Salford Medical Centre 1

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Salford Medical Centre 1 on the 1 October 2014 as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

We have rated the practice as good.

Comments we received from patients were positive about the care and treatment they had received. Patients told us they are treated with dignity and respect and involved in making decisions about their treatment options.

Our key findings were as follows:

- The practice was, safe, effective, caring, responsive and well led.
- Patients told us they were treated with dignity and respect and they were involved in care and treatment decisions.
- Staff understand their responsibilities to raise concerns, and report incidents.
- The practice is clean and well maintained.
- There are a range of qualified staff to meet patients' needs and keep them safe.
- Data showed us patient outcomes were at or above average for the locality. People's needs are assessed and care is planned and delivered in line with current legislation.
- The practice works with other health and social care providers to achieve the best outcomes for patients.
- The provider should improve the way they manage the recording of significant events.
- Systems around the safe handling of prescriptions need to be reviewed.
- The provider should ensure that visual checks of emergency equipment are recorded as evidence that equipment is maintained and in working order.

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?
The practice is rated as good for safe. The practice had a good track record for maintaining patient safety. Systems were in place to provide oversight of safety of patients. Learning from incidents took place. Staff took action to safeguard patients.

Good

Are services effective?
The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance is referenced and used routinely. Patients needs are assessed and care is planned and delivered in line with current legislation including the promotion of good health. Patient's needs were consistently met. Staff have received training and support appropriate to their roles. Multidisciplinary working was evidenced.

Good

Are services caring?
The practice is rated as good for caring. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good

Are services responsive to people's needs?
The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the CCG to secure service improvements where these were identified. Patients reported good access to the practice and a named doctor and continuity of care, with urgent appointments available the same day. The practice had good facilities and was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Good

Are services well-led?
The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision, their responsibilities in relation to this and staff felt supported by management. The practice had a number of policies and procures to govern activity and governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and

Good

Summary of findings

patients and this had been acted upon. The practice was trying to develop their patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We received 25 CQC patient comment cards and spoke with six patients who were using the service on the day of our inspection.

We spoke with people from different age groups and patients from different population groups, including young parents, patients with long term conditions, patients with a disability and patients who worked. The patients we spoke with were highly complementary about the service. Patients told us that they were treated with respect.

Patients told us they did not have to wait a long time to get an appointment. Some patients expressed frustration when telephoning the surgery in the morning to make an appointment.

Patients told us they knew who their GP was and all were happy to see any of the GPs. Female patients said they liked to see the female GP who had joined the practice this year.

Patients we spoke with told us they were fully involved in deciding the best course of treatment for them and they fully understood the care and treatment options that had been provided.

A number of patients who saw the practice nurses for reviews and ongoing monitoring told us that the nurses were 'caring and lovely.' They told us they were confident with the care provided by the nursing team.

Patients did not express any concerns about the repeat prescription process.

Patients said that staff at the practice were very caring and accommodating.

A patient participation group meeting was held in March 2014. It was the decision of the patient participation group to devise and send out a patient survey. The questionnaire was sent out to 200 patients over a two week period. Returned questionnaires showed that patients were happy with the care and treatment they received, though not all patients were aware of the services provided. In response to patient feedback ear syringing was reintroduced and a female GP was recruited.

We looked at feedback from the GP national survey for 2013/2014. Feedback included; 95% of respondents described their experience of making an appointment at the practice as good, compared with the CCG regional average of 75%.

We saw that 82% of respondents reported that the last GP they saw or spoke to was good at explaining tests and treatments.

Areas for improvement

Action the service SHOULD take to improve

- The provider should improve the way they manage the recording of significant events.
- Systems around the safe handling of prescriptions need to be reviewed and the provider should ensure that emergency drugs are made available at all times.
- The provider should ensure that visual checks of emergency equipment are recorded as evidence that equipment is maintained and in working order.

Care Quality Commission

Salford Medical Centre 1

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Salford Medical Centre 1

Salford Medical Centre 1 is located on a busy main road in the Langworthy area of Salford. The practice team comprises two GP partners (Male), a salaried GP (Female), a practice manager, a practice nurse, a health care support worker and five reception staff.

The practice provides diagnostic procedures including phlebotomy and cervical smears. The surgery has three consultation rooms, a treatment room and a patient reception and waiting area. All consultation rooms and treatment room are located on the ground floor. Access to the building is suitable for people who use a wheelchair and there is a disabled toilet which also provides baby changing facilities.

The practice provides primary medical services to registered patients. The practice is open Monday to Friday between the hours of 8am and 6:30pm, with the exception of Tuesday mornings when the practice opens at 7:30am and remains open until 7:30pm on Wednesday evenings. Home visits are available for people who are not well enough or physically able to attend the practice in person. Patients can make appointments by telephoning, or by calling in at the surgery.

The surgery is responsible for providing care to approximately 3000 patients.

The practice has a GMS contract.

This was the practice's first inspection by CQC.

Out of hours services are provided through the NHS 111 service.

The practice is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Maternity and midwifery services
- Treatment of disease, disorder or injury

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 October 2014. During our visit we spoke with a range of staff, GPs, practice manager, practice nurse and reception staff and spoke with patients who used the service. We reviewed treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

We found that the practice had systems in place that ensured the delivery of safe patient care. These included the review of incidents, health and safety concerns and complaints.

The practice held bi-monthly clinical meetings and bi-monthly administration practice meetings. These meeting provided an opportunity for discussion of significant events, developments in safeguarding and complaints.

We saw evidence that the practice responded to NHS patient safety alerts, for example, medication alerts. However this was not a 'rolling' item on either the clinical meeting or the administration meeting's agenda. Nevertheless arrangements were in place to share information from safety alerts both clinical and non-clinical staff when necessary.

The practice manager received a continual stream of safety information from organisations such as the European medicines agency.

There were strategies in place to reduce unscheduled outpatient attendance that included an increased use of patient health checks, identifying possible risk factors and patient searches to identify patients deemed high risk.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events, for example a significant event may be a 'needle stick injury'. A review of a significant event should include an analysis of what factors led to the event, how the event was handled, how it could have been handled differently, what action needed to be taken as a result of the event, including lessons learnt and systems to review the progress of the response to the event to the point of closure.

It was a positive feature that the practice had accepted the value of a significant events analysis (SEA) as a learning tool. There were many SEAs on file but the process currently used did not ensure that the process was carried through until it was satisfactorily resolved and actioned. Consequently records did not always show a clear audit of who had been involved in or contributed to resolving the event. Actions taken and lessons learnt were not always apparent from reading reports. The practice should improve the way they manage the recording of significant events.

We were made aware of an incident having been reported verbally by a GP to the practice manager. The incident had not been recorded and thus there was no audit trail to demonstrate actions taken to prevent further incidents occurring. There was a danger that this information could have been lost. However we saw that all clinical staff at the practice were aware of the incident. We saw that as part of the practice's quality monitoring and auditing arrangements (SEA) were discussed at the practice's bi-month and practice administration meetings.

From the review of compliant investigation information, we saw that the practice manager and GP partners ensured complainants were given full feedback in response to their concerns.

Reliable safety systems and processes including safeguarding

The practice followed Salford Council Safeguarding policy and protocol. One of the partner GPs was the lead for safeguarding at the practice and staff we spoke with knew they could approach the lead GP if they had concerns about a patient. The lead was knowledgeable about the contribution the practice made to multi-disciplinary child protection work and attended partnership meetings with the local CCG.

During our inspection we observed information in the patient waiting areas advising patients of who to contact should they have concerns about abuse or abusive relationships. Within the patient record system there was an alert system which alerted GPs, nursing staff and reception staff to any ongoing child protection issues. When safeguarding concerns were raised staff ensured these alerts were put onto the patient's electronic record. Systems were in place to monitor children or vulnerable adult's attendance at Accident and Emergency or missed appointments.

We saw that there was information informing staff how to raise a safeguarding concern displayed in the back reception area. This included a flow chart for staff to follow and contact numbers of local safeguarding and adult safeguarding contacts.

Good

Are services safe?

We spoke with GPs and the practice manager about their understanding of good safeguarding practice, their duty of care, and their responsibility to keep children and adults safe. We asked staff what action they would take in response to safeguarding concerns. We found that staff were able to tell us what action they would take in response to concerns and how they ensured patient safety.

We saw that all staff at the practice had completed training in safeguarding children and adult

Protection and there were plans in place for staff who were due to update this training. We saw that GPs were training to level 3.

The practice had a chaperone policy displayed in the patient waiting area and we were told that only the practice nurse or the health care support worker currently provided this service. Patients we spoke with were aware of this service but none had direct experience of it.

Medicines Management

The practice should improve the way they manage medicines in particular in respect of audits and arrangements around identifying patients when collecting prescriptions.

One of the partner GPs was the lead for prescribing.

We saw that there were up to date medicines management policies in place.

The practice stored vaccinations in one of two refrigerators. Systems were in place that ensured that vaccines were stored correctly. These included daily checks of temperatures of refrigeration. Whilst checks that vaccines were in date, stock count and rotation of stock took place on vaccines and other medicines no records of such checks were not recorded.

We saw that emergency drugs were stored in the treatment room and daily checks of the stock and expiry dates were recorded. However these records were not always signed, so it was difficult to know who had completed the audit.

GPs and nurses carried emergency drugs in their bag on home visits.

The practice worked with pharmacy support from the Clinical Commissioning Group (CCG) to support clinical staff in keeping up to date with medicine and prescribing trends. The CCG pharmacy support visited the practice weekly.

The practice did not store any controlled drugs.

GPs re-authorised medicine for patients on an annual basis or more frequently if necessary. Patients who received repeat prescriptions were alerted to book in for a medicine review. All repeat prescriptions were reviewed on a regular basis and only undertaken by clinicians.

We saw that reception staff did not always check the name and address of patients when they collected prescriptions. We were told this was because the practice had a smaller patient list and staff knew those patients who collected repeat prescriptions on a regular basis.

We saw uncollected prescriptions; some of which dated back four and five months. There had been no contact with the patient as to why the prescription remained uncollected. Systems around the safe handling of prescriptions need to be reviewed.

The practice maintained only one anaphylaxis shock box and within this they had one drug i.e. adrenaline.

Cleanliness & Infection Control

Patients we spoke with told us the practice was 'always clean and tidy'. We saw that the practice was clean throughout and appropriately maintained. We saw paper disposal privacy curtains were used in clinical areas but noted that the date of usage was not always recorded therefore it wasn't clear when curtains should be replaced.

The practice had procedures in place for the safe storage and disposal of sharps and clinical waste. We saw sharps boxes in clinical areas and all clinical waste bins were foot operated.

We looked at staff training records and saw that all staff at the practice both clinical and non-clinical had completed training in infection control.

The practice employed a cleaner, we saw copies of their cleaning schedule that recorded tasks completed. These ensured the overall cleanliness of the building. We saw that all areas of the practice were very clean and processes were in place to manage the risk of infection.

Good

Are services safe?

We spoke with the nurse who had the lead role for infection control and found her to be knowledgeable. We found the practice had a comprehensive system in place for managing and reducing the potential for infection.

There was an up-to-date Infection Control policy in place. We saw updated protocols for the safe storage and handling of specimens and for the safe storage of vaccines. Legionella testing was carried out.

We were told the practice did not use any instruments which required decontamination between patients and that all instruments were for single use only.

Equipment

The practice had a plan in place to ensure that all equipment used in the premises was maintained.

We found that arrangements were in place which ensured the safety and suitability of the building, for example tests of electrical installation, including portable appliance testing (PAT) of electrical equipment.

The practice manager had contracts in place for annual checks of fire extinguishers and portable appliance testing. We noted however that the last full fire evacuation at the practice took place 15 months ago, however the practice took action on this and are in the process of arranging a full fire drill to take place within the next month.

A defibrillator and oxygen were available for use in a medical emergency. These were stored in the treatment room and were in easy reach in the event of a medical emergency. We were told that visual records of this equipment were made on a regular basis; however records of observations were not kept to ensure that this equipment was in working condition.

A log of maintenance of clinical and emergency equipment was in place and there was a record noted on the log when any items identified as faulty were repaired or replaced.

Panic buttons were located in clinical and treatment rooms for staff to call for assistance.

Staffing & Recruitment

The practice operated a recruitment and selection process which ensured that only suitable applicants were employed. The majority of staff had been employed at the practice for over three years. The practice had recruited a new member of reception staff in August 2014. They had ensured that a number of pre-employment checks which included taking up Disclosure and Barring checks known as DBS checks were in place for both clinical staff and non-clinical staff.

We saw that as a routine part of the quality assurance and clinical governance processes the provider checked the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year to make sure the doctors and nurses were still deemed fit to practice.

Safe staffing levels were maintained. Three GPs provided a service to patients. There were five receptionists and one vacant position for the post of receptionist.

Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness.

Monitoring Safety & Responding to Risk

The practice has three clinicians . The number of patient sessions available to patients was 17, which meant the practice had an above average 'doctor-patient ratio.

The staffing group at the practice was made up of three GPs, nursing staff, reception and administrative staff. It was the practice that all reception and administration staff were trained to work across all areas. This meant that during holiday periods and episodes of ill health staff were able to work across both administrative tasks and reception tasks.

Staff were trained in fire safety and training in cardio pulmonary resuscitation (CPR) and infection control. Staff knew where emergency equipment was stored and how to access this quickly in the event of an emergency.

Within the patient record system there was a facility which alerted staff to patients who were at risk or who presented a 'potential risk' to staff, for example concerns in respect of 'over ordering medication' or violence to staff and children and young people who were known to local child protection teams. This enabled staff to monitor both patient and staff safety.

Arrangements to deal with emergencies and major incidents

The practice had a fire risk assessment dated 2011. We found that tests to fire alarms systems and other fire safety

Good

Are services safe?

equipment were done on a regular basis. A full fire drill should to be implemented as this had not been practised for some 15 months. All staff had completed fire safety training.

A detailed business continuity plan was in place. The plan covered business continuity, staffing, records/electronic systems, clinical and environmental events.

Staff had completed training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR) and other emergencies such as fire.

The Practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety.

Measures were in place that ensured adequate staffing levels were maintained, through periods of annual leave, and unexpected absences through staff sickness.

The practice manager and lead GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and daily patient demand for appointments including emergencies.

Patients were aware of how to contact the out of hours GP service and the practice website had provided updated information for patients on this facility.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice provided a service for all age groups including older people, people with learning disabilities, children and families, people with mental health needs and to the working population. We found GPs and nursing staff were familiar with the needs of each patient and the impact of local socio-economic factors on patient care.

A range of health promotion advice and information related to various conditions including advice on self-management were on display in the practice. Clinicians proactively case managed and completed long-term monitoring of these patients' needs. The practice held clinical meetings where all patients on the palliative care register were discussed. The clinicians we spoke with were familiar with, and were following current best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. We saw that the practice aimed to ensure each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed assessments and treatment plans, in line with NICE (National Institue for Health and Care Excellence guidelines. Thorough assessments of patients' needs had been completed and these were reviewed when appropriate.

The practice nurse told us they managed all aspects of patients care and treatment through two nurse clinics that operated. Clinical services provided asthma checks, Chronic obstructive pulmonary disease (COPD) reviews, cervical smears, smoking cessation, travel checks, ECG's, learning disability health checks and mental health checks.

The practice was also making strong efforts to reduce the frequency of any unscheduled hospital admissions of cancer patients and had arranged additional training for the practice nurse in palliative care.

Management, monitoring and improving outcomes for people

The Practice has a system in place for completing clinical audit cycles. Examples of clinical audits included a review of patients prescribed hypnotic medication, patients on repeat prescriptions and the use of antibiotics. The provider worked closely with the local CCG on clinical audits.

We noted the practice were proactive in contacting patients who had missed annual reviews, to ensure they attended appointments, this included letters being sent to the patient or contacting them by telephone in an attempt to ensure they engaged with any reviews of their treatment and or medication.

A patient recall system was in place for patients with chronic health conditions which provided on going monitoring of patients conditions. This included patients receiving treatment for asthma and COPD.

The practice used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. QOF was used to monitor the quality of services provided.

The practice had an ECG machine and interpretation of results was undertaken by a company of clinicians who provided diagnostic interpretation service initially via telephone reporting. We observed that although results were provided by fax or email staff did not record the details of verbal reported results. It was discussed that in terms of an audit trail and the reporting of concerns were immediate action was required details of the telephone report should be recorded at the time they were received.

Effective staffing

There was an induction programme and a mandatory training programme in place for all staff. Staff had access to training, the majority of which was completed through e-learning. We saw that the practice operated an induction programme and all staff including clinical and non-clinical were expected to complete the programme. We looked at the induction training for the most recently appointed member of staff and saw this was ongoing.

The practice manager kept a record of all training carried out by clinical and administration staff to ensure staff had the right skills to carry out their work.

From our discussions with staff and reviewing training records we saw all staff were appropriately qualified and competent to carry out their roles safely and effectively.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they were able to access training and received updates when required. We saw staff had completed mandatory training in child protection and safeguarding adults, information governance, infection control and health and safety. Some staff had completed training in the Mental Capacity Act 2005.

Staff had access to additional training related to their role. For example, the practice nurse had completed additional training in palliative care and some reception staff had completed training in conflict resolution and customer care. We found that collectively staff had the knowledge and skills required to carry out their roles.

We found that because the surgery was a small practice there were good informal supervision arrangements in place and staff told us that GPs and the practice manager were supportive and approachable.

All GPs took part in yearly appraisal. All of the GPs in the practice comply with the appraisal process and were due to be revalidated in 2015.

All reception staff received one to one formal written supervision on a monthly basis and the practice nurse underwent an annual appraisal with one of the GP partners. We saw that the practice manager had not received an annual appraisal.

Working with colleagues and other services

Multidisciplinary health care meetings took place at the practice and involved other health and social care professionals, for example the practice had recently started to hold regular meetings with health visitors. This was a recent development set up by the lead GP for safeguarding at the practice and the local CCG.

Midwifes were regular visitors to the practice and provided care and treatment to patients. Fortnightly clinics were held and one patient told us they had attended the practice for their antenatal care. They told us they were satisfied with the care and treatment they received and they preferred to attend their local GP practice rather than go to hospital.

Palliative care team meetings were held on a three monthly basis. We observed that the practice does not use the 'traffic light system' used by many practices within the country.

The practice worked with other agencies and professionals to support continuity of care for patients. Patients used the NHS111 facility to access out of hours care. Patients we spoke with knew how to contact out of hours services though none had direct experience of having done so.

The practice kept registers for patients with long term conditions such as asthma and chronic heart disease which were used to arrange annual health reviews. They also provided annual reviews to check the health of patients with learning disabilities and patients on long term medication for example for mental health conditions.

Information Sharing

Information received from other agencies, for example accident and emergency or hospital outpatient departments were read and actioned by GPs on the same day. Information was scanned onto electronic patient records in a timely manner. Systems were in place for managing blood results and recording information from outpatient's appointments.

All staff were required to sign a confidentiality agreement as part of their terms and conditions of employment at the practice. Staff fully understood the importance of keeping patient information in confidence and the implications for patient care if confidentiality was breached.

Consent to care and treatment

The practice had a consent policy which provided staff with guidance and information about when consent was required and how it should be recorded. Patients' verbal consent was recorded on their patient record for routine examinations.

GPs and clinicians ensured consent was obtained and recorded for all treatment. Where people lacked capacity they ensured the requirements of the Mental Capacity Act 2005 were adhered to.

It was the practice that for the majority of treatments patients gave implied or informed consent and arrangements were in place for parents to sign consent forms for certain treatments in respect of their children, for example, child immunisation and vaccination programmes. Where patients were under 16 years of age clinicians considered Gillick guidance.

Good

Are services effective?

(for example, treatment is effective)

All staff we spoke with understood the principles of gaining consent including issues relating to capacity. Patients we spoke with confirmed that their consent was always sought and obtained before any examinations were conducted.

Health Promotion & Prevention

All new patients were offered an initial health check with the practice nurse when a new patient assessment was completed; this included a review of the patient's lifestyle including family medical history and a review of their smoking and alcohol activity.

A number of 'health promotion' clinics were provided at the practice and these included, smoking

cessation and a number of chronic diseases clinics including Chronic Obstructive Pulmonary Disease (COPD) and diabetes clinics.

We saw a range of written information available for patients in the waiting area, on health related issues, local services and health promotion and carer's information.

The practice supported patients to manage their health and well-being. The practice offered national screening programmes, vaccination programmes, long term condition reviews and provided health promotion information to patients. They provided information to patients via their website and in leaflets in the waiting area about the services available.

The practice also provided patients with information about other health and social care services such as carers' support. We saw a range of information posters and leaflets in the practice and on the practice website. Staff we spoke with were knowledgeable about other services and how to access them.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We observed staff speaking with patients respectfully throughout the time we spent at the practice. We observed reception staff speaking to patients in a respectful way and we heard staff during telephone discussions also speaking in a courteous manner.

Facilities were available within the surgery and upon request for patients who wanted to speak in private.

We observed that staff took appointment calls on the reception desk close to the patient waiting area however we saw that there was a facility at the back office where calls to patients could be made and this provided some further confidentiality. We observed in the same area that one of the GP consultation rooms was at the back of the building behind reception and that patients walked through this area to access the GP. We were concerned that this may present the potential for patient confidentiality to be reduced as patient details/discussions may be overheard during telephone discussions. Despite our observations no incidents or concerns were reported to us during our inspection.

A large proportion of the patient comment cards we received indicated that patients had been treated with dignity and respect by all staff employed at the practice.

We looked at a sample of consultation rooms, treatment rooms and clinical areas, all areas had privacy curtains to maintain patient dignity and privacy whilst they were undergoing examination or treatment.

The service had a patient charter which was displayed in the reception area.

Staff we spoke with were aware of the importance of providing patients with privacy. They told us there was a room available if patients wished to discuss something with them away from the reception area.

The practice offered patients a chaperone service. Information about having a chaperone was in the waiting area. Staff we spoke with were knowledgeable about the role of the chaperone and only clinical staff undertook this role. Patients told us that they felt the staff and doctors effectively maintained their privacy and dignity.

We looked at 25 CQC comment cards that patients had completed as part of the inspection and spoke with six patients on the day of the inspection. Patients were positive about the care they received from the practice. They commented that they were treated with respect and dignity. Patients we spoke with told us they had enough time to discuss things fully with the GP and patients told us GPs listened to them.

The most recent practice patient survey showed that 86% of patients who responded said reception staff were exceptional or good.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us they had been consulted about their care and treatment. They told us that GPs and other staff had explained their treatment to them, including diagnosis and if further tests or referrals to secondary care were required.

We found that patients understood their care including the arrangements in respect of referrals to secondary care appointments at local and other hospitals and clinics.

The surgery provided access to interpreter services for those patients for whose first language was not English and this ensured patients fully understood proposed treatment plans.

Patients told us they were happy to see any GP and the nurses as they felt all were competent and knowledgeable. Some patients told us they liked to see the female GP and other's said it was good to have the choice.

Patients told us they usually got to see the GP of their choice when they made an appointment.

Staff were knowledgeable about how to ensure patients were involved in making decisions. Staff told us they understood and considered the requirements of the Mental Capacity Act 2005 where issues around capacity arose.

The practice had an 'access to records' consent policy that informed patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. Information was available for patients on the practice website and in leaflets.

Patient/carer support to cope emotionally with care and treatment

Good

Are services caring?

A patient’s charter was displayed in the patient waiting area along with information about patients’ rights, responsibilities and how their personal health information was stored and accessed.

Patients had access to both female and male GPs.

Nursing staff told us relatives, carers or an advocate were involved helping patients who required support with making decisions and help and support was available to patients following bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We saw evidence of service planning and the provision of appropriate service for different groups of patients.

The practice didn't offer specific clinics as all patients were treated through the GP and nurse appointment system, including diabetes reviews and COPD reviews. Patients told us that there health needs were met whilst attending GP consultations and or Nurse consultations.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. Patients' electronic records contained alerts for staff regarding, for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate.

There was evidence that the practice undertook more frequent chronic disease reviews and analysing the current QOF statistics the practice had totals all in excess of the national average across a wide variety of chronic disease management indicators including Asthma and smoking cessation.

The provider had a good understanding of the local area and the patient population group who were registered with the practice including a developing Eastern European patient group. Interpreter facilities were available to patients whose first language was not English if required. They told us of an incident when they had used a web based interpretation service to communicate and provide treatment to a patient whose first language wasn't English. This had resulted in the patient returning and thanking them for their efforts in supporting them to make themselves understood and in meeting their health needs and providing treatment.

The practice opened early on Tuesday mornings and closed late on Wednesday evenings to facilitate the needs of working patients, although appointments at these surgeries were not exclusively for patients who worked. Patients we spoke with told us they were aware of these surgeries and found them beneficial and it was helpful to know that they could see a GP after finishing work and they didn't have to take time out of work.

The surgery operated an electronic prescribing service. This enabled prescribers to send prescriptions electronically to a local pharmacy of a patient's choice.

Tackling inequity and promoting equality

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. Patients' electronic records contained alerts for staff regarding, for example patients requiring additional assistance in order to ensure the length of the appointment was appropriate.

The practice provided home visits for those patients who were too ill or frail to attend in person. GPs provided telephone consultations and extended appointments were made available for any patient whom was identified required additional time.

We saw that the building was suitable for people who used a wheelchair. Disabled toilet facilities were shared with baby changing facilities. The entrance to the practice had level floor access and was suitable for wheelchair users, with push button automatic doors. The reception desk was at a high level that was not suitable for patients in wheelchairs however the building was old and difficult to change.

There were comfortable waiting areas for patients attending an appointment and limited car parking was available nearby.

Access to the service

The majority of patients reported positively about accessing appointments. Though some patients expressed frustrations at trying to make an appointment by telephone.

We found that patients could access appointments by telephone, calling into the surgery and on line via the practice website

Patients told us that they could usually get an appointment within 2-3 days of contacting the practice and all patients told us if they needed to see a GP as an emergency this was always accommodated. One patient who was a mother of three young children was complimentary about GPs always seeing children when they were ill. Parents reported that children were always seen, and reception staff confirmed that this was the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We found that the practice supported patient choice and access to appointments as much as it was practical to do so. We found that patients could choose which GP they saw, whether they saw a female of a male GP.

Receptionists and patients told us the service was particularly good at trying to find them an appointment when it wasn't an emergency. It was the practice for receptionists to call back patients whom they had been unable to accommodate with an appointment should there be any cancelled appointments for the afternoon surgery.

Listening and learning from concerns & complaints

The surgery had a complaints policy and procedure. We saw a copy of the surgery's complaints policy and procedure which explained how the service responded to complaints and compliments from patients and their representatives or friends. The practice manager was mindful to respond and deal with patient's complaints as they arose in an attempt to avoid complaints escalating.

The patient practice leaflet informed patients of actions to take should they wish to make a complaint or make a suggestion. We observed that the complaints policy was not displayed in patient waiting areas and neither did the practice provide a facility for patients to provide feedback comments, compliments or complaints. The practice manager told us they would address this and ensure this information was made available for patients.

We saw that all complaints were logged and investigated by the practice manager who consulted with GPs and or nursing staff where relevant. We saw that the provider responded to complaints' in a timely manner and had taken action to resolve complaints.

We saw where patients had left comments on the NHS direct website about their experience of care with the surgery the practice did not always respond. The practice manager and the provider assured us that going forward all comments left on the NHS direct website would be responded to.

Are services well-led?

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

Our findings

Vision and Strategy

The practice had a clear vision around patient care. Staff we spoke with knew that the surgery was committed to providing good quality primary care services for all patients, including the management of long term health conditions.

We saw evidence that demonstrated the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing, medicines management and safeguarding meetings and shared information within the practice.

There were plans in place to facilitate the ongoing development of the practice following the planned retirement of one of the providers and this would provide the opportunity to develop IT systems to monitor SEA more effectively.

Governance Arrangements

The practice had systems to identify, assess and manage risks related to the service including health and safety issues. Systems were in place to record incidents, accidents and significant events and to identify risks to patient and staff safety. These included a bi monthly clinical meeting which were attended by partner GPs, salaried GPs, a nurse practitioner and the practice manager. The results were discussed at practice meetings, shared with staff and where necessary changes made. Systems could be improved to ensure that all information and decision making was fully shared and all parties were consulted.

In addition to these meetings a bi monthly administration meeting was held where imminent practice issues or any other events impacting on the day to day delivery of the service were discussed, for example safeguarding incidents, scheduled training.

Bi- monthly clinical meetings provided the opportunity for peer review.

The practice participated in the quality and outcomes framework system (QOF). This was used to monitor the quality of services in the practice. There were systems in place to monitor services and record performance against the quality and outcomes framework.

The practice manager attended the Salford practice manager's forum on a monthly basis. This

provided her with the opportunity to review how the service was performing in comparison to other GP practices across the Salford area

Leadership, openness and transparency

We observed that leadership was visible across the practice and with established lines of accountability and responsibility. However the practice operated two systems when handling and responding to patient information, one electronically and one paper, which was down to the personal preferences of each partner. Staff told us that there were times when this arrangement impacted on the day to day operations with some administrative tasks being duplicated. There were plans for this issue to be resolved from January 2015 when the whole system would be electronic.

The staff group was stable with relative small amount of turnover. Staff told us they enjoyed their work and had been supported since their appointment. Other staff told us they felt supported and there was good team work across the practice.

We saw evidence that demonstrated the practice worked with the Clinical Commissioning Group (CCG) to share information, monitor performance and implement new methods of working to meet the needs of local people. GPs attended prescribing, medicines management and safeguarding meetings and shared information within the practice.

Information sharing arrangements were good and each member of staffs contribution was valued. Staff told us they would feel comfortable speaking with the registered provider or the practice manager should they have any concerns.

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

Are services well-led?

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

The practice recognised the importance of the views of patients. The provider was committed to improving the services they provided to patients. They did this by gathering the views of people who used the service.

A patient participation group meeting was held in March 2014 and there were plans for another meeting to take place six months later and eventually for the group to be patient led. We were told that there had been a lack of continued interest from patients in continuing with the group but that there were plans to look at this and readvertise the group. Patients we spoke with were not aware that there was a patient participation group at the practice and some of them told us they would not wish to be involved.

It was the decision of the patient participation group to devise and send out a patient survey. The questionnaire was sent out to 200 patients over a two week period. The questionnaire focused on three areas, including access to appointments, prescriptions, facilities, what services patients were aware of and what improvements patients would like to see.

The practice reviewed information they received as part of their quality review to see what action could be taken to improve the performance of the practice and improve the service for patients. Overall the questionnaires showed that patients were happy with the care and treatment they received, though not all patients were aware of the services provided at the practice and other services were requested, for example, ear syringing and suture removal. In response to these findings the provider arranged for these services to be introduced and a female GP was recruited.

We received 25 completed CQC comment card and spoke with five patients on the day of our visit. We spoke with people from different age groups, including parents, patients with different physical health care needs and those who had various levels of contact with the practice. All these patients were very complimentary about the clinical staff and the overall friendliness and behaviour of all staff. They all felt the doctors and nurse were extremely competent and knowledgeable about their treatment needs. They felt that the service was exceptionally good and that their views were valued by the staff.

The practice periodically produced a practice newsletter. We saw the most recent newsletter focused on maintaining good health during the winter season and the consideration of flu vaccines for 2014.

The practice took complaints very seriously and systems were in place to monitor complaints and how they were responded to. However we observed that not all comments left on the NHS choices website about the practice were responded to by the provider.

Management lead through learning & improvement

The practice had systems in place to review incidents referred to as 'significant events analysis' (SEA) though these could be developed further to provide a learning opportunity.

Quality assurance arrangements at the service ensured that performance was reviewed regularly.

These included periodical reviews of clinical performance data provided by the local clinical commissioning group.

Other audits included a monthly drug stock take, a review of NHS health checks and of the corresponding patient groups who had attended.

NHS patient safety alerts, for example, medication alerts, were shared with staff.

We looked at the training records for both clinical and non-clinical staff. The records showed that staff were provided with a range of training which included: infection control, health and safety training, and information governance.

We saw that nursing staff had access to professional development. The majority of staff had an annual appraisal and arrangements were in place for non-clinical staff to receive supervision on a monthly basis. Staff were encouraged to attend various staff meetings and we saw from the minutes of clinicians meetings that they discussed improvements that could be made to the service.

The practice used information they collected for the Quality and Outcomes framework (QOF) and national programmes such as vaccination and screening to monitor patient quality outcomes. GPs told us they worked with the medicines manager and pharmacist from the CCG in identifying which clinical audits to carry out.