This was achieved by monitoring a daily list of patients in hospital, a GP contacted clinicians on the ward to share patient history and knowledge of those patients. GPs would then offer to support continued assessment and re-enablement in the community. As a result the practice liaised with the hospital discharge lead and had direct contact with ward discharge facilitators to aid communication and enabled, where possible, early discharge. The practice identified a number of barriers to the work in the initial phase but had established successful lines of communication and had several examples of successful early discharges. Early indicators showed as a result of the work, on average the number of bed days used by Lockside patients had reduced and was lower in comparison with neighbourhood practices.
- The practice identified they were higher than average prescribers of antibiotic items that are Cephalosporins or Quinolones. It was identified this was due in part to the one specific antibiotic being on the CCG preferred list until April 2015. Once new guidance was issued the practice made changes to their prescribing policy, started to monitor prescribing on a monthly basis and liaised with local microbiologist consultants regarding secondary care prescribing. As a result the practice had significantly reduced their prescribing of high risk antibiotics from 28 prescriptions per month in April 2015 to 7 per month in May 2016.
- The practice has implemented a programme to reduce the prescribing of strong opiate medication in line with good practice guidance. The GP's identified those patient prescribed strong opiate medication and worked with those patients, where appropriate to

reduce, stop and or make changes to the medication prescribed. . Data provided by the practice showed a significant reduction in prescribing and the practice are the lowest prescribers (0.19) in the CCG area (0.32) and below the England average (0.26).

- The practice provided examples of how they responded to Medicines and Healthcare products Regulatory Agency (MRHA) safety alerts.
- The practice wanted to ensure they followed NICE guidance by offering patients with a choice of warfarin or new oral anticoagulants (NOAC). The practice started a project to increase the number of patients offered NOAC in June 2016 and initial findings showed an increase of 10% of patients being offered NOAC. The project is being monitored monthly as part of the practice performance monitoring programme and results displayed on the performance board for all staff to access.
- The practice were looking at ways in which they could better identify patients with undiagnosed long term health conditions such as hypertension and chronic obstructive pulmonary disease (COPD). One way was to introduce spirometry checks (spirometry can help diagnose various lung conditions, such as COPD) as part of the pre-screening for patients attending annual reviews. Results showed the practice had increased prevalence and as a result were able to provide care and treatment to patients where required.

- The practice also introduced new initiatives in April 2016 to monitor performance and effectiveness which included:
  - Clinical care: The practice introduced a holistic annual review programme following a successful pilot in April 2016 for patients with long term health conditions. These reviews were scheduled annually around a patient's birthday where patients were invited for two thirty minute appointments. A long term conditions clinical template had been devised to ensure a holistic review. The patients were provided with a detailed follow up letter which incorporated results and action plans discussed during the consultation, with the aim of empowering patients to take a lead on their own care. To date 136 reviews had been carried out with positive feedback from patients. The programme was being monitored monthly during performance meetings; to date no formal data on outcomes was available. The PPG were involved in developing and testing the invitation letters and post review letter to ensure they were easy for patients to understand for patients.

The continuous quality improvement programme demonstrated an innovative approach which was embedded across the whole practice to care and improve outcomes for patients. We noted the use of evidence based techniques and technologies used to support the delivery of high-quality care. For example same day access to a GP via email consultation including the use of visual images such as photos of skin conditions.

Performance was monitored as part of the monthly performance meetings and the performance data was displayed in a central area for all staff to view.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- All staff were actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation were pursued.

- The practice had an induction programme for newly appointed members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme.
- The practice were also training reception staff to become health care assistants and phlebotomists to take on extended roles in the future, the time involved with training was supported by the appointment of an apprentice receptionist.
- The learning needs of staff were identified through 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 clinical sessions, one-to-one meetings, appraisals, facilitation and support for the revalidation of doctors and nurses.
- The practice used a nationally recognised appraisal system developed in partnership with the Royal Collage

of General Practitioners which involved gathering feedback from patients and colleagues. This appraisal system supported GPs and nurses with the revalidation process and continuing professional development requirements.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to e-learning training modules and in-house training.

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 investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services.
- One GP carried out ward rounds within at local residential homes and in- reach on wards within Tameside general hospital. As a result of this work the practice had improved communication with hospital discharge managers and residential care staff resulting in better outcomes for patients and early discharge from hospital.
- The practice worked closely with Active Tameside and community health improvement services to improve the health particularly for those patients with long term health conditions such as diabetes. For example Active Tameside was available for patients to speak with during weekly diabetic clinics.

Staff worked together with other health and social care services to understand and meet the range and complexity of peoples' needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place and were minuted. We noted a GP and practice nurse attended fortnightly local community care meetings.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- The GPs were fully aware of their responsibilities in relation to patients who had Deprivation of Liberty Safeguards (DoLS) in place.
- Clinical staff had undertaken training in relation to the MCA 2005.
- The GPs actively engaged with making best interest decisions and, where required, involved an independent mental capacity advocate (IMCA).
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patients' mental capacity to consent to care or treatment was unclear GPs would assess the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition, patients with poor mental health and those requiring advice on their diet and smoking and alcohol cessation. Patients who may be in need of extra support were identified by the practice and where they required emotional and or psychological support the practice referred them to the Healthy Minds service.

We noted a number of examples of how the practice were working with patients to lead healthier lifestyles. These included for example:

- Active Tameside attend the practice weekly during the diabetes clinic to provide patients with advice and guidance on leading a more active lifestyle
- The practice actively promoted self-management courses available in the community for conditions such as COPD or diabetes.
- The practice had set a target to increase the uptake of flu vaccinations among pregnant women. The first six month data showed an increase from one patient in October 2015 to 59 in February 2016, a 79% uptake rate, the highest in the CCG.
- The practice newsletter provided information on healthy lifestyles and provided information on local services such as health trainers and active Tameside.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive screening programme. The practice uptake for the cervical screening programme was 82% which was the same as the national average of 82%. 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. Following an audit the practice were working to increase the number of patients attending national screening programmes and had started to use a text message system to improve uptake.

Childhood immunisation rates for the vaccinations given were comparable to CCG averages. For example, NHS England figures showed that in 2015 91% of children aged 5 years had received the full measles, mumps and rubella (MMR) vaccination compared to the CCG average of 86%

Patients had access to appropriate health assessments and checks. These included health checks for new patients, annual health checks for carers and NHS health checks for patients aged 40–74. Appropriate follow-up for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed members of staff were courteous and helpful to patients and treated them with dignity and respect. We saw a strong patient-centred culture:

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example putting on additional surgeries to meet needs, providing a range of extended services in house and providing additional support to those patients over 75 year of age.
- Curtains or screens were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

The eight patients we spoke with and three members of the Patient participation group highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect.

The practice had scores on consultations with doctors and nurses above national and CCG scores. For example:

- 97% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and national average of 95%
- 93% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 96% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 99% of respondents had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 98% and national average of 97%.

The practice valued the importance of continuity of care for patients and set this as a key performance indicator. Working with the reception team to introduce a new appointment protocol to include asking patients 'which GP do you normally see', the practice saw significant results. Monitored using the National GP survey, The latest results from July 2016 showed when patients were asked 'those with a preferred GP usually get to see or speak to that GP' 83% stated they were able to see their usual GP, compared to 41% in July 2015. Data showed 83% was higher than the local CCG average (60%) and national average (59%)

Care planning and involvement in decisions about care and treatment

Patients we spoke with and comment cards received, told us that health issues were discussed with them and 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.

Results from the 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. These results were above the local and national averages. For example:

- 93% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 92% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 82%

Staff told us that translation services were available for patients who did not have English as a first language and an extended appointment would be book if an interpreter was required.

Outstanding ☆

Are services caring?

The practice used care plans to understand and meet the emotional, social and physical needs of patients, including those at high risk of hospital admission or had multiple long term health conditions.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room advised patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 72 patients as carers (1% of the practice list). All clinicians had information to pass onto patients they identified as carers during consultations. One of the reception team was the lead for carers and was a point of contact within the practice for carers and would signpost patients and carers to local services and additional support. The carers lead had put an information pack together providing additional information about support organisations for those patients and carers who were terminally ill. Written information and a dedicated display board were available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, a dedicated member of staff was responsible for contacting relatives where appropriate and arranged for a bereavement visit or consultation with the GP involved in the patients care. The practice would also contact the local pharmacy and also cancel any outpatient appointments as required to ensure the families did not receive any unwanted correspondence.

Information was also available in the waiting area guiding patients to local bereavement support.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, attending locality meetings and working with other health and social care professionals, this included neighbourhood teams.

People's individual needs and preferences were central in meeting patients' needs and the services provided were flexible and provided people with choice. The practice involved other organisations and patients in their planning to meet needs. We saw a range of examples of how the practice were actively responding and providing integrated person-centred care. For example:

- Extended appointments were available Tuesdays from early mornings 8:00am and evenings until 8:15pm. The practice also participated in a local extended hours pilot in which patients were able to access GP appointments at a local hub evenings and weekends.
- The practice operated a same day doctor service. The service was available 9am to 6pm. All patients wishing to see or speak to a GP would have their details passed to the duty doctor who would call patients back within one hour and either provide advice and treatment over the telephone or invite patients into the surgery for a consultation. Same day appointments were available for children and those with serious medical conditions.
- The practice provided access to a GP consultation via email. A specific email address had been set up and this was monitored by the duty doctor throughout the day. The service also enabled patients to securely send images such as rashes or skin conditions to the GP to enable them wherever possible without patients having to attend the practice.
- There were longer appointments available for patients with a learning disability or those who required them.
- Appointments with nurses could be booked up to 12 weeks in advance.
- There were facilities for people with disabilities, a hearing loop and translation services available.
- The practice used a text message service for patients which would include reminders for annual reviews and flu vaccinations. Patients could also receive test results via text message if they agreed.
- Home visits were readily available for older patients and patients who would benefit from these, this included visits from GPs, nurses and phlebotomists.
- The practice employed a pharmacist, whose role was to provide medication reviews and support patients and colleagues with medication queries. The pharmacist also reviewed patient's medication on discharge from hospital to ensure they were accurate and worked with patients within residential and nursing homes to rationalise medications prescribed.
- Anticoagulation clinics were provided and home visits for housebound anticoagulation patients. The pharmacist would carry out a monthly audit of those patients who had not booked appointments and where required these patients would be contacted by the HCA and appointments made.
- A phlebotomy service was available daily and via home visits for house bound patients.
- The practice employed a team including a GP for 3.5 sessions a week to provide care for those patients over 75 years. The GP was supported by a HCA and patient support worker. The care included a weekly review of patients within residential and nursing homes, a hospital in reach service, visiting patients on discharge from hospital and carrying out regular reviews of housebound patients. Additionally the patient support worker also provided holistic care and support to those patients over 75 who were not in residential or nursing homes but who had one or more chronic diseases. Data showed following the introduction of the scheme the practice had a lower than the local average rate of unplanned hospital admissions and shorter length of stay in hospital. Evidence also showed for those patients at the end of life, the scheme enabled more patients to have care in their place of choosing should that be at home or in a hospice for example. There was also positive individual feedback from patients and their families and it was noted patients were making better use of community services.
- To ensure those patients with multiple long term conditions had access to holistic reviews the practice had implemented a new system of calling patients for one review in the same month as their birthday for two 30 minute consultations to avoid them having to visit the practice multiple times for each condition. This was preceded by a visit to either the HCA or phlebotomist to have initial physical health checks such as blood test carried out ensuring all relevant information was

available during the consultation. As part of the practice commitment to quality and performance this new scheme was being routinely evaluated and outcomes monitored.

- The practice held a dedicated diabetic clinic weekly with a GP and nurse, as well as seeing patients throughout the week at a time to suit patients.
- Patients were able to receive travel vaccinations which were available on the NHS and patients were referred to other clinics for vaccines only available privately.
- The practice had introduced full patient access to their medical records, this was open to all patients and the practice was actively encouraging patients to sign up. To date the practice had 539 (7%) patients signed up for on-line access.

Access to the service

Appointments were from 9:00am to 11:30am and 3:00pm to 5:30pm Monday to Friday. Extended appointments were available Tuesdays from early mornings 8:00am and evenings until 8:00pm. The practice also participates in a local extended hours scheme in which patients are able to access GP appointments at a local hub evenings and weekends.

The practice regularly monitored the demand on the service and the number of appointments available and the appointment system had evolved over the last few years in response to patient demand and feedback. Access was monitored as part of the practice performance monitoring, the practice aimed to keep the number of days to the next routine appointment within 10 days. Where it identified patients were waiting more than 10 days for a pre bookable appointment, the GPs, wherever possible would add extra clinics to meet demand.

Results from the national GP patient survey showed that patient satisfaction with how they could access care and treatment was higher compared to the local and national averages. For example the GP survey results showed:

- 84% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 76%.
- 90% of patients said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.
- 95% of patients describe their overall experience of this surgery as good compared to the CCG average of 83% and national average of 85%.

The practice as one of their key performance indicators monitored telephone access. Following the installation of a new telephone system the practice identified up to 200 calls were abandoned when patients tried to contact the practice. As a result the practice implemented a number of improvements, including encouraging on-line access, sending test results where appropriate and allowing patients to cancel appointments by text. As a result the practice had reduced the number of abandoned calls to an average of eight.

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.

This was achieved by the GP triage, in which a GP would telephone the patient or carer in advance to gather information to allow an informed decision to be made on prioritisation according to clinical need. 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. Its 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.

We saw that information was available to help patients understand the complaints system Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice kept a complaints log for written and verbal complaints. We looked at three complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way with openness and transparency.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. The practice carried out reviews of complaints to identify any patterns or trends and these were shared during partner and clinical meetings.

Are services well-led?

Outstanding ☆

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

Our findings

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

- The practice had a mission statement which was displayed throughout the practice. There was a strong culture of improving outcomes for patients across the practice and this was reflected in their aims and objective. Staff knew and understood the aim and objective and showed a commitment to patient-centred care. The aims and objectives of the practice included:
  - At Lockside Medical Centre we aim to ensure high quality, safe and effective services and provide our patients with an environment which is safe, comfortable, relaxing and friendly.
  - We aim to understand and meet the needs of our patients, involve them in decision making about their treatment and care and encourage them to participate fully.
  - We will endeavour to treat all our patients with dignity, respect and honesty. Everyone at Lockside Medical Centre is committed to deliver an excellent service.
  - The provision of accessible evidence-based healthcare which is proactive to healthcare changes, efficiency and innovation and development.
- There was strong collaboration and support across all staff and a common goal in improving quality of care and patients experiences.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. The strategy and supporting objectives were clear, owned by all the staff, monitored regularly and challenged, while remaining achievable.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. Governance and performance management arrangements were proactively reviewed as part of the practice performance management programme and reflected best practice.

These governance arrangements, structures and procedures ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The practice had staff in lead roles and teams to support them in achieving good patient outcomes. This included a safeguarding lead and a lead for clinical governance.
- The practice had an internal performance management programme in which all staff were involved. Where a comprehensive understanding of the performance of the practice was maintained, for example:
  - There was a holistic approach to assessing, planning and delivering care and treatment to people who use services. For over three years the practice had adopted a process of continuous quality improvement and small cycles of change, a process which exceeded a clinical audit system by embedding and sustaining outcomes.
  - All quality improvement programmes had clearly defined aims and objectives, with means of measuring the outcomes embedded within the plans. For example the Length of stay project had the overall aim of 'reducing the number of patients who stay in Tameside hospital longer than 7 days following an unplanned admission by 50%'. The project was broken down into achievable objectives with clearly defined measurements.
  - All key performance indicators and the quality improvement programme were monitored as part of a monthly performance meeting. Updates and progress were displayed on a performance board for all staff.
- Practice specific policies were implemented and were available to all staff. New or policy updates were shared with staff and a record was maintained when staff had read the policy changes.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

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. We saw the partners had an inspiring shared purpose, to deliver positive outcomes for patients and encourage self-care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners and managers were approachable and always took the time to listen to all members of staff.

Are services well-led?

Outstanding ☆

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

The partners and managers drove continuous improvement and motivated staff to deliver

change. Safe innovation and team work was celebrated. There is a clear proactive approach to seeking out and embedding new ways of providing care and treatment.

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 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 was a clear leadership structure in place and staff felt supported by management.

- The practice held regular team meetings. Outcomes and actions were recorded and shared with all staff. The programme of internal meetings included, weekly partner's meetings, fortnightly practice team meetings, clinical and administrative meetings. Performance meetings were held monthly.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered.
- We saw all staff were encouraged to be part of the practice improvement and performance programme, one way this was shown was a performance board set up in a shared space demonstrating the progress the practice had made to improve patient experience.
- Partners within the practice were actively involved with the local neighbourhood and CCG. We noted one GP had previously been the Tameside and Glossop Appraisal lead and currently the CCG Quality Improvement lead, another the Cardiology lead, the third was a CCG Board Member and the fourth the local area Macmillan GP.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice used the data from the GP national survey to drive improvement and monitor changes made within the practice. Examples included projects to improve continuity of care and telephone access. Results of the projects showed improved patient satisfaction within the national GP survey.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.
- The practice with PPG input created a six monthly newsletter for patients, available on the practice website and in the waiting area. The newsletters provided practice updates with, information such as GP trainees joining the practice and health promotion advice.
- The practice used social media sites such as Facebook to communicate with patients. The PPG were involved in developing healthy lifestyle information to share via social media.

Continuous improvement

There was a clear 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

Are services well-led?

Outstanding ☆

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

Innovative approaches to improving outcomes for patients such as a hospital in reach and rapid reviews to patients over 75 when discharged from hospital and the 'length of stay' project both were in addition to the contract the practice held with NHS England.