

Irlam Clinic

Quality Report

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Irlam Clinic on 3 September 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Patients told us that they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there was one area of practice where the provider should make improvements:

The practice had a system in place for handling complaints and concerns. However the information to people should be updated to advise them how to pursue their complaint if dis-satisfied with the response provided by the practice.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

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

Good



Are services effective?

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. The practice reviewed the needs of its local population and engaged with NHS England and the local Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available. However this information should be updated to advise people how to pursue their complaint if dis-satisfied with the response provided with by the practice. The practice also informed us that they recognised the need to generally review their systems for processing complaints to ensure all patients concerns were captured, monitored and responded to appropriately.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. It had a clear vision and strategy. 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 in place to govern activity and held regular clinical and staff meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 that outcomes for patients were good for conditions commonly found in 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. It was responsive to the needs of older people, and offered 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 care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Good



Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

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

Good



Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing in line with local and national averages. There were 112 responses which represents about 3.7% of the practice population.

- 73.5% find it easy to get through to this surgery by phone compared with a CCG average of 73% and a national average of 74.4%.
- 92.2% find the receptionists at this surgery helpful compared with a CCG average of 86.8% and a national average of 86.9%.
- 73% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 83.3% and a national average of 85.4%.
- 89.2% say the last appointment they got was convenient compared with a CCG average of 92.5% and a national average of 91.8%.

- 64.9% describe their experience of making an appointment as good compared with a CCG average of 71.6% and a national average of 73.8%.
- 80% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 66.4% and a national average of 65.2%.
- 71.8% feel they don't normally have to wait too long to be seen compared with a CCG average of 60.1% and a national average of 57.8%.

We spoke with 13 patients who used the service on the day of our inspection and reviewed 46 completed CQC comment cards. The patients we spoke with were very complimentary about the service. Patients told us that they found the staff to be extremely person-centred and felt they were treated with respect. The comments on the cards provided by CQC were also very complimentary about the service provided and the access to that service.

Areas for improvement

Action the service **SHOULD** take to improve

The practice had a system in place for handling complaints and concerns. However the information to people should be updated to advise them how to pursue their complaint if dis-satisfied with the response provided by the practice.

Irlam Clinic

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a second CQC inspector, a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience who is a person who uses services and wants to help CQC to find out more about people's experience of the care they receive.

Background to Irlam Clinic

Irlam Clinic is GP surgery is situated in the Irlam area of Salford. Irlam Clinic is one of two GP practices in Salford operated by Cornerstone Medical Practice. At the time of this inspection we were informed 2,950 patients were registered with Irlam Clinic.

The practice population experiences similar levels of income deprivation than the practice average across England. There is a higher proportion of patients above 65 years of age (17.7%) than the practice average across England (16.7%). The practice has a similar proportion of patients under 18 years of age (15.2%) than the practice average across England (14.8%). 59.2 per cent of the practice's patients have a longstanding medical condition compared to the practice average across England of 54%.

At the time of our inspection two salaried GPs were providing primary medical services to patients registered at the practice supported by a partner GP (who also works at a separate practice operated by Cornerstone Medical Practice). The GPs were supported in providing clinical services by a practice nurse and an assistant practitioner. Clinical staff were supported by the practice manager and the other members of the practice team.

The opening times of the practice were 8am to 6.30pm Monday to Friday. Appointment times were 9am to 11am and 3.30pm to 5.30pm Monday to Friday. The practice has opted out of providing out-of-hours services to their patients. In case of a medical emergency outside normal surgery hours advice was provided by NHS 111. They would then arrange for the out of hours GP service to see patients if required. The practice website and patient information leaflet available at the practice details how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

The practice contracts with NHS England to provide Personal Medical Services (PMS) to the patients registered with the practice.

We noted that there had been changes in the management structure that has implications for the provider's Care Quality Commission (CQC) registration. In particular one of the GP partners named on the provider's registration has left the partnership. This person had also been approved by CQC as the registered manager for Irlam Clinic. We advised the provider about the need to take action to make the relevant applications to ensure their CQC registration is up to date.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

Detailed findings

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?

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)

The inspector :-

- Reviewed information available to us from other organisations e.g. NHS England.
- Reviewed information from CQC intelligent monitoring systems.
- Carried out an announced inspection visit on 3 September 2015.
- Spoke to staff and patients.
- Reviewed patient survey information.

Reviewed the practice's policies and procedures.

Are services safe?

Our findings

Safe track record and learning

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations (for example NHS England and Salford Clinical Commissioning Group (CCG)) to share what they knew. No concerns were raised about the safe track record of the practice. A range of information sources were used to identify potential safety issues and incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients and others. The practice used the Datix significant event reporting system. This system was used throughout primary and secondary care in Salford. We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. This GP had been trained to level 3 safeguarding vulnerable adults and children. Staff demonstrated they understood their responsibilities and all had received training relevant to their role.
- A notice was displayed in the waiting room and consulting rooms, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire

drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as assessments relating to infection control and legionella.

- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead. There was an infection control protocol in place and staff had received up to date training. Infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including the obtaining, prescribing, recording, handling, storing and security of medicines). Regular medication audits were carried out with the support of the local medicines management team to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- Recruitment checks were carried out and the staff files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. We noted that the practice was actively engaged in recruiting staff to cover permanent and temporary vacancies.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training. Oxygen with adult and children's masks was available and this was checked regularly to ensure there were adequate supplies available. The practice did not have a defibrillator. We were informed that the practice had access to the defibrillator belonging to the dental surgery that shares the building

Are services safe?

housing the practice. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines were regularly checked to ensure they were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GP and nurse we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We looked at minutes of regular clinical and practice meetings where new guidelines were shared, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we looked at confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

Discussion with one of the GPs, the practice nurse and assistant practitioner and looking at how information was recorded and reviewed, demonstrated that systems were operating to ensure patients were being effectively assessed, diagnosed, treated and supported.

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 sought 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. It was evident from the discussions we had with one of the GPs that clinical audit was an important feature of clinical practice and documentation relating to a number of such projects was seen. We looked at two clinical audits in detail. These related to repeat prescribing and high risk drugs.

We saw evidence of individual peer review and support to discuss issues and potential improvements in respect of

clinical care. The recent practice meeting minutes we looked at provided details of how the actions to make improvements taken were monitored over time to ensure they were embedded and effective.

Feedback from patients we spoke with, or who provided written comments, was very positive and complimentary in respect of the quality of the care, treatment and support provided by the practice team. There was no evidence of discrimination or barriers in relation to the provision of care, treatment or support.

Effective staffing

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

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, information governance, infection control, manual handling, equality and diversity and mental capacity awareness. Staff had access to and made use of e-learning training modules and face to face training. Staff were given protected time for training.
- We saw evidence that any locum GPs used by the practice had all received an induction into the practice clinical and non-clinical routine ways of working.

Coordinating patient care and information sharing

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 patients who had complex needs or had been diagnosed with a long term condition. There were clear mechanisms to make such referrals promptly and this ensured patients received effective, co-ordinated and integrated care. We saw

Are services effective?

(for example, treatment is effective)

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.

We saw clinicians at the practice followed a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings with other health care professionals to plan and co-ordinate the care of patients. For example gold standard framework meetings were held regularly to discuss the palliative needs of patient's nearing the end of their life. There was also a co-ordinated approach to communicating and liaising with the provider of the GP out of hour's service. In particular the practice provided detailed clinical information to the out of hour's service about patients with complex healthcare needs. Also all patient contacts with the out of hour's provider were reviewed by a GP the next working day.

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

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Health promotion and prevention

All new patients, including children, were provided with appointments to establish their medical history and current health status. This enabled the practice clinicians

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.

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health. A wide range of health promotion information was available and accessible to patients particularly in the patient waiting area 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. Childhood immunisation rates for the vaccinations given to under two year were 100% and for two years to five years ranged from 95.6% to 100%. In respect of influenza vaccinations 86.48% of patients over 65 years had received a seasonal influenza vaccination. The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 82% (The national average is 81.88%). These figures were higher than the national averages.

The provision of health promotion advice was also an integral part of each consultation between clinician and patient. Patients were also enabled to access appropriate health assessments and checks. 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 with long term sickness 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 46 completed CQC comment cards and spoke with 13 patients on the day of inspection. We spoke with people from various age groups and with people who had different health care needs.

Comments we received from patients were very positive in respect of the care and treatment they received at the practice. They told us the practice staff communicated with them well. They also told us staff at the practice treated them with respect, in a polite manner and as an individual. The July 2015 GP patient survey reflected that 73.8% of respondents said the last GP they saw or spoke to was good at treating them with care and concern (CCG average; 85.1%, England average; 85.1%). 87% of respondents said the last nurse they saw or spoke to was good at treating them with care and concern (CCG average; 91%, England average; 90.4%). 91.9% of respondents had confidence and trust in the last GP they saw or spoke to (CCG average; 95.1%, England average; 95.3%). 98.3% of respondents had confidence and trust in the last nurse they saw or spoke to (CCG average; 97.2%, England average; 97.2%).

We observed staff to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patient appointments were conducted in the privacy of individual consultation rooms. Patients said their privacy and dignity was respected and maintained including when physical or intimate examinations were undertaken. 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 if they witnessed any discriminatory behaviour or where a patient's 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.

Care planning and involvement in decisions about care and treatment

Comments we received from patients demonstrated that practice staff listened to them and concerns about their health were taken seriously and acted upon. They also told us they were treated as individuals and provided with information in a way they could understand and this helped them make informed decisions and choices about their care and treatment. A wide range of information about various medical conditions was accessible to patients from the practice clinicians and was prominently displayed in the waiting area.

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 accessible if required.

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 patient care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers. One of the practice team took the lead in this area to maximise the support provided to carers. The practice waiting room contained prominently displayed information about carers and patients are invited to self-refer to the practice with regard to their caring responsibilities. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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 care and treatment to ensure that patient's needs were appropriately met. One of the GPs regularly attends the CCG neighbourhood forum and subsequently updates colleagues at the practice at the regular clinical and practice meetings.

Efforts were made to ensure patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Patients were able to access appointments with a male or female GP if preferred. Longer appointments could be made for patients such as those with long term conditions or who were carers. Home visits were provided by the GPs to patients whose illness or disability meant they could not attend an appointment at the practice.

Systems were in place to ensure that 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. Where patients did not attend such appointments there was a system in place to establish the reasons why and offer another flexible appointment to encourage patients to attend and discuss any concerns they may have.

We saw the practice carried out regular checks on how it was responding to patients' medical needs. This activity analysis was shared with Salford CCG and formed a part of the Quality and Outcomes Framework monitoring (QOF). It also assisted the practice 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.

The practice had a reception area, a patient waiting area and three consultation and treatment rooms. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There were also facilities to support the administrative needs of the practice.

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 services that were individualised and responsive to individual needs 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.

Access to the service

We received 46 completed CQC comment cards and spoke with 13 patients on the day of inspection. We spoke with people from various age groups and with people who had different health care needs. Patients we spoke with or received comments from expressed satisfaction about being able to get through to the practice on the telephone in the mornings and securing an appointment to see a clinician.

The results of the January 2015 GP survey reflected 60.2% of respondents were satisfied with the surgery's opening hours. 75.5% of the respondents found it easy to get through to the practice by phone. 73% were able to get an appointment to see or speak to someone the last time they tried and 73.5% said the last GP they saw or spoke to was good at giving them enough time. 92.2% of respondents found the receptionists at the practice helpful. Also 89.2% said the last appointment they got was convenient and 64.9% described their experience of making an

Are services responsive to people's needs?

(for example, to feedback?)

appointment as good. 64.2% said they would recommend this surgery to someone new to the area. We noted that the practice had acknowledged the results of patient surveys and had implemented action in June 2015 to improve patient access to clinicians. This included increasing the numbers of appointments available and the triage of emergency appointments.

The opening times of the practice were 8am to 6.30pm Monday to Friday. Appointment times were 9am to 11am and 3.30pm to 5.30pm Monday to Friday. The practice has opted out of providing out-of-hours services to their patients. In case of a medical emergency outside normal surgery hours advice was provided by NHS 111. They would then arrange for the out of hours GP service to see patients if required. The practice website and patient information leaflet available at the practice details how to access medical advice when the practice is closed. Patients are also provided with these details via a recorded message when they telephone the practice outside the usual opening times.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. However the information to people should be updated to advise them how to pursue their complaint if dis-satisfied with the response provided by the practice. The practice also informed us that they recognised the need to generally review their systems for processing complaints to ensure all patients concerns were captured, monitored and responded to appropriately as well as formal complaints. This will enable early detection if patterns of concerns are emerging in the issues being raised by patients.

The practice kept a complaints log for written complaints. We looked at all complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was a culture of openness and transparency by the practice when dealing with complaints.

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

The practice manager and one of the GPs 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. Discussions with one of the GPs, other members of the practice team and patients supported that this perception of the practice was widely shared.

Governance arrangements

There were defined lines of responsibility and accountability for clinical and non-clinical staff. Regular clinical and practice meetings were held. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. Discussion with one of the GPs and other members of the practice team demonstrated the practice operated an open and fair culture that enabled staff to challenge existing practices and thereby make improvement to the services provided. 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 partner GP, salaried GPs, practice manager and practice nurse actively participated and interacted with Salford Clinical Commissioning Group (CCG) to keep up to date with local health care trends and developments and shared this knowledge with their colleagues in order to enable them to consider what improvements could be made to develop and improve the services they provided to patients.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and identify areas for improvement. We saw that QOF data was regularly discussed within the practice and action was taken to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought 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. It was evident from the discussions we had with one of the GPs that clinical audit

was an important feature of clinical practice and documentation relating to a number of such projects was seen. We looked at two clinical audits in detail. These related to repeat prescribing and high risk drugs.

Leadership, openness and transparency

The service was transparent, collaborative and open about performance. There was a clear leadership structure. We spoke with ten members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw that clinical and practice 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, during individual appraisal meetings or during the regular informal discussions that took place.

Measures were in place to maintain staff safety and wellbeing. Induction and ongoing training included safety 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 patient surveys and compliments and complaints received. This had prompted the practice to recently implement actions to improve patient access to clinicians. This included increasing the numbers of appointments available and the triage of emergency appointments.

The practice was actively seeking to re-establish a patient participation group in order to maximise feedback from patients and involve them more in developing and improving services at the practice.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they were able to give feedback and discuss any concerns or issues and that their contributions were respected and valued.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through regular

Are services well-led?

Good 

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

training and appraisal. We saw that staff appraisals had taken place and included a process for documenting, action planning and reviewing appraisals. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

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.