

Dearden Avenue Medical Practice

Quality Report

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Website: No website at the time of this inspection

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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?

Requires improvement



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

Dear Dr Ahuja

Dearden Avenue Medical Practice was inspected on the 28 October 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspect a number of practices in the area overseen by Salford Clinical Commissioning Group (CCG).

We rated Dearden Avenue Medical Practice as requiring improvement in respect of being safe and good in relation to being effective, caring, responsive and well-led. The overall rating for the practice was good.

Our key findings were as follows:

Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control.

The practice had systems in place to ensure best practice was followed. This is to ensure that people's care, treatment and support achieves good outcomes and is based on the best available evidence.

Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.

Patients spoke positively in respect of accessing services at the practice. A system was in place for patients who required urgent appointments to be seen the same day. Patients accessed appointments by telephone as the practice did not have a web site.

There were however also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Take action to ensure that people who use the service are protected by operating effective recruitment and

Summary of findings

selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed. Regulation 21(a) (b) Health & Social Care Act 2008 (Regulated Activities) Regulations 2010.

In addition the provider should:

The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that

whilst performance, quality and risks had been discussed the minutes of meetings we looked at lacked detail of this discussion and how actions taken are monitored over time to ensure they are 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?

The practice is rated as requires improvement for safe as there are areas where improvements must be made. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were enough staff to keep people safe. Risks to patients who used services were assessed but systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. Specifically the system of staff recruitment must be improved to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.

Requires improvement



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. 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 could identify all appraisals and the personal development plans for all staff. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently positive. We observed a patient centred culture and found evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

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 NHS Local Area Team (LAT) and Salford 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

Good



Summary of findings

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.

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 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. Staff had received induction and regular training, appraisals and attended staff meetings.

Good



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 is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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.

Good



People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Processes were in place to make urgent referrals to specialists where patients in this group had a sudden deterioration in their health. When needed longer appointments and home visits were available. All these patients had regular reviews to check their health and medication needs were being met. For those people with the most complex needs the GP and practice nurse worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the population group of 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 high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies. All children were seen on the day the appointment was requested. We were provided with examples of joint working with midwives, health visitors and school nurses. Processes were in place to make urgent referrals to specialists for children and pregnant women who had a sudden deterioration in health.

Good



Working age people (including those recently retired and students)

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

Good



Summary of findings

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. The practice was proactive in offering a full range of health promotion and screening which reflects the needs for this age group. This included the practice providing NHS health checks for patients aged 40 to 74.

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and a system was in place to follow up those who did not attend. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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. There were no barriers to people in vulnerable circumstances registering with the practice and accessing the services provided.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health including people with dementia. A system was in place to ensure people experiencing poor mental health had received an annual physical health check. The practice regularly worked with the local mental health team and other mental health professionals in the case management of people experiencing poor mental health including those with dementia. The practice had had a system in place to refer patients for counselling where appropriate to do so. The counsellor held a clinic at the practice every Thursday.

Good



Summary of findings

What people who use the service say

We received thirty eight completed patient comment cards and spoke with eight patients at the time of our inspection visit. 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 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 that their privacy and dignity was maintained.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

91% of respondents describe their overall experience of this surgery as good.

93% of respondents had confidence and trust in the last GP they saw or spoke to at the practice.

97% of respondents said the last nurse they saw or spoke to at the practice was good at treating them with care and concern.

Areas for improvement

Action the service **MUST** take to improve

Staff recruitment procedures were not safe. The practice must take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.

Action the service **SHOULD** take to improve

The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that whilst performance, quality and risks had been discussed the minutes of meetings we looked at lacked detail of this discussion and how actions taken are monitored over time to ensure they are embedded and effective.

Dearden Avenue 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 themselves and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dearden Avenue Medical Practice

Dearden Avenue Medical Practice is situated in the Little Hulton area of Salford. At the time of this inspection we were informed 2,200 patients were registered with the practice. The practice population experiences higher levels of income deprivation affecting children and older people than the practice average across England. There are also lower levels of unemployment among the working age population than the practice average across England. A lower proportion of the practice's patients were above 65 years of age (10.3%) than the practice average across England (16.53%). Also 27.2% of the practice patients are under the age of 18 years compared to the average across England (20.9%).

At the time of our inspection one full time GP (female) and one 1 part time salaried GP (female) were providing general medical services to registered patients at the practice. The GPs are supported in providing clinical services by a

practice nurse (female) who worked part time. Clinical staff are supported by the practice manager and her team who are responsible for the general administration and organisation of systems within the practice.

The practice delivers commissioned services under the Personal Medical Services (PMS) contract.

Deardon Avenue 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. Prominently displayed information in the patient waiting area 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.

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?

Detailed findings

- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on the 28 October 2014 and spent seven hours at the practice. We reviewed all areas that the practice operated, including the administrative areas. We received thirty eight completed patient comment cards and spoke with eight patients during our inspection visit. We spoke with people from various age groups and with people who had different health care needs. We spoke with the full time GP, the part time salaried GP, the practice manager and two members of the practice team.

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 such as 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 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 has 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 open and fair and that they were encouraged to report incidents/mistakes and were supported when they did so. The examples we looked at showed how incidents were investigated by defining the issue and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again. We were told that learning from significant events was discussed at practice staff meetings which were held every two months. However the minutes of meetings we looked at lacked detail of this discussion and how actions taken are monitored over time to ensure they are embedded and effective.

The practice has a system for managing safety alerts (from external agencies). These were reviewed by the GPs, practice nurse and practice manager and action was taken where appropriate to do so.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. The full time GP took the lead role for safeguarding. Their

role 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 patient record system alerted the GPs and practice nurse 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. Staff training records (and the revalidation records of the two GPs) 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) safeguarding training had been completed by the GP safeguarding lead. The practice nurse had also been supported by the practice to attend level 2 and 3 safeguarding training in November 2014. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly.

Patient appointments were conducted in the privacy of individual consultation rooms. Where required a chaperone was provided. No issues in respect of chaperoning were raised by patients we spoke with or received information from. However it was noted that the non-clinical staff who carried out chaperoning duties did not have a Disclosure and Barring Service (DBS) check. We saw records that demonstrated applications had been submitted for DBS checks in respect of three staff prior to our visit. These had not been completed at the time of our visit.

Medicines management

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

Are services safe?

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 and infection control

Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our visit. A system was in place for managing Infection prevention and control. The practice nurse and practice manager provided leadership in this area. Staff had been provided with 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 hand washing 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 (in May 2014) had identified some action points and we established these had been addressed.

We also saw that practice staff were provided with equipment (for example goggles, disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms.

The practice was registered and contracted to carry out surgical procedures. We looked at the designated treatment room used for carrying out minor surgical procedures such as the removal of small moles and skin tags and the insertion of contraceptive devices. This room was clean, suitably furnished, appropriately equipped, well lit and provided privacy. Appropriate hand washing facilities were in place and medical instruments used for

minor surgical procedures were disposed of after single use. Unused medical instruments and dressings were stored in sealed packs. We looked at these and found all to be within the expiry date stipulated on the packs.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely (in specially designated bags) before being removed by a specialist company for safe disposal. We saw records that detailed when such waste was removed.

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 and recruitment

The practice was staffed to enable the personal medical service needs of patients to be met. The staff team (totalling six in number) were well established and most had worked at the practice for many years.

We looked at staff recruitment practices and records. Whilst a formal recruitment process was in place we found that staff personnel records did not include all of the information required to demonstrate that safe recruitment practices were being operated at the practice. For example we looked at the personnel record of the most recently recruited staff member (non-clinical). This did not contain proof of identity (including a recent photograph) or any written references. We also looked at the personnel file of one of the clinical staff working at the practice. We could find no evidence of written references, proof of identity (including a recent photograph) or a DBS check having been made in respect of this person. We saw records that demonstrated an applications had been submitted for DBS checks in respect of this person prior to our visit. These had not been completed at the time of our visit. The provider must take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.

Are services safe?

Monitoring safety and responding to risk

Procedures were in place for dealing with medical emergencies. Resuscitation medicines and equipment, including a defibrillator and oxygen, were readily accessible to staff. Records and discussion with staff demonstrated that clinical practice staff received annual basic life support training. We saw records that demonstrated an update to this training was scheduled for early November 2014. 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 local GP practices that would provide support in the event of an emergency or major incident occurring at Dearden Avenue Medical Practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence. Practice was based on 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 full time GP and looking at how information was recorded and reviewed, demonstrated that patients were being 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. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these at the practice relating to managing urinary tract infections and the identification and management of osteoporosis. The first had been completed and the second was incomplete. Whilst the practice demonstrated some commitment to clinical audit action should be taken to ensure that these are fully completed.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. However

the minutes of the meetings we looked at could be improved by providing more detail of this discussion and how the actions taken are monitored over time to ensure they are embedded and effective.

The GPs, practice nurse and administration staff had developed areas of expertise and took the lead in a 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, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. There was no evidence of discrimination of any sort in relation to the provision of care or treatment.

Effective staffing

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. Staff we spoke with said they being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the GMC, that they were up to date and fit to practice. Both the GP's had undergone recent clinical appraisals. The practice nurse confirmed that she was also supported to attend updates to training that enabled her to maintain and enhance her professional skills.

Working with colleagues and other services

Systems were in place to ensure 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

Are services effective?

(for example, treatment is effective)

effective, co-ordinated and integrated care. We saw that referrals were assessed as being urgent or routine. Patients we spoke with, or received written comments from, said that if 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 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 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 the GP the next working day.

A system was in place for hospital discharge letters and specimen results to be reviewed by the 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. The 2014 GP patient survey reflected that 86% of respondents said that the last GP they saw or spoke with at the practice was good at involving them in

decisions about their care. 94% said the last GP they saw or spoke to was good at explaining tests and treatments and 97% say the last nurse they saw or spoke to was good at explaining tests and treatments.

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.

All clinical staff demonstrated a clear understanding of the Gillick competencies. (These help clinicians to identify children under 16 who have the capacity to consent to medical examination and treatment).

Health promotion and prevention

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to quickly 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. The practice nurse conducted the initial health screening assessments and made referrals to the GP for further assessment as appropriate.

A wide range of health promotion information was available and accessible to patients particularly in the patient waiting areas of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and 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.

The provision of health promotion advice was an integral part of each consultation between clinician and patient.

Are services effective?

(for example, treatment is effective)

Patients were also enabled to access appropriate health assessments and checks. The practice was actively participating in providing NHS health checks for patients aged 40 to 74.

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.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received patient feedback from eight patients in person and thirty eight via completed comments cards.

Information we received from patients reflected that practice staff interacted with them in a positive and empathetic way. They told us that they were treated with respect, always in a polite manner and as an individual.

There was a strong, visible, person-centred culture. Staff were highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between people who used the service, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the lead GP and practice manager. Staff were observed to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us that their privacy and dignity was always respected maintained particularly during physical or intimate examinations. 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. We saw no barriers to patients accessing care and treatment at the practice.

We looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results reflected that 95% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 94% of respondents said the last nurse they saw or spoke to was good at listening to them.

Care planning and involvement in decisions about care and treatment

The 2014 GP patient survey reported that 86% of respondents said the last GP they saw or spoke to at the

practice was good at involving them in decisions about their care. 93% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Comments we received from patients reflected that practice staff listened to them and concerns about their health were taken seriously and acted upon.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians and prominently displayed in the waiting areas.

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.

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 and in the reception area.

A counselling support service was also available at the practice to provide emotional support to patients following referral by the GP. A counsellor provided a weekly clinic at the practice to ensure patients needing emotional support could access this service in a timely and appropriate way.

The 2014 GP patient survey reported that 96% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 94% say the last nurse they saw or spoke to at the practice was good at listening to them. Patients we spoke with or received written comments from spoke positively about being listened to and supported by all the staff at the practice.

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 to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that meet patient'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. Arrangements had been made with another local GP (male) to enable patients at both the practices to access an appointment with a GP of the same sex if preferred. Longer appointments could be made for patients such as those with long term conditions or who were carers. The GPs and practice nurse also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

The two GP's and practice nurse 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 annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, 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 Clinical Commissioning Group 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.

Systems were in place to identify when people's needs were not being met and informed how services at the practice were 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. This information was then used to inform how services were planned and developed at the practice.

Dearden Avenue Medical Practice had a reception area, two patient waiting areas and three consultation and treatment rooms. One of the consultation/treatment rooms is designated for carrying out minor surgical procedures. There were also facilities to support the administrative needs of the practice (including a reception office, practice manager's office and a meeting room). The building was easily accessible to patients (including those with a disability). We were informed that plans were at an advanced stage to bring together a number of 'single handed' GPs (such as Dearden Avenue Medical Practice) in a new local purpose built surgery. Staff and patients had been consulted about this development. The aim of the project is to share resources and develop services to enhance the way patients needs are met.

Tackling inequity 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."

Access to the service

We received thirty eight patient comment cards and spoke with eight patients on the day of our visit. There were no negative comments about being able to access the services at the practice. We also looked the results of the 2014 GP survey. 91% of the respondents found it easy to get through to the practice by phone. 92% were able to get an appointment to see or speak to someone the last time they

Are services responsive to people's needs?

(for example, to feedback?)

tried and 96% said the last GP they saw or spoke to was good at giving them enough time. Also 99% said the last appointment they got was convenient and 97% described their experience of making an appointment as good.

The opening hours and surgery times at the practice were prominently displayed in the reception and patient waiting areas and were also contained in the practice information leaflet readily available to patients in the reception area. To improve patient access a system of extended hours had been introduced. 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. Patients accessed appointments by telephone as the practice did not have a web site.

Listening and learning from concerns and 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 three complaints received in the last twelve months. In line with good practice all complaints/concerns were recorded and investigated 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 that indicated how it was established if the improvements 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 GP and practice manager met with the Salford 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 GP was an active member of the Local Medical Committee (LMC) and attended all the local clinical meetings. Similarly the practice nurse regularly attended the practice nurse support group established by Salford CCG to provide support and share good practice.

The 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 and patients generally demonstrated this perception of the practice was widely shared.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found that whilst performance, quality and risks had been discussed, the minutes of meetings we looked at lacked detail of this discussion and how actions taken are monitored over time to ensure they are embedded and effective. Discussion with GPs and other members of the practice team demonstrated that a 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.

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. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw two recent examples of these at the practice relating to managing urinary tract infections and the identification and management of osteoporosis. The first had been completed and the second was incomplete. Whilst the practice demonstrated commitment to clinical audit, action should be taken to ensure that these are fully completed.

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

The service was transparent, collaborative and open about performance. There was a clear leadership structure which had named members of staff in lead roles. For example the practice nurse led on infection prevention and control, and the GP led on safeguarding. We spoke with four 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. The staff team had worked together for many years and there was a very low turnover of staff.

We saw that practice staff meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at staff meetings, individual appraisal meetings or during the regular informal discussions that took place.

The GP and practice manager showed us plans for developing the quality and range of services provided at the practice and increasing the existing collaboration with other practices in the area. Plans were at an advanced stage to bring together a number of 'single handed' GPs (such as Dearden Avenue Medical Practice) in a new local purpose built surgery. Staff and patients had been consulted about this development. The aim of the project is to share resources and develop services to enhance the way patients needs are met.

Measures were in place to maintain staff safety and wellbeing. Induction and on going training included safety

Are services well-led?

Good 

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

topics such as the prevention of the spread of potential infections and other health and safety issues. A procedure for chaperoning patients was also in place to protect staff as well as patients.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the 2014 GP patient survey and the survey conducted by the practice in January 2014. Both surveys reflected high levels of satisfaction with the care, treatment and services provided at Dearden Avenue Medical Practice. However where issues were identified action had been taken to address them.

The practice did not currently have an active patient participation group (PPG). We were told that it had proved very difficult to recruit and retain members to such a group although efforts to do so were on going. Despite these difficulties we saw that patients were provided with prominently displayed information about the health services currently provided at the practice (and in the local community) and what was planned for the future of the practice. Patients were being encouraged to actively comment on the services available and the planned developments.

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 and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. We looked at two 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 was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The full time GP was an active member of the Local Medical Committee (LMC) and attends all the local clinical meetings. Similarly the practice nurse regularly attended the practice nurse support group established by Salford CCG to provide support and share good practice.

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.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers People who use services were not protected against the risks associated with ineffective recruitment procedures and not carrying out relevant checks when employing staff. The provider must take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.