Brooks Bar Medical Centre

Quality Report

162-164 Chorlton Road
Old Trafford
Manchester
Greater Manchester
M16 7WW
Tel: 0161 226 7777
Website: No website

Date of inspection visit: 10th November 2015
Date of publication: 04/02/2016

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brooks Bar Medical Centre on 10th November 2015. Overall the practice is rated as Inadequate. Our key findings across all the areas we inspected were as follows:

- The practice was working under pressure to provide a caring and responsive service for the specific population groups associated with their practice, such as patients with mental health problems.
- We saw that staff treated patients with kindness and respect, and maintained confidentiality.
- There was a system in place to report and record significant events and staff were able to give examples of incidents and actions taken to make change, but they were unable to evidence that the changes were effective or ongoing.
- Clinical audits had been carried out with evidence that audits were driving some improvement but patient outcomes remained lower than average for the locality.
- Patients' needs were assessed but care was not always planned and delivered following best practice guidance, such as NICE (National Institute for Health and Clinical Excellence) guidance for referrals.
- Risks to patients were not appropriately assessed and well managed, specifically in relation to medicines management, recruitment and medical emergencies.
- Not all systems, processes and practices were embedded and followed to keep patients safe and safeguarded from abuse. The arrangements within the practice to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and required improvement.
- Staff training was not sufficiently monitored and renewed to ensure all staff had the appropriate knowledge and skills to support their job roles.

The areas where the provider must make improvements are:

Summary of findings

- Ensure that care and treatment is provided in a safe way.
- Ensure that all members of clinical and non-clinical staff understand what constitutes an event of significance to be recorded and reported including informal comments and complaints from patients.
- Ensure that arrangements to safeguard children and vulnerable adults from abuse reflect relevant legislation.
- Ensure that all potential risks are assessed and managed appropriately, specifically in relation to training, Control of Substances Hazardous to Health (CoSHH), health and safety, recruitment checks and Data Barring Service (DBS) Checks.
- Ensure that there are sufficient numbers of suitably qualified and experienced staff to meet the requirements of the service.
- Seek and act on feedback from staff and patients on the services provided and continually evaluate and improve those services

In addition the provider should:

- Identify the positive treatment options the practice is providing to patients with mental health conditions and those who abuse substances. They should liaise with the Clinical Commissioning Group (CCG) and initiate plans to secure improvements.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

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?

Inadequate

The practice was rated as inadequate for providing safe services and there were areas where improvements must be made.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when there were unintended or unexpected safety incidents, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement.
- The practice did not have clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. These risks related to training, Control of Substances Hazardous to Health (CoSHH), health and safety, recruitment checks and Disclosure and Barring Service (DBS) Checks.

Are services effective?

Requires improvement

The practice was rated as requires improvement for providing effective services, and there were areas where improvements must be made.

- Knowledge of and reference to national guidelines were inconsistent. Although patients' needs were assessed, care was not always planned and delivered following best practice guidance. For example we were told that NICE guidance for referrals (which were being looked at through the peer review scheme) were not always being followed.

A number of investigations/checks which were not clinical audits were carried out relating to patient outcomes but there was no evidence that these investigations were driving improvement in performance. The practice were not comparing their performance to other local or national standards.

- Clinical audits had been carried out and these audits were driving some improvement but patient outcomes remained lower than average for the locality.
- Although staff were appraised, this was very much a paper exercise and there was limited recognition of the benefit of the appraisal process and little support for any additional training that may be required.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- The staff at the practice were very caring and were providing a responsive service for the population groups which were associated with their practice such as patients with mental health problems.
- Data showed that patients rated the practice higher than others for some aspects of care such as care and treatment offered by the nurse at the practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Inadequate

The practice was rated as requires improvement for providing responsive services and there were areas where improvements should be made.

- Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. For example there was a large number of patients with mental health problems which the practice responded to, but this had not been discussed with the Clinical Commissioning Group to secure improvements.
- Patients responded differently when asked about making appointments. Some patients said they could easily make an appointment with a GP of their choice but when they got to the surgery there were long waiting times.
- Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised.
- Learning from complaints was not consistently shared and reviewed to ensure it was effective. The practice manager was the person responsible for handling complaints but staff did not fully understand how to process informal concerns from patients.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well led and there were areas where improvements must be made.

Summary of findings

- The leadership structure was fragmented and the GPs worked in isolation. However, there was new and impressive leadership coming from the one of the newly appointed partners and improvements were being made.
- There was a vision to provide responsive, effective, safe and well led care, and the values of staff were in line with that vision, but lack of effective leadership made that impossible to sustain. Staff felt supported by management and listened to, but unable to effect change
- The practice had a number of policies and procedures to govern activity, most of which were overdue a review.
- Feedback from patients had recently been initiated by way of a patient participation group (PPG) and work to develop that relationship was in its initial stages.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. However, staff did not have access to appropriate training to meet those needs and some staff who had requested further training had not received it.

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

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups, resulting in an inadequate rating for that group.

However we also found that :

- All patients over the age of 75 had a named GP.
- The practice provided an in-house phlebotomy/ECG and 24-hour BP monitoring service so that older people did not have the difficulty and cost of travelling elsewhere for this service.
- The practice nurses saw housebound elderly patients at home when required and the health care assistant (HCA) undertook home visits for phlebotomy if required.
- Reception staff had assisted elderly patients to complete bus pass forms and blue badge applications which needed to be done electronically.
- The practice obtained a wheelchair to help patients with poor mobility move around the surgery.

People with long term conditions

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups resulting in an inadequate rating for that group.

However we also found that :

- Patients with chronic diseases received health checks carried out by the practice nurses. The practice had a recall system reminding them when checks were due. If patients were housebound they would receive a home visit by one of the practice nurses.
- Information in the waiting area promoting health care around long term conditions was regularly updated.
- Pre-bookable appointments were available.

Families, children and young people

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups resulting in an inadequate rating for that group.

Summary of findings

However we also found that :

- Ante-natal clinics were held in the surgery by attending midwives.
- Regular baby and immunisation clinics were held. Staff liaised with the community paediatric nursing team .
- No child was ever refused a same day appointment

Working age people (including those recently retired and students)

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups resulting in an inadequate rating for that group.

However we also found that :

- Extended hours surgeries and telephone consultations were available as were telephone consultations. Students were registered as temporary residents and advice was provided on health promotion and contraception when appropriate.
- The practice advised patients of Pharmacy First if they could not attend the surgery during core hours when there was an appointment available.
- Secure e-mail was used via nhs.net and online access to communicate with patients when appropriate and this was monitored daily.
- Electronic prescribing was available for working patients to access this service through their nominated pharmacy and decrease disruption to their working day.

People whose circumstances may make them vulnerable

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups resulting in an inadequate rating for that group.

However we also found that :

- The practice provided 20 minute appointments with the use of face to face interpreters to assist with their high ethnic mix of patients, many with limited use of the English language. Staff used Google translation services in a confidential area to communicate with new patients who spoke no English at all.
- Patients with mental health problems or confusion were never turned away.

Summary of findings

People experiencing poor mental health (including people with dementia)

Inadequate

Although the practice were caring, there were key aspects across the other four domains which were either inadequate or required improvement and this impacted on all the population groups resulting in an inadequate rating for that group.

However we also found that :

- There was a service in place for substance abusers.
- Patients with mental health conditions were seen outside of the appointment structure if they turned up unexpectedly for treatment such as depo injections.
- The practice has attended multidisciplinary meetings when they felt it appropriate to ensure continuity of care.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was performing in line with local and national averages. 445 survey forms were distributed and 112 were returned. This was a 25% response rate and represented approximately 2% of the practice population.

- 79% found it easy to get through to this surgery by phone compared to a CCG average of 79% and a national average of 73%.
- 90% found the receptionists at this surgery helpful (CCG average 89%, national average 87%).
- 73% were able to get an appointment to see or speak to someone the last time they tried (CCG average 85%, national average 85%).
- 92% said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 72% described their experience of making an appointment as good (CCG average 76%, national average 73%).
- 50% usually waited 15 minutes or less after their appointment time to be seen (CCG average 68%, national average 65%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 27 comment cards and the comments contained in the cards were mixed. 14 of the cards contained only positive comments about the practice, the staff and the services received. The remaining 13 cards contained eight negative comments about long waits for appointments, five negative comments about reception and medical staff, two comments about lack of privacy at reception and three negative comments about confusion around prescriptions.

We spoke with 14 patients during the inspection. Most of the feedback from patients was positive about the GPs and the services provided. At least half of the patients spoken to said they waited a long time to get an appointment, and once they arrived at the surgery could wait in excess of 45 minutes to see the doctor. However, most of the patients reported that they received sufficient, appropriate care in a clean environment. One person was very dissatisfied with the treatment they had received and another very dissatisfied with the environment which although clean, (according to the patient) was very old and inadequate.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Ensure that care and treatment is provided in a safe way.
- Ensure that all members of clinical and non-clinical staff understand what constitutes an event of significance to be recorded and reported including informal comments and complaints from patients.
- Ensure that arrangements to safeguard children and vulnerable adults from abuse reflect relevant legislation.
- Ensure that all potential risks are assessed and managed appropriately, specifically in relation to training, Control of Substances Hazardous to Health (CoSHH), health and safety, recruitment checks and Data Barring Service (DBS) Checks.
- Ensure that there are sufficient numbers of suitably qualified and experienced staff to meet the requirements of the service.
- Seek and act on feedback from staff and patients on the services provided and continually evaluate and improve those services.

Action the service SHOULD take to improve

In addition the provider should:

Summary of findings

- Identify the positive treatment options the practice is providing to patients with mental health conditions and those who abuse substances. They should liaise with the Clinical Commissioning Group (CCG) and initiate plans to secure improvements.

Brooks Bar Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience.

Background to Brooks Bar Medical Centre

Brooks Bar Medical Practice was based in Trafford and offered services under a General Medical Services contract to 5737 patients in the Trafford and surrounding areas. The practice lay on the boundary of four areas and the information systems available to the practice did not link with all the secondary care services where patients could be referred.

Information published by Public Health England rated the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. According to the data the practice had a lower than national average number of patients over the age of 65 years, but a higher number of those patients (compared to nationally) were affected by income deprivation. The practice also had a higher population of patients under the age of 18 compared to the rest of the CCG.

There were five GPs in total offering a total of 20 clinical sessions per week. (Two of the partners had recently joined the practice in June and October). One of the previous partners continued to work at the practice as a locum on a part time basis (2 sessions). There were two female and three male GPs. Nursing staff consisted of two female practice nurses working part time, a male health care assistant (in training), 10 administration staff and a practice manager.

The surgery opening times were listed as 8am to 7.30pm on Mondays, Tuesdays, Thursdays and Fridays, closing between 1pm and 2pm for lunch. On Wednesdays the surgery opened at 8.30am until 12.30pm and did not re-open that day. On Saturdays and Sundays the practice was closed. When the practice was closed the patients were directed to the Out of Hours Services. The practice tried not to turn any patients away and sometimes appointments were booked when the reception or surgery was closed.

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. The inspection was planned to check whether the provider is 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.

Detailed findings

How we carried out this inspection

Before visiting we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28th October 2015.

During our visit we:

- Spoke with three GPs, the practice manager, two practice nurses, the health care assistant and several of the reception and administration staff.
- Spent time with the practice manager reviewing various documentation about the practice.
- Observed how people were being cared for and talked patients, patients who were also carers and members of the patient participation group.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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)

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

- There was a system in place for reporting and recording significant events, staff we spoke to told us they understood their responsibilities in this regard and gave examples where action had been taken and learning had been achieved.
- There was no specific policy or protocol to follow about how to record and report events of significance and understanding of events to be reported differed dependenant on what staff were spoken to. When learning was identified there was no documented audit trail to ensure that actions were completed or that learning was effective.
- We were told of a fridge incident which was thoroughly investigated, but this was not recorded on the summary of significant events. We were also told about needle stick injuries, and an incident involving a child where action had been taken following a review., Two of these incidents were recent but were not recorded on the significant event summary. This meant that although events were reported and action was taken, recording was not consistent, in order to analyse trends and to ensure that learning was effective and could be evidenced over time.
- The partners discussed clinical events at meetings but these were not formalised. The significant event process was under review with a plan to hold formal clinical meetings with a formal agenda.

Safeguarding

- Not all systems, processes and practices were embedded and followed to keep people safe and safeguarded from abuse. The arrangements to safeguard children and vulnerable adults from abuse did not reflect relevant legislation and required improvement.
- A generic safeguarding document was stored on the shared drive and had been sent to staff in October 2015 but there was no evidence that staff had obtained and reviewed the document. Levels of knowledge and understanding varied, dependent on who was spoken to. The practice manager told us that admin staff and the GPs had undergone child safeguard training at the appropriate levels but were not adult trained. There was no documented evidence or certificates to support training.
- The nursing staff told us they had undergone safeguard training in adult and children as part of the requirements of their nursing practice and their level and understanding was apparent. GPs told us they were trained to the appropriate levels but there was no documented evidence submitted to support that.
- Staff (including medical staff we spoke with) had limited knowledge and understanding around the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) and Gillick competencies (assessing capacity in children under the age of 16 years).
- There was no formal system in place to highlight concerns about vulnerable patients, any new concerns, missed appointments or children at risk. We saw from meeting minutes that this had been discussed in October and GPs agreed they had their own robust ways of following up missed appointments, for example, families being well known to the practice. This was not a failsafe process and and a protocol was under development.
- The GPs sent reports to the Clinical Commissioning Group (CCG) safeguard meetings but did not attend. There was no evidence to show that any issues in the reports were responded to or followed up.
- There was no chaperone information in the waiting room although there were signs in the consulting rooms. Nurses and administration staff were used as chaperones. Not all administration staff were appropriately trained for this purpose or had the necessary Disclosure and Barring Service (DBS) checks and no risk assessments completed to explain that a DBS check had not been required. The chaperone protocol did not contain the correct information for staff on how to chaperone – for example where to stand when the examination was taking place.

Managing Medicines

Not all of the arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe. The cold chain process was well managed. Patient Group Directives had been adopted by

the practice to allow nurses to administer medicines in line with legislation. However, there were areas which did not reflect relevant legislation and required improvement. For example :

- The practice carried out regular medicines checks, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice advice for safe prescribing. However, best practice advice not always followed as patients still received medicines such as diclofenac and cephalexin which was not in line with best practice due to the adverse side effects and contra indications of these medicines.
- Prescription pads were securely stored in a safe, but there was no system in place to monitor their use.

Other risks to patients were not always assessed and well managed and required improvement. For example :

- We reviewed three personnel files and found that not all appropriate recruitment checks had been undertaken prior to employment and most files were incomplete. For example, we looked at the personnel file for the most recently recruited GP partner. There were no references, employment history or pre-employment medical checks. There was no current DBS check. We were told that the practice did not undertake annual checks of certification and registration with the Nursing and Midwifery Council (NMC) or General Medical Council (GMC), with an assumption that this was maintained by the clinicians.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead and liaised with the local infection prevention teams to keep up to date with best practice. An infection control audit had taken place which identified a number of actions. Those actions had been taken and others were due to be completed. Updates on infection control for staff had not taken place since 2012 and knowledge and understanding of responsibilities ranged dependent on which staff were spoken to.
- The practice manager was responsible for ensuring equipment such as weighing scales, blood pressure machines and other clinical equipment was callibrated and maintained regularly. We saw that this was done in May 2015. However, portable appliance testing had never been carried out to check that electrical equipment was safe to use.
- The practice had a mecury blood pressure machine. There was no protocol to follow or spill kit in the unlikely event of a mercury spill. Mercury spill kits should be on hand anywhere that these mercury blood pressure machines are in use.
- We saw that a gas boiler in the kitchen did not appear to be working and asked the practice manager what steps were taken to maintain the gas boilers in the building. We were told that the gas boiler in the kitchen had been been condemned by the gas board after concerns over a leak. However there was no notice on the boiler that it had been condemned and the practice were unable to produce certification that the gas boilers on the premises were regularly checked.
- There were no legionella or asbestos tests carried out

Arrangements to deal with emergencies and major incidents

- The practice had arrangements in place to respond to emergencies and major incidents but they required improvement.
- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- There was a fire marshall who carried out regular checks of the alarm systems and we saw that equipment such as fire extinguishers had been checked and were in date. There were no regular fire drills and staff had not received appropriate fire training in line with requirements. Responses about what to do in the event of fire varied, dependent on who was spoken to, and no one made reference to a specific protocol.A fire risk assessment had been undertaken in March 2015 resulting in an action plan. Not all the actions on the plan had been completed at the time of our inspection.
- The practice had a defibrillator, first aid kit, emergency medicines and an accident book available on the premises. There was no oxygen with adult and children's masks, and no risk assessment as to whether oxygen

Inadequate

Are services safe?

was required.Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

- There was a health and safety policy, but staff were not aware of it and it had not been reviewed since 2011. There were no regular informal checks of the premises to ensure that they remained safe.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan did not include utility and suppliers contact details and there were no emergency contact details for staff .

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs but did not always deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- There was a system in place to keep all clinical staff up to date with relevant guidance but it was not consistent across all staff. For example, the practice manager disseminated alerts to all staff, regardless of what they were about, and each member of staff was reliant on deciding whether the alert was relevant to them.
- There was no formal sharing of this information, or acknowledgement that all staff had received and actioned the alert. Staff had access to guidelines from NICE(National Institute for Health and Clinical Excellence) but did always use this information to deliver care and treatment that met patients' needs. (Such as following appropriate protocols for referrals)
- The practice did not monitor that guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 491 out of a possible 559 points. This practice was an outlier for some QOF (or other national) clinical targets. Data from 2013/2014 showed:

- The ratio of reported versus expected prevalence for Coronary Heart Disease (CHD) (0.45% against 0.72% respectively) and for Chronic Obstructive Pulmonary Disease (COPD) was lower than the national average. (0.44% against 0.61% respectively)
- The number of recommended Non-steroidal anti-inflammatory drug items (NSAIDs) prescribed as a percentage of all (NSAIDs) prescribed was lower than the national average. (53% against 75% respectively)
- The percentage of non-recommended antibiotic items prescribed was higher than the national averages.(11.5% against 5.3% respectively)
- The practice had high percentages of patients with mental health problems; The good treatment that the practice were undertaking for patients with mental health related illnesses was not reflected in the data that they were providing. All reported mental health related indicators were worse than the local and national averages.

Indicators for patients with diabetes were in line with local and national averages. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 93.62%. The national average was 88.35%.

Other reported indicators were also in line with local and national averages such as :

- The percentage of patients aged 75 or over with a fragility fracture on or after 1 April 2012, who were currently treated with an appropriate bone-sparing agent was 100% compared to the national average of 81.27%
- The percentage of patients with atrial fibrillation (with CHADS2 score of 1), measured within the last 12 months, who were currently treated with anticoagulation drug therapy or an antiplatelet therapy was 100% compared to the national average of 98.32%
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 9 months was 150/90mmHg or less was 90.73% compared to the national average of 83.11%

We saw that completed clinical audit cycles evidenced quality improvement.

- The practice carried out investigations of the data in the system rather than structured clinical audits with action, learning, analysis and review. We saw one example of a full audit cycle relating to unrecorded visits. The audit demonstrated an issue and the practice were able to evidence on the second cycle that the issue was partially improved. Another completed audit cycle related to the number of metabolic effects of atypical antipsychotics. A change was introduced and when the cycle was repeated, the outcome demonstrated that the numbers were reduced.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Although data was analysed and changes to working practice were acknowledged, there was no consistency to monitor that changes were maintained in the long term.

Effective staffing

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. However, we saw that the process to carry out induction was not robust. The most recently employed members of clinical staff had not completed a structured induction.
- The nursing staff were able to demonstrate how they ensured role-specific training and update in relation to patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. This was not something that was monitored by the practice.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. However, staff did not have access to appropriate training to meet those needs and some staff who had requested further training had not received it.
- Basic and mandatory training was not monitored and structured to ensure that it was consistent across all staff. We reviewed the training of three members of staff and found they were not up to date with fire safety training, health and safety, first aid, safeguarding adults, chaperoning, mental capacity or infection control.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available when people moved between services, when they were referred, or after they were discharged from hospital.
- The practice shared relevant information with other services, for example when referring people to other services.
- The practice had a high number of patients with mental health conditions and staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment.
- The practice had direct information links only to Trafford General Hospital and this created limitations when sharing patient information such as referral and discharge letters with Manchester Royal and Salford Royal Hospitals but the practice dealt with that appropriately.
- The practice held monthly district nurse and palliative care meetings which one of the GPs attended. They held other meetings where they discussed clinical registers such as cancer, dementia, depression and other clinical matters. However it was not clear how matters arising out of those meetings were actioned and reviewed. For example there was no review in future meetings about actions arising out of previous ones.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff had a limited understanding of 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, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.
- The practice did not monitor the process for seeking consent to ensure it met the responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice were keen to help patients maintain good health. They had promoted Stoctober (helping patients to stop smoking) and held clinics to provide flu vaccinations. They monitored hepatitis B status in young mothers and provided immunisation to the babies of positive parents.

They identified patients who may be in need of extra support such as those with mental health conditions, and those requiring advice on their diet, smoking and alcohol cessation. They pro-actively identified high drug and alcohol abuse during other health screening visits, offered advice and signposted patients to other support groups or counselling services. They also offered travel vaccinations and had their own phlebotomy services twice a week on a Tuesdays and Thursday mornings.

The practice's uptake for the cervical screening programme was 81% which was comparable to the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test.

Childhood immunisation rates for the vaccinations given were comparable to the national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 66% to 100% and five year olds from 87% to 98%. Flu vaccination rates for the over 65s were 66%, and at risk groups 52%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that members of staff were courteous and very helpful to patients and treated people with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity 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 reception area was not private. However, reception staff knew that when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The responses in the patient CQC comment cards we received were mixed about the service experienced. Some patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect whilst others responded that they had experienced problems when accessing appointments, receiving prescriptions and speaking with some of the staff.

We also spoke with two members of the patient participation group. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey July 2015 showed patients felt they were treated with compassion, dignity and respect. The practice was average for its satisfaction scores on consultations with doctors and nurses. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 90% and national average of 89%.
- 87% said the GP gave them enough time (CCG average 88%, national average 87%).
- 91% said they had confidence and trust in the last GP they saw (CCG average 97%, national average 95%)
- 82% said the last GP they spoke to was good at treating them with care and concern (CCG average 87%, national average 85%).
- 90% said the last nurse they spoke to was good at treating them with care and concern (CCG average 87%, national average 85%).
- 90% said they found the receptionists at the practice helpful (CCG average 89%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us that they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed that some patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 74% said the last GP they saw was good at involving them in decisions about their care (CCG average 83% , national average 81%)

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice did have a carers register but there was no formal system to identify carers and the GPs utilised their long term knowledge of the patients in the practice to identify any issues. Written information and personal

Good

Are services caring?

advice was available directly to carers by the GPs and they were able to signpost them to other avenues of support when required. The Trafford Carers' Booklet was available to patients in reception.

Staff told us that if families had suffered bereavement there was no formal protocol to follow and individual GPs contacted the family and would support them if required.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- Patients could be seen on-the-day if they felt their appointment was urgent, and sometimes arrangements were made to see patients when the practice was closed. However, there were no specific extended hours' surgeries and the practice did not open after 1pm on a Wednesday which meant that patients had to seek other services if they needed to see a GP at those times.
- The practice was very responsive to patients with mental health problems providing longer appointments and one-to-one support. They were flexible with patients who presented with confusion or dementia and never turned anyone away if they presented at the practice unexpectedly.
- They maintained continuity of care for patients with learning disabilities offering full reviews during other consultations in order to minimise the number of appointments

Access to the service

The surgery opening times were listed as 8am to 7.30pm on Mondays, Tuesdays, Thursdays and Fridays, closing between 1pm and 2pm for lunch. There were no specific appointment times listed on the NHS choices website and the practice did not have a website of their own. We were told by the staff at the practice that appointments ran alongside the times when the practice was open. On Wednesdays the surgery opened at 8.30am until 12.30pm and did not re-open that day. On Saturdays and Sundays the practice was closed. When the practice was closed the patients were directed to the Out of Hours Services. The practice tried not to turn any patients away and sometimes appointments were booked when the reception or surgery was closed.

70% of appointments were booked in advance and this took up a third of the day's appointments. The practice operated an urgent access list which was not triaged and patients were accepted on to this list if the patients themselves felt it was necessary. This over-responsiveness meant that waiting times upon arrival were lengthy, with most pre-booked patients waiting longer to be seen than those who had booked an urgent slot. No child was ever refused a same day appointment.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. People told us on the day that they were were able to get appointments when they needed them.

- 70% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.
- 79% patients said they could get through easily to the surgery by phone (CCG average 79%, national average 73%).
- 72% patients described their experience of making an appointment as good (CCG average 76%, national average 73%.
- 50% patients said they usually waited 15 minutes or less after their appointment time (CCG average 68%, national average 65%).

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns.

- Its complaints policy and procedure followed guidance and contractual obligations for GPs in England. Information about how to complain was available and easy to understand and evidence showed that the practice responded to issues raised.
- Learning from complaints was not consistently shared and reviewed to ensure it was effective. The practice manager was the person responsible for handling complaints but staff did not fully understand how to process informal concerns from patients
- We saw that information was available to help patients understand the complaints system

We looked at four complaints received in the last 12 months one of which was referred to the Ombudsman. Formal complaints and concerns were dealt with satisfactorily in an open and transparent way and lessons to change working practice were implemented. One complaint led to a change in the practice's policy for prescribing antidepressents and the action point was placed on the patient's records. The action was not monitored or reviewed to see if the change had improved outcomes for all patients.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

Staff expressed a desire to deliver good care and felt passionate about their roles but there was no formal vision and strategy being fed down from the leads of the practice.

- The leadership structure was fragmented and the GPs worked in isolation.
- There was new leadership coming from one of the newly appointed partners and improvements were being made but there was no formal mission statement and the values were not yet well enough embedded to create a positive impact.
- Most of the staff we spoke to shared the values to deliver good care and were passionate about their roles and responsibilities in that regard. However, the ineffective leadership did not support staff to be clear about how to improve the service in a structured and formal way.
- There were no formal strategies, business plans or leadership which supported the individual visions and values of the staff.

Governance arrangements

The practice had an overarching governance framework but it did not support delivery of the vision and values and good quality care.

- Most of the policies and procedures in place required review and renewal and staff did not refer to them.
- Staff were aware of their own roles and responsibilities but these were mostly carried out in isolation with differences in working practice. This prevented effective change and improvement being brought about .
- The practice did not hold any governance meetings. The GP informed us that they discussed governance on an informal basis and no minutes were kept.
- There was no risk log to address potential issues, such as control of substances hazardous to health (COSHH) or a robust analysis of significant events over time.
- Although clinical and internal audit was completed, the arrangements for identifying, recording and mitigating risks were not effective and there was no continual monitoring with a view to improving outcomes for patients.

Leadership, openness and transparency

The partners were visible in the practice and all the staff we spoke to said they were approachable and listened to their views. However they said they felt powerless to effect change. It was evident that their views were not taken on board as little or no change had been brought about to improve the service.

- The partners were working in isolation and acknowledged that change was required to improve outcomes for patients.
- Leadership in the practice was ineffective for the purpose of bringing about improvements to the service.
- One of the newly appointed partners was taking an influential role and was working with the lead partner to implement change in the practice. They were engaged in a process to prioritise safe, high quality responsive and well led care.

Seeking and acting on feedback from patients, the public and staff

- Feedback from patients, the public and staff was minimal and was not pro-actively encouraged.
- The practice had recently set up a patient participation group which was in its early stages and feedback we received from patient representatives was positive.
- The new partner had attended the initial meeting with the practice manager and they were trying to use the information given to them by the representatives to improve the services offered at the practice.Suggestions included review of the appointment system and better education of patients about other services available to them before accessing their GP.

Continuous improvement

We identified that continuous learning and improvement was not consistent at all levels within the practice.

- Administration and reception staff were not pro-actively encouraged to keep up to date with their required mandatory skills.

Are services well-led?

Inadequate

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

- Nursing and medical staff kept their own skills up to date through their own peer review channels but this was not monitored.
- There was no evidence that training was being monitored and led by the practice in a pro-active way to ensure that staff skills were maximised.
- They had identified that more staff was required if the practice was to run efficiently but no plans for future recruitment had been made.
- There was an opportunity for the practice to move into new premises with other practices and because of this opportunity, plans to make improvements at the existing premises had been placed on hold. The delay was not sustainable and improvements were required in the interim.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not sufficiently assess the risks to the health and safety of patients** **Regulation 12(1) and (2)(a)(b)(c)(g)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **Systems and processes were not established and properly operated to ensure that all patients were prevented from abuse** **Regulation 13 (1) (2) and (3)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Staff did not receive appropriate support, supervision and qualifications to enable them to carry out their duties effectively** **Regulation 18 (2) (a) and (b)**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Recruitment procedures were not established and operated effectively to ensure that persons employed met the conditions in paragraph (3) of the regulation.**

This section is primarily information for the provider

Requirement notices

Not all the personnel files contained all the information specified in Schedule 3 - Information required in respect of persons employed or appointed for the purposes of a regulated activity.

Regulation 19 (2)(a) and (3)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Systems and processes were not properly established and effectively operated to ensure the quality and safety of the services provided.** **Regulation 17 (1) and (2) (a)(b)(e) and (f)**