Silverdale Medical Practice

Quality Report

Silverdale Medical Practice
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Dear Dr Ballin

Silverdale Medical Practice was inspected on the 9 October 2014. This was a comprehensive inspection.

We rated Silverdale Medical Practice as good in relation to being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. A system was in place for managing Infection prevention and control.
- Staff were observed to be respectful, pleasant and helpful with patients and each other during our inspection visit. All patient appointments were conducted in the privacy of individual consultation room. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided.
- The main concern reported was the difficulty patients experienced getting through to the practice by telephone in the mornings. The 2013/2014 practice patient survey (published on the practice website)reflected that 22.41% of respondents rated the ability to get through to the practice on the telephone as 'poor'. The senior members of the practice team were very aware of the issue, shared their patients concerns and were proactively seeking to resolve the issue in conjunction with the practice patient participation group (PPG).

In addition the provider should:

Improve records relating to significant events analysis by providing details of how the actions taken were monitored over time to ensure they were embedded and effective.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is effective. Data showed patient outcomes were at or above average for the locality. NICE guidance is referenced and used routinely. People's needs are assessed and care is planned and delivered in line with current legislation. This includes assessment of capacity and the promotion of good health. Staff have received training appropriate to their roles and further training needs have been identified and planned. The practice can identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is caring. Data showed patients rated the practice higher than others for several aspects of care. 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.

Are services responsive to people's needs?

Good

The practice is responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management.The practice had a number of policies and procedures to govern activity and regular 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 patients and this had been acted upon. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings.

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
The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

Good

People with long term conditions
Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good

Families, children and young people
Systems were in place for identifying and following-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. Appointments were available outside of school hours and the premises was suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Good

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 offer continuity of care.

Good

People whose circumstances may make them vulnerable
The practice had carried out annual health checks for people with learning disabilities and offered longer appointments for people with learning disabilities. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various

Outstanding

Summary of findings

support groups and third sector organisations and had arranged for a welfare benefits advisor to be accessible at the practice once a week. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. People in vulnerable circumstances were able to register with the practice, including those with "no fixed abode." We saw a recent example of how a member of the practice team had enabled a homeless person to register with the practice and helped them access benefits advice. Practice staff sought to work with patients who had at times presented with behaviour that was challenging. The approach adopted at the practice was to seek to resolve the issue and keep engaging with the individual patient.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice had carried out annual health checks for people experiencing poor mental health. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations such as MIND. The practice had a system in place to follow up on patients who did not attend practice appointments or had attended accident and emergency where there may have been mental health needs.

Summary of findings

What people who use the service say

We received fifteen completed patient comment cards, other written comments from twenty four patients via our website, spoke with six patients and met with four members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards were very positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They also told us that they were treated with respect and their privacy and dignity were maintained. The representatives of the PPG told us they met with the practice management team regularly, were consulted appropriately and that their views were sought and valued.

However a repeated issue that was raised with us by patients (and the practice staff team) was the difficulty patients experienced getting through to the practice by telephone in the mornings.

The 2013/2014 practice patient survey (published on the practice website) reflected high levels of satisfaction with the care, treatment and services provided at Silverdale Medical Practice. A number of issues emerged from the survey. These included patients experiencing difficulties with telephone access, disabled access to one of the practice nurse rooms and waiting times for consultations to begin. The practice team (in conjunction with the patient participation group (PPG) had discussed these issues and developed an action plan to address them.

Areas for improvement

Action the service SHOULD take to improve

The examples of significant event analysis we looked at showed how incidents were investigated by defining the issue clearly and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again. However the records we looked at did not provide enough detail of how the actions taken were monitored over time to ensure they were embedded and effective.

Outstanding practice

People in vulnerable circumstances were able to register with the practice, including those with "no fixed abode." We saw a recent example of how a member of the practice team had enabled a homeless person to register with the practice and helped them access benefits advice.

Practice staff sought to work with patients who had at times presented with behaviour that was challenging. The approach adopted at the practice was to seek to resolve the issue and keep engaging with the individual patient.

Silverdale Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager). Our inspection team also included an Expert by Experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive.

Background to Silverdale Medical Practice

Silverdale Medical Practice is situated in the Pendlebury area of Salford. At the time of this inspection we were informed 11,950 patients were registered with the practice. The Silverdale Medical Practice population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There is also a higher proportion of patients above 65 years of age (20.3%) than the practice average across England (16.53%). 64 per cent of Silverdale Medical Practice Patients have a longstanding medical condition compared to the practice average across England of 53.54%.

A wide range of medical services are provided at the practice (details of which are provided on the practice website). At the time of our inspection 10 partner GPs (6 male and 4 female), 1 part time salaried GP (female) and 1 GP registrar (male) were providing general medical services to registered patients at the practice. The GPs are supported in providing clinical services by 2 practice nurses (female), 1 assistant healthcare practitioner (female), 1 healthcare assistant (male) and 1 phlebotomist (female).

Clinical staff are supported by the 20 strong practice team. This team, who are led by the practice manager and her deputy, are responsible for the general administration and organisation of systems within the practice.

Silverdale Medical Practice is accredited by the North Western Deanery of Postgraduate Medical Education as a GP Training Practice.

Silverdale Medical Practice contract with NHS England to provide General Medical Services (GMS) to the patients registered with the practice.

Silverdale Medical Practice has opted out of providing out-of-hours services to their patients. This service is provided by a registered out of hours provider. The practice website provides patients with details how to contact the out of hours provider (Salford Royal NHS Foundation Trust). Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

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?

Detailed findings

- 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 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 the 9 October 2014 and spent eight hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received fifteen completed patient comment cards, received other written comments from twenty four patients via our website, spoke with six patients and met with four members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs. We spoke with the lead GP, two of the partner GP's, one registrar GP, the practice manager and their deputy, a practice nurse, and four administration and reception staff who were on duty.

Good

Are services safe?

Our findings

Safe Track Record

There were clear lines of leadership and accountability in respect of how significant incidents (including mistakes) were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and Salford Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A wide range of information sources were used to identify potential safety issues/incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. We spoke with staff from across the practice team. They told us that the culture at the practice was fair and open and that they were encouraged to report incidents/mistakes and were supported when they did so. The learning from significant events were discussed at regular staff and clinical meetings. We looked at records relating to how the practice team learnt from incidents and subsequently improved safety standards. The examples we looked at showed how incidents were investigated by defining the issue clearly and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again. However the records we looked at did not provide enough detail of how the actions taken were monitored over time to ensure they were embedded and effective. Discussion with senior staff at the practice and written records of significant events revealed that significant events were escalated to appropriate external authorities for example NHS England or the CCG.

The practice had a system for managing safety alerts (from external agencies). These were emailed to the GPs and practice nurses and action was taken where appropriate to do so. However a record of actions taken was not maintained. We were informed that a new system to manage safety alerts was to be introduced in the near future and would capture such details.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. Two of the GPs and one of the administrative staff had lead roles for safeguarding. Their roles included providing support to their practice colleagues for safeguarding matters and liaising with external safeguarding agencies, such as the local social services and CCG safeguarding teams and other health and social care professionals as required. We discussed how safeguarding was managed at the practice and looked at the systems used to ensure patients safeguarding needs were addressed.

The systems identified to the GPs and practice nurses when a safeguarding issue or safeguarding plan had been identified and developed for individual patients. We also saw that the practice team were communicating regularly with the safeguarding leads for children and adults at Salford social services and Salford CCG. They provided reports to them when requested to do so. We also saw a recent example where clinical staff at the practice had raised a safeguarding alert with Salford social services. Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3) children's safeguarding training had been provided to the GPs who lead on safeguarding at the practice and to 90% of the other GPs (all had done at least level 2). We were informed that plans were in place (November 2014) for the remaining 10% of GPs to attend level 3 safeguarding training.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. Staff were provided with training to ensure that chaperoning was safe and effective. Where a chaperone was provided this was recorded in the patient's medical records (and included the name of the chaperone). No issues in respect of chaperoning were raised by patients we spoke with or received information from.

Medicines Management

Systems were in place for the management, secure storage and prescription of medicines within the practice.

Good

Are services safe?

Management of medicines was the responsibility of the clinical staff at the practice. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. A procedure was operated to enable patients to request and obtain their repeat prescriptions. It was established practice to monitor the amount of medicines prescribed particularly for the frail elderly and others with complex health needs. Medicine errors were treated as significant events. We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained. We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date.

Cleanliness & Infection Control

We looked around the practice during our visit. Systems were in place for ensuring the practice was regularly cleaned. We looked at records that reflected a cleaning schedule was in place. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control. One of the practice nurses provided leadership in this area. Staff had been provided with regular infection prevention and control training and this included the use of appropriate hand washing techniques. We saw that appropriate hand washing facilities (including liquid soap and disposable towels) and instructions were available throughout the practice. Checks (audits) had been conducted to ensure actions taken to prevent the spread of potential infections were maintained. The last audit had identified some action points and we established these had been addressed. The practice water system had been routinely tested for legionella bacteria (that could potentially cause a serious infection) in February 2014. No legionella bacteria was found and no action was required.

We also saw that practice staff were provided with equipment (for example goggles and disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Medical instruments were used once only and disposed of.

Equipment

A record of maintenance of clinical, emergency and other equipment was in place and recorded when any items were repaired or replaced. We saw that all of the equipment had been tested and the practice had contracts in place for personal appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration, where needed, of equipment.

Staffing & Recruitment

The practice was staffed to enable the general medical service needs of patients to be met. We were informed by senior staff at the practice that they were currently reviewing their staff mix and numbers to meet the changing and increasing demands on the services provided. One of the administration staff was responsible for planning surgery times and ensuring a GP was available to for all the sessions. Their duties included accessing GP locum cover when the need arose. Records we looked at indicated that the practice used the services of locums who were familiar to the practice and therefore known to the partner GPs wherever possible.

We looked at staff recruitment practices and records. A formal recruitment process was in place. This included obtaining information to demonstrate appropriate checks had been made to ensure new staff were appropriately qualified, had medical indemnity cover and were currently registered with a professional body, for example The General Medical Council (GMC). Also a Disclosure and Barring Service (DBS) check had been conducted to assess the person's suitability to work with potentially vulnerable people. We saw that this latter check was conducted following a risk assessment but was in place for all clinicians at the practice (including locum GPs).

Monitoring Safety & Responding to Risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, was readily accessible to staff. Records and discussion with staff demonstrated that all clinical practice staff received annual basic life support training (the most recent was April 2014).

Good

Are services safe?

Non-clinical staff received such training every three years. We also looked at records that showed that resuscitation medicines and equipment were checked on a regular basis to see they were in date or functioned correctly.

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice. The plan had been developed in conjunction with Salford CCG and identified two local 'buddy' practices that would provide support in the event of an emergency or major incident occurring at Silverdale Medical Practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice was structured, organised and had introduced systems to ensure best practice was followed. Practice was evidence based and underpinned by nationally recognised quality standards and guidance. These included the quality standards issued by the National Institute for Health and Care Excellence (NICE), guidance published by professional and expert bodies, and within national health strategies were used to inform best practice at the practice. We saw that such standards and guidelines were easily accessed electronically by clinicians.

Discussion with the GP's and the practice nurse, and looking at how information was recorded and reviewed, demonstrated how patients were effectively assessed, diagnosed, treated and supported. GP's and other clinical staff were conducting consultations, examinations, treatments and reviews in individual consulting rooms to preserve patients' privacy and dignity and to maintain confidentiality.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to anti-coagulant therapy, cancer, significant events analysis and drug misuse. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that where audits identified actions these were clearly described and communicated to staff. If necessary a timescale for re-auditing was identified.

We saw evidence of peer review and support and regular clinical and practice meetings being held to monitor and identify possible issues and improvements in respect of clinical care.

The GPs, practice nurses and administration staff had developed areas of expertise and took 'the lead' in a wide range of clinical and non-clinical areas such as dementia and safeguarding children and vulnerable adults. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, were predominantly complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. However there was widespread concern (shared by the practice team and PPG) regarding the difficulty patients experienced getting through to the practice by telephone in the mornings.

Effective staffing

We were informed that Silverdale Medical Practice came into existence following the merger of two practices in April 2013. However many of the staff were well established at the health centre for a number of years. The practice team comprised of clinical and non-clinical staff.

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. New staff were provided with a programme of induction that included training relevant to their role. We saw that appraisals took place regularly and included a process for documenting, action planning and reviewing appraisals. We saw documentary evidence of action taken where there has been an issue with staff performance to support the person to improve and monitor the situation to ensure improvement was maintained.

GP's were supported to obtain the evidence and information required for their professional revalidation. This is where doctors demonstrate to their regulatory body, the GMC, that they are up to date and fit to practice. The practice was also an accredited as a GP training practice by the North Western Deanery of Postgraduate Medical Education, providing experience for one GP registrar. A GP registrar is a qualified doctor undertaking post graduate general practice training. We talked with the GP who provided supervision and support to the registrar GP. They described the process whereby GP registrars were supported and supervised to ensure they are enabled to develop the required skills and knowledge to manage, monitor and improve outcomes for patients. The GP registrar we spoke with confirmed that their mentor and

Good

Are services effective?

(for example, treatment is effective)

other partner GPs were always available to provide help and support. Patients were therefore being treated and supported by an appropriately recruited staff team who were able to provide an effective, consistent and appropriate service.

Working with colleagues and other services

We saw that appropriate processes were in place that ensured patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine. Secretarial capacity at the practice had been increased to deal more effectively with referrals. The majority of the patients we spoke with, or received written comments from said that where they needed to be referred to other health service providers this was discussed fully with them and they were provided with enough information to make an informed choice. The practice had established and well developed links with the integrated care programme in Salford.

We saw that clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings with professionals such as health visitors to discuss child health and safeguarding issues and McMillan nurses and district nurses to plan and co-ordinate the care of patients coming to the end of their life. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hours service. In particular the practice provided detailed clinical information to the out of hours service about patients with complex healthcare needs. Also all patient contacts with the out of hours provider were reviewed by a GP the next working day.

A system was in place for hospital discharge letters and specimen results to be reviewed by a GP who would initiate the appropriate action in response.

Information Sharing

All the information needed to plan and deliver care and treatment was stored securely (electronically) but was accessible to the relevant staff. This included care and risk assessments, care plans, case notes and test results. The system enabled staff to access up to date information quickly and enabled them to communicate this information when making an urgent referral to relevant services outside the practice. We saw examples with this when looking at how information was shared with local authority and CCG safeguarding teams.

Consent to care and treatment

Patients we spoke with told us that they were communicated with appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment.

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. People were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. Where people lacked the mental capacity to make a decision, 'best interests' decisions were made in accordance with legislation. Clinical staff we spoke with clearly understood the importance of obtaining consent from patients and of supporting those who did not have the mental capacity to make a decision in relation to their care and treatment. Training records demonstrated that regular training was provided to relevant staff in relation to mental capacity.

Health Promotion & Prevention

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma.

A wide range of health promotion information was available and accessible to patients particularly in the reception area and on the practice website. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation services and a weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation and influenza vaccinations were provided. At the time of our visit patients were provided with a number of 'open' flu vaccination clinics to maximise the opportunity for eligible people to be protected.

Good

Are services effective?

(for example, treatment is effective)

A system was in place to provide health assessments and regular health checks for patients when abnormalities or long term health conditions are identified. This included sending appointments for patients to attend reviews on a regular basis. When patients did not attend this was followed up to determine the reason and provide an alternative appointment.

Patients were provided with fitness to work advice to aid their recovery and help them return to work.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Comments we received from patients, including members of the practice participation group (PPG), predominantly reflected that practice staff interacted with them in a positive and empathetic way. They predominantly told us that they were treated with respect, always in a polite manner and as an individual.

We looked at the results of the 2013/2014 practice patient survey (published on the practice website). This reflected that 59% of respondents thought the practice team's ability to treat them with respect and maintain their dignity was excellent and 35% responded that it was good. Approximately 5% thought it acceptable and 1% thought it poor. There were also high levels of satisfaction with patient confidentiality being maintained in the reception area. Thirty none per cent rated this as being excellent, 36.77% as good, 14.45% as acceptable and 8.93% as poor. Discussion with senior practice staff and members of the PPG indicated the outcome of surveys were reflected upon and action was taken to improve patients experience.

Staff were observed to be respectful, pleasant and helpful with patients and each other during our inspection visit. All patient appointments were conducted in the privacy of individual consultation room. Examination couches were provided with privacy curtains for use during physical and intimate examination and a chaperone service was provided.

Staff we spoke with said that if they witnessed any discriminatory behaviour or where a patients privacy and dignity was not respected they would be confident to raise the issue with the practice manager.

Care planning and involvement in decisions about care and treatment

The 2013/2014 patient practice survey reflected that the majority of respondents were satisfied with the way the doctor explained their condition and treatment. Fifty six per cent rated this as excellent, 35.15 % as good, 9.22% as acceptable and 0.34% as poor.

The 2013/2014 patient practice survey asked patients how well they felt involved in making decisions about their care and treatment. Forty four per cent rated their involvement as excellent, 43.34% as good, 9.22% as acceptable and 3.07% as poor.

Comments we received from patients, including members of the practice participation group (PPG), predominantly reflected that practice staff listened to them and concerns about their health were taken seriously.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians, in the practice reception area and on the practice website.

Where patients and those close to them needed additional support to help them understand or be involved in their care and treatment the practice had taken action to address this. For example language interpreters were readily accessed (face to face or by telephone) and extended appointment times were provided to ensure this was effective.

Patient/carer support to cope emotionally with care and treatment

There was a person centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patients carers. Two members of practice staff took the lead with this and were actively engaged with the local carer group.

A wide range of information about how to access support groups and self help organisations was available and accessible to patients from the practice clinicians, in the reception area and on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive in meeting the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, the patient participation group (PPG), and patients and those close to them to support the provision of coordinated and integrated pathways of care that meet people's needs.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Patients were able to choose to consult with a male or female doctor if they so wished. The GP's and practice nurses had developed areas of special interest and expertise and took 'the lead' in particular clinical areas. These clinical areas included considering the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as for monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, anticoagulation clinics or cervical screening.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This activity analysis was shared with Salford CCG and formed a part of the quality framework monitoring. It also assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews. Two of the GPs were designated practice leads in respect CCG matters.

Systems were in place to identify when people's needs were not being met and informed how services at the practice was developed and planned. A variety of information was used to achieve this. For example profiles of the local prevalence of particular diseases, the level of social deprivation and the age distribution of the population provided key information in planning services. Significant events analysis, individual complaints, survey results and clinical audits were also used to identify when patients needs were not being met.

We met with four of the practice's patient participation group (PPG). They told us that they met regularly with senior members of the practice team. They were also actively involved in obtaining patients views generally and specifically during the formal practice patient survey. When issues were identified the PPG were actively consulted to develop plans to address them. They felt their views and contributions were respected and valued. At the time of our visit the group had been involved in seeking ways to address the difficulties patients were experiencing with telephone access of the practice in the mornings, improving disabled access at the practice and issues relating to consultation times. Actions had been taken in respect of these issues and it had been agreed the PPG would receive formal feedback about progress made in December 2014.

Silverdale Medical practice used the facilities and premises provided at Pendlebury Health Centre. The centre provided a reception area, a waiting room, and individual consultation and treatment rooms. There were also facilities to support the administration needs of the practice (including a meeting room). The building was easily accessible to patients (including those with a disability). However a recent significant event identified an issue with a disabled patient accessing one of the practice nurses consulting/treatment rooms. The practice and PPG had jointly identified a long term solution to this issue and were in the process of consulting the centre's landlord. Progress in this matter was due to be reviewed in December 2014.

Tackling inequality and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. People in vulnerable circumstances were able to register with the practice, including those with "no fixed abode." We saw a recent example of how a member of the practice team had enabled a homeless person to register with the practice and helped them access benefits advice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Practice staff sought to work with patients who had at times presented with behaviour that was challenging. The approach adopted at the practice was to seek to resolve the issue and keep engaging with the individual patient.

Access to the service

We received fifteen completed patient comment cards, other written comments from twenty four patients via our website, spoke with six patients on the day of our visit and met with four members of the practice's patient participation group (PPG). The main concern reported was the difficulty patients experienced getting through to the practice by telephone in the mornings. We also looked at the results of the 2013/2014 practice patient survey (published on the practice website). This reflected that 22.41% of respondents rated the ability to get through to the practice on the telephone as 'poor'. The senior members of the practice team were very aware of the issue, shared their patients concerns and were proactively seeking to resolve the issue. For example in the mornings (the busiest period) all the incoming telephone lines were staffed to take calls. Patients were encouraged only to telephone the practice between 8am and 11am to book appointments or home visits. The practice team and the patients participation group were also meeting with the organisation providing the telephone lines to the practice to determine how this situation can be improved.

The practice was open from 8am to 6.30pm Monday to Friday. To improve patient access a system of extended hours had been introduced. Some weeks this may be a Saturday morning from 9am to 1230pm or Monday and Wednesday mornings from 7am to 8am and Wednesday evening 6.30pm to 8pm. This was particularly helpful to patients who work. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

GP appointments were provided in 10 minute 'slots'. Where patients required longer appointments these could be booked by prior arrangement. A system was in place for patients who required urgent appointments to be seen the same day. Detailed information about accessing appointments was provided on the practice website.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their 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 in the form of a summary leaflet. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at 46 complaints received in the last twelve months (including 6 about accessing the practice by telephone). In line with good practice every complaints or concerns was recorded and investigated (including near misses) and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. However where improvements had been identified and implemented there was no record to demonstrate if improvements made were effective and sustained.

Are services well-led?

Good

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

Our findings

Vision and Strategy

There was a well-established leadership structure with clear allocation of responsibilities amongst the partner GP's and the practice team. We saw evidence that showed the service engaged with the local Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

The lead GP described to us a clear value system which provided the foundations for ensuring the delivery of a high quality service to patients. The culture at the practice was one that was open and fair. Discussion with members of the practice team, the patient participation group and patients generally demonstrated this perception of the practice was an accurate one.

Governance Arrangements

There were clearly defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular clinical and practice meetings for staff. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. The contents of the minutes and our discussion with GPs and other members of the practice team demonstrated that the fair and open culture at the practice enabled staff to challenge existing arrangements and improve the service being offered. These arrangements supported the governance and quality assurance measures taken at the practice and enabled staff to review and improve the quality of the services provided.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

For example action had been taken in respect of dementia diagnosis rates, emergency cancer admissions and the medicines management of patients over 75 years with a fragility fracture.

The practice has a system in place for completing clinical audit cycles. These are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to anti-coagulent therapy, cancer and significant events analysis and drug misuse. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that where audits identified actions these were clearly described and communicated to staff. Where appropriate a timescale for re-auditing was identified.

The governance and quality assurance arrangements at the practice combined with the open and fair culture enabled risks to be assessed and effectively managed in a timely way. By effectively monitoring and responding to risk patients and staff were being kept safe from harm.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example one of the practice nurses led on infection prevention and two of the GPs and one of the administration team led on safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that clinical and staff meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were comfortable to raise issues at staff meetings or at individual appraisal meetings.

Senior members of the practice team told us of plans for developing the quality and range of services provided at the practice. This included plans for increasing collaboration with other local practices and recruiting an advanced nurse practitioner (this post was in the process of being advertised at the time of this inspection).

Measures were in place to maintain staff safety and wellbeing. For example induction and ongoing training included safety topics such as the prevention of the spread of potential infections and other health and safety issues. An emergency alarm system could be activated by staff in each room to summons assistance. A clear procedure for chaperoning patients was also in place to protect staff as well as patients.

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

Are services well-led?

Good

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice website also encouraged patients to provide feedback electronically. We looked at the results of the 2013/2014 patient survey (published on the practice website). The survey reflected high levels of satisfaction with the care, treatment and services provided at Silverdale Medical Practice. However a number of issues emerged from the survey. These included patients experiencing difficulties with telephone access, disabled access to one of the practice nurse rooms and waiting times for consultations to begin. The practice team (in conjunction with the patient participation group (PPG) had discussed these issues and developed an action plan to address them.

The practice had an active patient participation group (PPG). We met with four members of the PPG. They told us that they were met regularly with senior members of the practice team. They were also actively involved in obtaining patients views generally and specifically during the formal practice patient survey. When issues were identified the PPG were actively consulted to develop plans to address them. They felt their views and contributions were respected and valued. At the time of our visit the group had been involved in seeking ways to address the difficulties patients were experiencing with telephone access of the practice in the mornings, improving disabled access at the practice and issues relating to consultation times. Actions had been taken in respect of these issues and it had been agreed the PPG would receive formal feedback about progress made in December 2014.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

GP's were supported to obtain the evidence and information required for their professional revalidation. This is where doctors demonstrate to their regulatory body, The General Medical Council, that they are up to date and fit to practice. The practice was also an accredited as a GP Training Practice by the North Western Deanery of Postgraduate Medical Education, providing experience for one GP registrar. A GP registrar is a qualified doctors undertaking post graduate general practice training.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved.