Salford Health Matters Eccles

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This is the report of findings from our inspection of Salford Health Matters Eccles. The practice is registered with the Care Quality Commission to provide primary care services.

We carried out a comprehensive inspection on 3 October 2014. We spoke with patients, members of the patient participation group (PPG), and staff including the management team.

The practice is rated as Outstanding. An effective, responsive and well-led service is provided that meets the needs of the population it serves.

All regulated activities provided by Salford Health Matters Eccles were inspected.

Our key findings are as follows:

- The service is safe. Staff understand and fulfil their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents are maximised to support improvement.
- The service is effective. The practice is using innovative and proactive methods to improve patient outcomes and it links with other local providers to share best practice. It is involved in a local scheme where a holistic approach to health and social care is being trialled.
- The practice is caring. Feedback from patients about their care and treatment is consistently and strongly positive. There is a patient centred culture and strong evidence that staff are motivated and inspired to offer kind and compassionate care, working to overcome obstacles to achieve this. There are many positive examples to demonstrate how people's choices and preferences are valued and acted on.
- The practice is responsive to people's needs. The practice implements suggestions for improvements and makes changes to the way it delivers services as a consequence of feedback directly from patients and from the patient participation group (PPG).
- The practice is well-led. They have clear vision which has quality and safety as its top priority. A business plan is in place that is monitored and regularly reviewed by the board, and discussed with all staff. The practice is a social enterprise and has a board of

Summary of findings

directors, including a non-clinical chief executive, responsible for making business decisions. High standards are promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- All patients who require an appointment with a GP are seen on the day their request is made. Requests can be made at any time of the day, and the practice has late night and weekend opening so patients not available during working hours can access appointments easily.
- Appointment length is need-specific so GPs arrange longer appointments when they think this is necessary. Longer appointments are routinely offered to some patients, for example patients with a learning disability.
- Patients have the facility to attend another practice within the group that has different late night or a different Saturday opening if this is more convenient for them.
- As well as discussing significant events with staff, they are discussed with people outside the practice so that ideas for improvement can be shared.
- The practice has a very good skills mix which includes advanced nurse practitioners (ANPs). The ANPs are able to have more responsibility than practice nurses and see a broader range of patients. There is a preceptorship programme in place to support new ANPs to the practice. There is an excellent system for completing and learning from clinical audit cycles, and learning is shared within the practice and with external organisations.
- The practice takes the care of vulnerable people seriously. A GP from the practice attends a drop-in centre three times a week and homeless patients have access to that GP without an appointment. All patients can access the practice for appointments if they prefer.
- The practice takes the care of people with dementia seriously. All staff are 'dementia friends', so know more about how they can help people with the condition.
- The practice proactively looks for feedback from patients and sends a text message to all patients following an appointment to ask one question about their satisfaction. They contact patients who are not satisfied to discuss areas for improvement.
- The business plan is discussed and monitored by the board. At any given time detailed information about the performance of all areas of the practice is available.
- Communication with staff is excellent. Weekly meetings away from the workplace take place and staff receive weekly email correspondence from the chief executive informing them of any relevant information.

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?

Outstanding ☆

The practice was rated as outstanding for safe. Safety within the practice was monitored and ways to improve were identified. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised to support improvement. As well as discussing significant events with staff, they were discussed with people outside the practice so that ideas for improvement could be shared. Information about safety was highly valued and also used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff. There were enough staff to keep people safe.

Are services effective?

Outstanding ☆

The practice was rated as outstanding for effective. Our findings at the inspection showed systems were in place to ensure that all clinicians were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines, and we also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. The practice was using innovative and proactive methods to improve patient outcomes and it worked in partnership with other neighbourhood practices and community organisations to share best practice. There was an excellent system for completing and learning from clinical audit cycles, with learning being shared within the practice and with external organisations. The practice had a very good skills mix which included advanced nurse practitioners (ANPs). The ANPs were able to have more responsibility than practice nurses and see a broader range of patients. There was a preceptorship programme in place to support new ANPs to the practice. The practice was involved in a local scheme where a holistic approach to health and social care was being trialled.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for caring. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient centred culture and found strong 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.

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Are services responsive to people's needs?

Outstanding

The practice was rated as outstanding for responsive. We found the practice had initiated positive service improvements for their patients that were over and above their contractual obligations. The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback directly from patients and from the patient participation group (PPG). The practice had reviewed the needs of their local population and engaged with other services in the area, including the Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients reported excellent access to the practice, with telephone and face to face appointments always available on the day requested. 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?

Outstanding

The practice was rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. A business plan was in place that was monitored and regularly reviewed by the board, and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Staff worked well with the other practices within the group to share expertise. We found there was a high level of constructive staff engagement and a high level of staff satisfaction, and this was monitored. The practice sought feedback from patients, which included using new technology, and it had an active PPG.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Outstanding ☆

The practice was rated as outstanding for the population group of older people. The practice had a register of all patients over the age of 75 and these patients had a named GP. Patients at risk of an unplanned hospital admission had a care plan in place. Housebound patients were routinely visited so they could be given information and advice to prevent hospital admissions. The practice had found their appointment system, where patients could speak with a clinician by telephone on the day they contacted the practice, worked particularly well for older people. They found older patients engaged with the practice at an earlier stage so more serious illnesses could be prevented. The practice worked as part of a multi-disciplinary team to take a holistic approach to caring for the over 65 age group. This was a trial for their area.

People with long term conditions

Outstanding ☆

The practice was rated as outstanding for the population group of people with long term conditions. Patients had an annual review of their condition and their medication needs were checked at this time. When needed, longer appointments and home visits were available. Patients at risk of being admitted to hospital due to their condition had a care plan in place, and this was regularly reviewed by a GP.

Families, children and young people

Outstanding ☆

The practice was rated as outstanding for the population group of families, children and young people. Systems were in place for identifying and following-up children who were at risk. Childhood immunisations were carried out at the practice. The immunisation rate was monitored and take up was good. 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 were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Outstanding ☆

The practice was rated as outstanding for the population group of working age people (including those recently retired and students). Appointments were routinely offered until 6.30pm, with appointments until 8pm one evening each week. The practice was also open one Saturday morning each month. Patients had the

Summary of findings

facility to attend another practice within the group who had different late night or Saturday opening times if this was more convenient. Telephone calls to patients who were at work were made at times convenient to them.

NHS Health Checks were offered to all patients between the ages of 40 and 74. This was an opportunity to discuss any concerns the patients had and identify early signs of medical conditions. Different ways of engaging patients to increase the attendance rate were being trialled and the practice had reported an increase in the take-up rate following invitations being issued by text message.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice was rated as outstanding for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with learning disabilities. They took the care of vulnerable people seriously. Homeless patients could access a GP from the practice without an appointment at a drop-in centre three times a week. They could also be seen at the practice if they preferred. The practice offered longer appointments for people with learning disabilities.

Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice was rated as outstanding for the population group of people experiencing poor mental health (including people with dementia). All staff at the practice were 'dementia friends' which gave them an understanding of dementia and the things that could make a difference to people living in their community. A primary care mental health worker regularly attended the practice and patients were able to see them in the setting they were familiar with. The practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues such as smoking to improve all aspects of their health. Arrangements had been made to see patients who displayed aggressive behaviour at one of the other practices within the group. Additional training had been provided for the staff at the other practice and the premises had been deemed more suitable.

Summary of findings

What people who use the service say

We spoke with seven patients including three members of the patient participation group (PPG).

The patients we spoke with said they were very happy with the service they received. They told us they were unsure about the appointment system when it was changed but everyone we spoke with told us access to GPs had improved, with same-day appointments being the norm. They all told us they spoke to a medical professional on the same day they made contact with the practice, and appointments were made if required. They told us there was no difficulty getting through to the practice by telephone.

Patients told us they were able to request to see a GP of their choice and they felt their requests were met whenever possible. They also told us they could request an appointment with a GP of a specific gender. Patients told us that privacy at the reception desk was difficult as the desk was shared with another practice based in the same building. However, they were aware there was a private room available if they wanted to speak in confidence with a receptionist.

Patients told us they had been offered a chaperone during consultations if this was appropriate, and they said there were notices in consultation rooms telling them that chaperones were available.

The patients we spoke with told us they were routinely asked for their opinion after consultations, or by text messages a few days later. They said they thought this was so improvements could be made. They said staff were helpful and treated them with dignity and respect. We spoke with one patient who usually accessed a GP via the homeless drop-in centre run by the provider. They said they found this to be very helpful.

We were told that the GPs, nurses and healthcare assistants explained procedures in great detail and were always available for follow up help and advice. They said they were given printed information when this was appropriate.

A PPG was in place. This group was a way for patients and the GPs to listen to each other and work together to improve services, promote health and improve the quality of care. Requests for volunteers was advertised in the reception area and text messages were sent to patients to advise them when meeting was due to take place. Most patients told us they were aware of the PPG.

Outstanding practice

- All patients who required an appointment with a GP were seen on the day their request was made. Requests could be made at any time of the day, and the practice had late night and weekend opening so patients not available during working hours could access appointments easily.
- Appointment length was need-specific so GPs arranged longer appointments when they thought this was necessary. Longer appointments were routinely offered to some patients, for example patients with a learning disability.
- Patients had the facility to attend another practice within the group who had different late night or Saturday opening times if this was more convenient for them.
- As well as discussing significant events with staff, they were discussed with people outside the practice so that ideas for improvement could be shared.
- The practice had a very good skills mix which included advanced nurse practitioners (ANPs). The ANPs were able to have more responsibility than practice nurses and see a broader range of patients. There was a preceptorship programme in place to support new ANPs to the practice.
- The practice took the care of vulnerable people seriously. A GP from the practice attended a drop-in centre three times a week and homeless patients had access to that GP without an appointment. All patients could access the practice for appointments if they preferred.

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- The practice took the care of people with Dementia seriously. All staff were dementia friends, so knew more about how they could help people with the condition.
- The practice proactively asked patients for feedback about their experience. A weekly text message was also sent out to all patients who had been seen during the previous week, asking one question. If patients indicated they were unhappy with the service provided they received a follow-up telephone call to ask for more information.
- There was a business plan in place that was regularly discussed and monitored by the board. The practice could give information about their performance at any given time and ways performance could be improved were discussed in meetings as a regular agenda item.
- Communication with staff was excellent. Weekly meetings took place outside the workplace so there were no distractions. The chief executive sent all staff a weekly 'staff matters' bulletin by email. This provided them with any information about the practice including staffing matters, training opportunities, and any changes within the practice. Staff were also regularly asked for their opinion of the practice and areas where improvements could be made. They said they felt comfortable making suggestions and felt listened to by the management team.

Salford Health Matters Eccles

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, a CQC inspector and a specialist practice manager.

Background to Salford Health Matters Eccles

Salford Health Matters Eccles is based in Eccles Gateway, a multi-occupied building in the centre of Eccles. Other services in the building include a library, council services, and other health services such as a community dentist and a smoking cessation service. Primary care is delivered to 4384 patients.

Salford Health Matters (the provider) is a social enterprise, so all staff, including GPs, are employed. The provider has three GP practices and a homeless drop-in service in the area. The practice has a Personal Medical Services (PMS) contract with NHS England.

There are two GPs at the practice, one male and one female, with seven more GPs employed by the social enterprise. All the GPs work across all the practices. Two practice nurses, an advanced nurse practitioner and two healthcare assistants work at the practice. There are administration staff and receptionists, and some of the management team are also based at the practice. Telephone calls are initially answered at another practice in the group.

There were no previous performance issues or concerns about this practice prior to our inspection.

Salford Health Matters Eccles is registered to provide the regulated activities diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease, disorder or injury. These are all provided from Eccles Gateway.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

This provider had not been inspected before under our new inspection process and that was why we included them.

How we carried out this inspection

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

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

Detailed findings

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

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

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked Salford Clinical Commissioning Group and the local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection. The information reviewed did not highlight any areas of risk across the five key question areas.

We carried out an announced inspection on 3 October 2014. During our inspection we spoke with staff including GPs, the chief executive, other members of the management team, a practice nurse, a healthcare assistant and reception and administration staff. We also spoke with seven patients, including three members of the patient participation group (PPG). We observed interaction between staff and patients in the waiting room.

Outstanding ☆

Are services safe?

Our findings

Safe Track Record

We saw evidence that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. They showed us examples of significant events that had been reported to NHS England using the incident reporting system.

The management team, GPs and practice nurses discussed significant events at their regular meetings. These were also discussed by staff within the group of practices and other external staff that attended the meetings so that the provider as a whole learnt from incidents, shared ideas for improvement and took action to reduce the risk of the event re-occurring. The meeting minutes we reviewed provided evidence of new guidelines, complaints, and incidents being discussed positively and openly. These significant events were also discussed at meetings between senior managers who ensured there was shared learning from incidents.

All the staff we spoke with, including reception staff, were aware of the significant event policy and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw evidence to confirm that staff had completed a significant event analysis which included identifying any learning from the incident.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and the senior management team. The team recognised the benefits of identifying any patient safety incidents and near misses. We saw that shared learning from incidents and areas of good practice benefitted the whole service. As well as discussing significant events with staff, they were discussed with people outside the practice so that ideas for improvement could be shared. We saw examples where processes had been changed following incidents being reported. These included ensuring newborn babies were included on their mother's records prior to them being officially registered at the practice.

We reviewed the significant events that had been reported during the year prior to our inspection. These had all been considered and the action taken had been recorded. Significant events and incidents had been discussed by appropriate staff at the practice.

We also reviewed complaints that had been made by patients. We saw that these had been investigated, with patients being given full feedback about their concerns. Evidence was provided that where necessary support or refresher training was given to staff so that improvements could be made.

Reliable safety systems and processes including safeguarding

The practice had an up to date 'safeguarding children, young people, and vulnerable adults' policy in place. This provided staff with information about safeguarding legislation and how to identify, report and deal with suspected abuse. One of the GPs took the lead for safeguarding, and all the staff we spoke with were aware of who the lead was and how they could access the policy on their computers. Staff also had access to the contact details of child protection and adult safeguarding teams in the area.

Clinical staff had received safeguarding training up to level 3, and non-clinical staff up to level 2a. We saw that the training for the majority of staff was up to date, and where a training update was due this had been booked.

All the staff we spoke with were able to discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. The safeguarding lead attended local case conferences and completed necessary reports. Non-clinical staff were aware of their responsibilities and said they would feel confident raising concerns.

Outstanding ☆

Are services safe?

We saw that safeguarding was an agenda item for the regular clinical meetings. We saw evidence that safeguarding and neglect plans were appropriately put in place by the practice where they had concerns.

The practice had an up to date chaperone policy in place. This provided staff with information about when a chaperone should be considered, the role of a chaperone, and who should carry out chaperone duties. We saw that staff had received chaperone training, but it was very rare for staff other than nurses or the healthcare assistant to act as a chaperone. We saw notices in the reception area and next to examination couches in the surgeries informing patients that they could request a chaperone. The patients we spoke with told us they had been offered a chaperone if they required an intimate examination.

Medicines Management

There were clear systems in place for medicine management. If patients required medicines on a repeat prescription these were re-authorised by a GP at least once a year following a medicine review. For patients with long term conditions this was usually at the same time as their annual check-up. There was an electronic system in place to alert the practice if a patient was approaching their medicine re-authorisation date. We saw the process that was followed when this alert was received to ensure medicine was reviewed and re-authorised.

All prescriptions were printed and there were checks in place to ensure prescriptions were secure. Reception staff were aware of questions to ask to ensure the security of prescriptions being collected by patients.

The practice had pharmacy support from the Clinical Commissioning Group (CCG). A pharmacy technician visited the practice each week, and they also provided support to the other practices run by Salford Health Matters. The Chief Executive told us they were discussing with the CCG the possibility of a pharmacist being based at the practice.

We saw there were medicines management policies in place, and the staff we spoke with were familiar with these. We checked the medicines held at the practice. These were all appropriately stored. Medicines to be used in the case of an emergency were available. We saw that these were checked by the practice nurse to ensure they were available and within their expiry date. There was a system in place to re-order medicines when their expiry date was approaching. Clear records were kept whenever medicines were used. Controlled drugs were not held at the practice.

Some medicines and vaccines were kept in a fridge. The fridge temperature was monitored electronically and each day the practice nurse took a print out of the temperatures for the previous 24 hours in graph format. This gave an accurate minute by minute account of the temperature so if there were any fluctuations, for example while vaccines were being removed from the fridge, the safety of the medicines and vaccines could be assessed. The fridge was also alarmed to alert staff to any prolonged temperature changes.

Evidence was seen of medicine audits being carried out. The practice was responsive when new advice was received and carried out medicine audits appropriately. We saw evidence that changes to medicine prescribing were made when required.

When new patients registered with the practice their electronic records were noted that their medicine must be reviewed when their paper records from their previous practice were received. We saw that where a new patient had regular medicines the GP checked this and made an appointment to see the patient to discuss any changes that may be required.

Cleanliness & Infection Control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared hygienic.

Cleaners were employed by the building management company and based in another part of the building. There was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every morning and evening. The staff we spoke with told us that if there were any spillages during the day they telephoned the cleaners who responded very quickly.

There was an infection control policy in place that had been updated in August 2014. This gave full information

about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. It also set out the responsibilities of various staff members at the practice. The practice nurse was the lead for infection control in the practice.

Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated annually. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated to them by the infection control lead.

We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable and had been replaced in September 2014. Examination couches were washable and were all in good condition. Each clinical room had a sharps disposal bin secured to the wall. There was a record of when each bin started to be used.

An infection control audit had been carried out in February 2014 by the infection control team from Salford City Council and the infection control lead. A score of 99% had been given and the next audit was due in August 2015. An infection control audit for minor surgery in community settings had also been carried out in February 2014. A score of 100% had been given.

Equipment

There was a contract in place between the practice and the building management company. The building management company had the responsibility for some equipment checks, such as fire extinguishers. Evidence was kept at the practice to confirm annual safety checks, such as for fire extinguishers, portable electrical appliances and equipment calibration, had been carried out.

Vaccines were kept in a locked fridge. The fridge temperature was monitored with a graph produced every day to show the temperature, at one minute intervals, in the previous 24 hours. Staff were aware of the action to take if the temperature was not within the acceptable range.

The computers in the reception and clinical rooms had a panic button for staff to call for assistance.

Staffing & Recruitment

The practice had an up to date recruitment policy that covered all aspects of the recruitment of staff. We looked at a sample of personnel files for doctors, nurses and reception staff. Most staff had worked for the provider for several years. We saw that pre-employment checks, such as obtaining a full work history, evidence of identity, references and a Disclosure and Barring Service (DBS) check, had been carried out prior to staff starting work.

The provider routinely checked the professional registration status of GPs and practice nurses against the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) register each year to make sure they were still deemed fit to practice. Appropriate checks were also carried out when the practice employed locum doctors.

Safe staffing levels had been determined by the provider and rotas showed these were maintained. Procedures were in place to manage planned absences, such as to cover training and annual leave, and unexpected absences such as staff sickness. The practice worked with the other practices in their group where necessary to ensure there was always a safe number of staff available.

There were clear lines of accountability for all aspects of care and treatment. The GPs and practice nurses had been allocated lead roles, with all GPs having a particular clinical interest.

Monitoring Safety & Responding to Risk

The Practice had a system in place for reporting, recording and monitoring significant events. There were procedures in place to assess, manage and monitor risks to patient and staff safety. The building management company were responsible for aspects of environmental safety. The practice ensured the appropriate checks and risk assessments had been carried out. There was a system in place to inform the building management company of any concerns they had.

The management team had procedures in place to manage expected absences, such as annual leave, and unexpected absences, for example staff sickness. Annual leave for staff was managed to ensure there were sufficient reception staff on duty each day. The practice worked with the other practices managed by the provider, with staff being able to work across more than one site when necessary. The

management team also managed the GP and practice nurse rota so there were enough clinical staff on duty to manage the telephone consultations, face to face consultations and home visits.

We spoke with three members of the patient participation group (PPG). They told us the GPs and management team shared the lessons they had learned around actions that could be taken to improve the service. They said the management team were responsive to any concerns they had, and they were encouraged to share any ideas or any areas they felt the practice could be developed.

We saw that staff refresher training was monitored to ensure staff had the right skills to carry out their duties. There were checks in place to ensure vaccines and other consumables were in date and ready for use. An automatic external defibrillator (AED) was available in the practice. Regular checks on the AED were carried out by staff so they could be satisfied it was available and ready for use. Staff had received training in cardiopulmonary resuscitation (CPR) and use of the AED.

Arrangements to deal with emergencies and major incidents

We saw evidence that all staff had received training in Basic Life Support. This was updated on a regular basis. There was an AED in the practice. All staff knew where this was kept and how it should be used. The reception team leader carried out weekly checks so the practice was assured the AED was in working order. A second AED was located elsewhere in the building.

Comprehensive plans to deal with any emergencies that occurred which could disrupt the safe and smooth running of the practice were in place. We saw the business continuity plan that had been reviewed in September 2014. This covered business continuity such as adverse weather, loss of building use, loss of communications and responses to major incidents. There was a business continuity lead at the practice and all senior staff members had a copy of the plan at their home addresses. All staff had access to the plan on the practice's website. Key contact names and telephone numbers were recorded in the plan.

The staff we spoke with were aware of the action to take in an emergency and how they could access additional advice. They told us that they were made aware of any changes in emergency procedures during weekly meetings or the weekly newsletters received by email from the chief executive.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All GPs and nurses demonstrated how they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical and practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The GPs interviewed were aware of their professional responsibilities to maintain their knowledge.

We saw that patients were appropriately referred to secondary and community care services. Referrals were discussed during clinical meetings. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. The staff we spoke with and evidence we reviewed confirmed that these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinicians base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Practice nurses managed clinical areas such as diabetes or asthma. During regular assessments patients over the age of 55 years were asked if they had any memory problems. Any issues were then monitored and advice given when appropriate.

A member of the management team was responsible for ensuring patients with long term conditions had regular health checks. Patients with some conditions, such as diabetes, had a two-part annual review. The first appointment was with the healthcare assistant, who carried out general wellbeing checks and took blood samples. An appointment was made with the practice nurse for when the blood results had been returned. This meant that all relevant information was available and a new development plan for the patient could be put in place. We saw that annual health reviews were scheduled for the month of the patients' birthday. A 'Happy Birthday' letter was sent to patients that included a reminder that their annual health check was due. The patients we spoke with told us they appreciated receiving these letters and as the system had been in place for a while it served as a reminder that their annual health check appointments should be made around the time of their birthday.

GPs, nurses and the healthcare assistant had the facility to offer longer appointments where they thought this would be helpful. It was usual practice to discuss symptoms with a patient on the telephone prior to an appointment being arranged. Staff could therefore ensure longer appointments were provided where it was felt a more in-depth needs assessment was required. Longer appointments were also made for patients with, for example, a learning disability, so staff had the time to communicate effectively with the patient.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The management team told us clinical audits were often linked to medicines management information and safety alerts. We saw an example of a clinical audit cycle relating to the prescribing of specific medicines. Medicine reviews were carried out for patients where it was felt a change in prescribing guidelines would affect their medication. Records were kept of the decision making process, and where changes to medicines were not appropriate the reasons were recorded.

Doctors undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. Clinical audits were undertaken on their results and the audits were used as a learning tool.

The practice monitored the number of patients who attended for regular reviews of their long term conditions. Where the practice found it difficult to engage with patients they received a telephone call or home visit to see if there were any underlying reasons for their lack of engagement.

Effective staffing

We saw that all new staff, from GPs to receptionists, were provided with an induction pack and a formal induction to Salford Health Matters. This had been created by staff

working with the management team, and the inclusion of all staff in the creation ensured it was fit for purpose and included relevant information. When a new staff member started work the length of the induction period was discussed with them. However, we saw that there was an ethos of supporting staff and the induction period could be extended when necessary. We saw evidence that when a staff member was not performing to the required standard this was investigated and appropriate action was taken.

Systems were in place to ensure all nurses were registered with the Nursing and Midwifery Council (NMC) and GPs with the General Medical Council (GMC). Doctors were revalidated.

The practice employed advanced nurse practitioners (ANPs). The ANPs were able to have more responsibility than practice nurses and see a broader range of patients. There was a preceptorship programme in place to support new ANPs to the practice as it was recognised that working in a GP practice, rather than the more usual hospital setting for ANPs, was very different. The management team told us they had received positive feedback about the availability of ANPs from GPs, nurses and patients, and they were an integral part of the clinical team.

All staff had an annual appraisal. During these meetings a personal development plan was put in place and training needs were identified. All staff were aware of the company objectives and their performance was measured against these, and their personal objectives.

All the patients we spoke with were complimentary about the staff. We observed staff who appeared competent, comfortable and knowledgeable about the role they undertook. The practice and company was organised so there were enough staff to meet the fluctuating needs of patients at all times.

Working with colleagues and other services

The practice was part of a group of three practices plus a homeless service in the area. The management team, including a board of directors, was responsible for the company as a whole. This meant that good practice and areas for improvement could be shared between the practices. Staff at the other sites knew each other as they attended meetings together. Staff had their own base site but were comfortable working on other sites if the need arose.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood test results, letters from the local hospital including discharge summaries and out of hours provider communication could be received electronically and by post. We saw that all letters were scanned so they were available electronically. It had been recognised that there was a delay actioning hospital discharge letters so a new system was put in place and the medical director reviewed all correspondence. They then divided the correspondence between the GPs on a quantitive basis. The medical director told us they had considered allocating correspondence to the patient's named clinician but it was felt this system was most effective. They told us GPs were able to follow up individual patients' results as the correspondence had been scanned, and they did this where they thought continuity was particularly important. The medical director explained that this system was used as an informal quality audit as GPs were used to seeing each others work and could discuss findings and solutions when required.

District nurses and Macmillan nurses attended the regular clinical meetings at the practice. Health visitors and midwives were also based in the same building as the practice. We saw evidence in meeting minutes that the practice involved other professionals appropriately in the care of their patients. If a person with caring responsibilities received certain diagnoses we saw evidence that the relevant social services department was involved. Patients were included in the discussions around this information sharing.

Information Sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Staff reported that this system was easy to use.

Regular meetings were held throughout the practice. These included all-staff meetings, clinical meetings and meetings of the Salford Health Matters board. Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about

how improvements could be made. The management team attended Clinical Commissioning Group (CCG) meetings and information from these meetings was fed back to staff.

The chief executive sent a weekly 'staff matters' bulletin to all staff. This gave information about any changes within any of the group's practices, information from the CCG, and any updates staff would find useful.

There was a practice website with information for patients including signposting, services available and latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area. This waiting area was shared with another practice but the information in the area was managed by Salford Health Matters Eccles. The practice also had a Facebook and Twitter account and these were used to provide timely updates to patients. There was a private room with relaxed seating available where patients could discuss sensitive information with staff away from other patients.

Consent to care and treatment

The practice had an up to date Mental Capacity policy and consent policy in place. Full guidance and examples of forms to record written consent were included. We found that staff were aware of their duties in fulfilling the Mental Capacity Act 2005. The clinical staff we spoke with understood the key parts of the legislation and described how they implemented it. Staff were able to describe the action they would take if they thought a patient did not understand any aspect of their consultation or diagnosis. They were aware of how to access advocacy services. Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing.

Staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to consent. All clinical staff demonstrated a clear understanding of Gillick competencies, used to identify children under the age of 16 who have the legal capacity to consent to medical examination or treatment. All the staff we spoke with were aware of when written consent should be obtained and when informed consent could be given verbally. They knew when patients' records should be noted that their verbal informed consent had been provided.

Health Promotion & Prevention

Some groups of new patients were invited to attend a new patient health check. These included patients who were vulnerable, who had long-term conditions or who had mental health needs. Patients were given a half hour appointment so they were not rushed. As well as being given full information about the practice and all the services they could access, their health check consisted of an assessment of their height, weight and blood pressure. Their lifestyle was discussed to see if self-awareness could improve their health. Depending on the family and medical history of individual patients, blood tests or further investigations could be carried out. The healthcare assistant told us they felt spending this time with a patient when they first registered with the practice was very useful as patients understood all the facilities and services available to them from the practice, had the opportunity to speak to a healthcare professional in a more informal manner and could be alerted to any complications identified from their lifestyle questionnaire.

The practice offered NHS Health Checks to all patients aged 40 to 74 years old. The healthcare assistant had taken responsibility for organising the appointments across the three practices in the group. Since the organisation for the checks had been centralised there had been a large increase in patients booking in for the health checks. Some patients were invited for an appointment via a text message, and this method was proving successful. These appointments were for 30 minutes and patients were given printed information about their risk of developing certain conditions such as cardio-vascular disease.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

The practice identified 224 vulnerable patients over the age of 65 years who had three or more conditions or who received palliative care. Any housebound patients with long term conditions were routinely visited each year at home so they could be given information and advice that may prevent them being unnecessarily admitted to hospital. We saw one of the practice's business objectives was to reduce inappropriate emergency hospital admissions. Personal care plans were put in place for the

Outstanding ☆

Are services effective?

(for example, treatment is effective)

patients most at risk of hospital admission. These were regularly reviewed during weekly meetings and good progress was being made. There was also an Accident and Emergency avoidance scheme looking at preventing paediatric admissions. This was based in one of the other practices within the group but GPs from this practice were involved in the scheme and shared ideas throughout the other practices.

The practice paid particular attention to preventative health and were involved in the Being Well Salford initiative. This initiative worked with patients in areas such as reducing smoking and alcohol intake, weight management and encouraging patients to be more active. The chief executive had been involved in creating, designing and implementing the initiative. Other practices in the area could refer patients to the service, and the practice was the only one in the area to deliver the service. Salford Health Matters Eccles hosted a Being Well Salford 'coach' who worked as part of the practice's team. The practice had a social prescribing service so patients could be referred to programmes such as help to become more active or stop smoking.

The area had a multi-disciplinary group that was in place to achieve greater independence and improved wellbeing for patients over the age of 65. Staff from the practice were fully involved in this group, helping to improve wellbeing by integrating care within communities. This was a pilot for the wider area, and it looked at ways patients could be helped to navigate through the health and social care system. The group looked at a fictional patient called 'Sally Ford'. Aspects of caring such as the use of volunteers, single starting points for care and integrated health and social care were being considered, all with a view to improving outcomes for patients.

The management team explained that the new appointment system, where all patients spoke with a clinician and were then given an 'on the day' appointment with a GP if needed, was working particularly well with older people. They had found that older people were contacting the practice at an earlier stage in their illness, or when they noticed a change in their condition, rather than waiting until they considered themselves 'ill'. This meant that preventative discussions could take place and earlier interventions were preventing more serious illnesses.

Outstanding ☆

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, practice surveys and the friends and family test. The evidence from most of these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the latest national patient survey showed the practice was above average for the clinical commissioning group (CCG) area for receptionists being helpful and the level of privacy when speaking with a receptionist. We saw that 85% of patients said they had confidence and trust in their GP and 72% of patients said their GP was good at treating them with care and concern. These figures were below average for the CCG area. However, all the patients we spoke with told us they were always treated in a caring and dignified manner by all staff, and staff always fully explained everything to them.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The practice switchboard was located in a central hub so calls could not be overheard. The reception desk was shared with another GP practice in the same building. This was a small desk and patients were not given privacy due to the close proximity of the other receptionist. The reception area was quite small, with the door leading to the consultation rooms next to it. The practice had considered ways of improving privacy for their patients but this was proving difficult due to them not owning the building and it being managed by a community health partnership. Under the terms of their agreement they were unable to make some changes that would be beneficial to patients. The staff we spoke with told us they were always careful about what questions they asked patients at the reception desk and they were aware of the need to maintain confidentiality. However, we observed patients disclosing personal information about themselves that other patients and visitors to the building could hear. Although the reception area was not ideal, the level of patients stating they were satisfied with the amount of privacy they had when speaking to a receptionist was above average for the CCG area.

We saw there was a private room available where patients could speak with staff confidentially. This contained informal seating and a coffee table and staff told us it was also used if patients were particularly emotional when they attended the practice.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed, from the national and practice surveys, showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The number of patients who stated the nurse was good at involving them in their care was above average for the CCG area. The patients we spoke with told us they felt fully involved in decisions about their care and treatment and the GPs and nurses explained all aspects of their care to them in a way they understood. They told us they felt listened to and were able to freely express their opinions during consultations.

We saw that care plans were in place for some patients with a view to avoiding unnecessary hospital admissions. In addition all patients with long term conditions such as chronic obstructive pulmonary disease (COPD) or asthma were invited to attend an annual review of their condition. An assessment was carried out to make sure they were on the most appropriate medication for their condition. Patients who required an inhaler were asked to demonstrate how they used it so the nurse carrying out the assessment could be assured they were being used effectively. The records of all patients with long-term conditions were reviewed by a senior clinician, and where invitations to attend an annual review were not taken up other ways of engaging with patients were considered with a view of optimising the care they received.

Regular appointments to manage long term conditions along with NHS Health Checks for patients over the age of 40 years old meant there were opportunities for patients to discuss any concerns they may have with a medical professional. This type of appointment was given enough time so patients were not rushed.

Outstanding ☆

Are services caring?

The consent policy in place provided information so staff knew when patients should be formally involved with and give consent to care or treatment. We were given examples of when family members or carers had supported patients during appointments and helped to explain some aspects of care and treatment. The staff we spoke with were aware of when this was appropriate and when independent advocates should be sourced. All the staff we spoke with told us they took time to be assured patients fully understood everything that went on during consultations. Written information was provided when it was appropriate so patients could refer to this following their appointment.

Patient/carer support to cope emotionally with care and treatment

The appointment system meant that all patients were able to speak with a medical professional within a short time of them contacting the practice. An 'on the day' appointment was always offered when this was appropriate. This on the day contact gave patients assurance that their emotional, as well as physical, needs would be met on the day they requested it. Staff were able to give us examples of where they had gone over and above what was expected of them to support patients emotionally. This included offering appointments outside the usual opening hours when it was felt the need was urgent.

Notices and leaflets in the patient waiting room signposted patients to a number of support groups and organisations. Patients were able to self-refer to these when they had been brought to their attention. In addition, we saw evidence that patients were referred to counselling services, including bereavement counselling, when this was appropriate. We spoke to patients who had received counselling arranged by the practice and they said their needs had been met in a caring way.

The practice routinely asked patients if they had caring responsibilities. They were offered additional support and GPs were aware of local carer support groups that could be beneficial to carers registered with the practice. The patient participation group (PPG) gave us examples of support given to recently bereaved patients. They told us about systems in place to assess their well-being, and said one GP had referred one patient to an organisation where they could have a holiday to look after their well-being following a bereavement.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They were currently trialling different ways of inviting patients for an NHS health check. Early indications were that notifying certain groups of patients by text message had a more positive effect than writing to them. Appointment reminders by text message also decreased the number of patients who did not attend their appointments. If patients did not attend an appointment they received a telephone call to see if everything was okay. Where a patient was housebound or could not attend the practice due to their condition a home visit was arranged.

The NHS Local Area Team (LAT) and Clinical Commissioning group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw that the practice regularly discussed ways of improving access to all population groups. They were intending to submit a bid to deliver 24 hour access for older patients, in partnership with an out of hour's provider. This initiative had been developed by the practice as a way improving access and continuity of care.

The appointment system meant that although patients could always see a GP when required, the appointment was not always with their preferred GP. The patients we spoke with told us that this was rarely a problem and they were able to request an appointment with a specific GP. One patient told us that 99% of the time they saw their preferred GP. They told us that if this was not possible it was explained to them. Patients also told us they could request to see a GP of a specific gender and these requests were usually met.

The practice worked collaboratively with other agencies, regularly updating shared information to ensure good, timely communication of changes in care and treatment.

District nurses and Macmillan nurses attended the monthly clinical meetings where individual patients could be discussed if appropriate. In addition health visitors and midwives were based in the same building and called into the practice when information needed to be shared.

We spoke with three members of the patient participation group (PPG). They gave us examples of improvements that had been made following discussions between the PPG and the practice. These included telephones being answered by a central hub, rather than by each practice within the group, because previously patients found it difficult to get through on the telephone. Changes to the way repeat prescriptions were ordered were also suggested and these suggestions had been used to make positive changes in the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, arrangements were in place to ensure homeless people had regular access to a GP. Homeless patients were registered at the practice and were able to make an appointment there. They were also able to access a GP without an appointment at certain times during the week. These appointments were with a GP from the practice but at a more accessible site. We spoke with a patient who accessed this service regularly. They said they valued being able to do this and felt this was a way of seeing a regular GP who was familiar with their needs.

We saw that travellers were registered at the practice, and it was felt that the regular availability of 'on the day' appointments worked particularly well for some groups of patients, including travellers, at the practice.

The practice had access to a telephone translation service when a patient did not speak English as a first language. One of the practices within the group had interpreters on their site and these could be accessed at times.

The practice was fully accessible for patients with disabilities. It was located on the first floor of a multiple occupancy building and there was a passenger lift. The corridors were wide and all rooms were wheelchair-accessible. There was also an accessible toilet at the practice.

Access to the service

Being responsive to patients' needs was taken very seriously, and this included accessibility to appointments.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice used an appointment system called Doctor First. Appointments with the nurse or healthcare assistant could be booked in advance but it was normal practice for patients requesting a GP appointment to be seen on the day they requested it. Patients telephoned a central hub for the group of practices run by the provider. They were asked for brief information about why they needed to see a GP, then a GP or nurse telephoned them back. Sometimes a telephone consultation was sufficient, but where a face to face appointment was required this was offered for the same day. There were no dedicated appointment slots, so the GP determined the appointment length according to the needs of each individual patient.

If a patient knew they would have difficulty answering a telephone call from the GP, for example if they were at work, they could specify a convenient time. The GP could then schedule a call for during the patient's lunch break or when they had finished work. The patients we spoke with told us there was no difficulty contacting the practice by telephone, and telephones were usually answered within a very short time.

Appointments were available until 6.30pm Monday to Friday, with late night appointments available every Monday until 8pm. The practice was also open one Saturday morning a month, where pre-bookable appointments could be made. The other practices in the provider's group were open late on different nights, and on different Saturday mornings in the month. Patients were able to attend these practices if this was more convenient. Patients did not have to telephone the practice before a certain time in order to access an 'on the day' appointment. All calls made throughout the day were actioned in the same way. The building was open until 10pm, and GPs said that appointments could be booked for later than 6.30pm if there was an urgent need.

We spoke with three members of the PPG. They said that patients on the whole were not receptive to the new appointment system when it was introduced, and patients did not think it would work. However, they all said the system worked very well, and they never had to wait to see a GP. They told us that same day advice from a GP or nurse was the minimum they would receive, and an appointment was made whenever it was required. The practice worked actively with the PPG to improve the service it provided.

Members of the PPG and some patients gave us examples of where they or members of their family had been given appointments to fit in with their requirements, not the GP. They said they were not made to feel they had to have an appointment at a certain time. Their personal circumstances and work arrangements were taken into account. The patients we spoke with told us they were very happy with the appointments system.

The practice was fully accessible to people with disabilities. There was a passenger lift to the first floor practice, and all consultation rooms were along one corridor.

Some patients registered at the practice were homeless. Homeless patients could access any of the three practices run by the provider, but in addition the provider ran a drop in clinic three days a week where homeless patients could access a GP without an appointment. This was located in a centre for the homeless in the area.

All the staff we spoke with were aware of how they could access translation services for patients who did not speak English as their first language. Staff also confirmed that where a translation service was booked a longer appointment for the GP or nurse was made to accommodate the patients' needs.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. It had been recognised that just one person reviewing complaints may not be effective so a new system had been put in place where a minimum of three people had sight of each complaint.

We saw the summary of complaints that had been received in the 12 months prior to our inspection. A summary of the complaint, details of the investigation, the person responsible for the investigation and whether or not the complaint was upheld was recorded. How the practice were made aware of the complaint was also recorded, and we saw that any verbal indications of dissatisfaction were investigated.

We looked at the most recent complaints the practice had investigated. We saw that these had all been thoroughly investigated and the patient had been communicated with

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

throughout the process. The practice was open about anything they could have done better, and there was a system in place so learning as a result of complaints received was disseminated to staff.

Patients' comments made on the NHS Choices website were monitored. These were discussed at practice meetings and where changes could be made to improve the service these were put in place.

All the staff we spoke with were aware of the system in place to deal with complaints. They told us feedback was welcomed by the practice and seen as a way to improve the service. There was a notice in the reception area informing patients how to make a complaint. There was also a notice summarising the stages of the complaints process and patients' rights during the process.

We saw evidence that the Salford Health Matters board received a log of all complaints made so these could be scrutinised. These were looked at by the practice and also at the provider level so the company as a whole could be assessed.

The patients we spoke with told us they would be comfortable making a complaint if required. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. It actively promoted a learning culture. We saw the business plan that was in place, and saw the practice's vision and values were included in various documents. The staff we spoke with were aware of the values of Salford Health Matters.

We spoke with eight members of staff. They were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance Arrangements

We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. All the staff we spoke with were aware of each other's responsibilities. The practice had a number of policies and procedures in place to govern activity and these were available to staff electronically. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place.

There was a management team in place to oversee the systems, ensuring they were consistent and effective. The management team covered all the practices run by the provider. The management team were responsible for making sure policies and procedures were up to date and staff received training appropriate to their role. We saw evidence that feedback from patients was discussed at the weekly staff meetings and learning was applied. The management team also met on a regular basis.

We saw the minutes of four recent clinical meetings. The meetings followed a regular agenda and patient feedback, clinical cases and safeguarding were always discussed. The practice regularly submitted governance and performance data to the Clinical Commissioning Group (CCG).

The Salford Health Matters board produced a quarterly performance report. This gave in-depth information about business objectives. These objectives included improving the quality of essential services, providing preventative health services, and providing out of hospital care. We saw that all performance was measured, and the quality and outcomes framework (QOF) score provided when appropriate.

We saw evidence that there were systems in place to identify poor performance across the staff team. Examples were seen of how this process worked and how poor performance was appropriately investigated. We saw an example of the practice's systems identifying the poor performance of a staff member. We saw evidence that following this being identified it was investigated by senior staff and dealt with appropriately.

Leadership, openness and transparency

We were shown a clear leadership structure which had named staff members in lead roles. For example, there were staff members responsible for the areas of complaints, infection control, and the management of long term conditions. The staff we spoke with were all clear about their own roles and responsibilities. They told us they felt valued and well supported, and they knew who to go to in the practice with any concerns.

We saw minutes from the team meetings that were held weekly. Team meetings were held at a venue away from the practice so there were no distractions. Although a staff member was required to be on the reception at the practice this was on a rota and all staff were able to see the meeting minutes. Staff told us there was an open culture within the practice and they had the opportunity to and were happy to raise issues at team meetings.

Human resources policies and procedures were in place to support staff. We saw these were available to all staff electronically. Polices regarding equality and bullying and harassment at work were included. Staff told us they were aware of the policies and how to access them.

All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise.

Are services well-led?

Outstanding ☆

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

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

The practice carried out an annual patient satisfaction survey over a two week period. In addition to this they used another satisfaction measure called a net promoter score (NPS). This asked patients one question: "On a scale of 0 to 10 how likely is it that you would recommend Salford Health Matters to a friend or family member if they were looking for a new GP service?" A weekly 'NHS friends and family test' was also carried out asking a similar question. This was carried out by sending a text message to all patients who had received a service in the preceding week. Where a patient responded negatively to the friends and family test they were given a personal telephone call to ask for further information. This was then used to make direct improvements to the service.

Previous feedback from patients had indicated they were dissatisfied with the length of time they had to wait for an appointment. We saw that various systems had been trialled and the majority of patients were satisfied with the current system, called Doctor First. In 2009 11% of patients said they were seen by a GP on the day they telephoned, with 72% stating they waited longer than 24 hours. By 2013 80% of patients were seen on the day they contacted the practice, with just 8% stating they waited longer than 24 hours. Current information showed that all patients who required an 'on the day' appointment were given one.

The practice had an active patient participation group (PPG), where 18 members regularly attended. The PPG was open to all patients, so at times up to 25 patients attended the meetings. Information about the PPG was available on the practice's website and notices were displayed in the reception area. We spoke with three members of the PPG. They told us that they met at least once a quarter and patients were notified in advance of any meeting. The practice made use of text notifications to keep patients informed of important news within the practice, including PPG meetings.

Members of the PPG told us they felt valued and thought their views were listened to. We were given examples of where the PPG had highlighted areas where improvements could be made, for example improvements to the telephony system or the way repeat prescriptions were managed. They told us the management team listened to their concerns, made improvements, and monitored these to ensure patients were happy.

The patients we spoke with told us they were often asked for their views on the service they received. They said this was in writing, in the way of formal surveys, by text, or verbally during or following consultations. They told us they felt the practice did this as they wanted to ensure patients were happy and find ways of improving. Patients also told us they had been asked if they would be a 'mystery shopper' for the practice. None of the patients we spoke with had done this, but they said they were told they could report on their experiences after a consultation so the practice had up to date information on what patients thought worked well and not so well.

We saw that all staff received a weekly 'staff matters' bulletin from the chief executive. This gave information about the practice such new staff, information from the CCG and events in the area. Staff were asked for their opinion on matters concerning the practice and they told us they would feel comfortable making any suggestions to improve the service. Staff said the management team constantly looked for areas where they could improve and there was an ethos of improving outcomes for patients and staff within the practice.

Staff were aware there was a whistleblowing policy. They knew who they should approach if they had any concerns and knew the contact details of senior managers within the company who they could contact if required.

Management lead through learning & improvement

We saw evidence that staff had access to learning and improvement opportunities. Mandatory training was provided during the weekly staff meetings. These meetings were also an opportunity for other training to be delivered during protected learning time, and we saw training was monitored and arranged when required.

Peer support and regular formal appraisals were evident. The staff we spoke with told us they regularly attended training courses. Mandatory training was arranged for them and they were able to request relevant training courses that would enhance their performance at work. Clinical staff told us they were supported to maintain their continual professional development (CPD). Staff told us they felt very well supported at work and that the management team had an open door policy so they could raise any concerns

Are services well-led?

Outstanding ☆

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

they had at any time. Clinical supervision and staff appraisals were monitored, with a quarterly report being compiled to be presented to the board. Staff training was also included in this report.

GPs and clinical staff met with other members of the management team regularly. During these clinical meetings cases were examined and GPs discussed if they would have managed any aspect of the case differently. The practice as a whole were focussed on how they could improve the service they provided.

The practice had completed reviews of significant events and other incidents and shared these with staff via their regular meetings to ensure the practice improved the outcomes for patients. This included asking additional questions when patients presented with particular symptoms and consideration of the need for follow up face to face appointments in some circumstances.

The staff files we examined provided evidence that training was up to date and staff had attended appraisal meetings with their line manager. We also saw that new staff followed a formal induction programme where they received regular feedback and were in turn asked for their opinion of how their induction programme was being managed. The management team explained that pay increases were not awarded to staff unless they had completed their mandatory training. Although additional learning was encouraged this was not authorised unless mandatory training had been completed. We saw evidence that all staff had ample opportunity to complete this training.