

North Trafford Group Practice

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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



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 North Trafford Group Practice on 19 January 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing effective, caring and responsive services. It was also required improvement for providing services for all the population groups that we assess. It required improvement for providing safe and well led services.

Our key findings 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 not always fully assessed and managed.

- People's 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.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it was usually easy to make an appointment with their 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.
- The leadership structure was new and not yet embedded fully.
- Staff were not always fully supported and their feedback not routinely sought.

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

Summary of findings

The areas where the provider must make improvements are:

- Ensure medication stock is appropriate and well monitored.

The areas where the provider should make improvements are:

- Ensure the level of nursing support is sufficient to meet the practice needs.

- Review equipment that is no longer used or has not been tested or calibrated.
- Ensure that clinical audit cycles are completed.
- Clarify leadership and the practice vision and embed amongst staff with more support for staff where required.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. 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. For example medicine management and staffing levels for nursing services.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. Multidisciplinary working was evidenced.

Good



Are services caring?

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



Are services responsive to people's needs?

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

Good



Summary of findings

Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it. Most staff felt supported by management but at times they weren't sure who to seek guidance from about issues they had. Governance meetings were held regularly but not all staff attended these. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All staff had received inductions but not all staff had received regular performance reviews, attended staff meetings and events or been requested to feedback their views.

Requires improvement



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 requires improvement for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



People with long term conditions

The practice is rated as requires improvement for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. An electronic system had been introduced to assist in ensuring that people with multiple long term conditions were quickly identified. 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. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the population group of families, children and young people. Immunisation rates were high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises was suitable for children and babies, emergency appointments were reserved daily for children less than three years. All children were seen on the day the appointment was requested. We were provided with examples of joint working with midwives, health visitors and district nurses. Processes were in place to make urgent referrals to specialists for children and pregnant women who had a sudden deterioration in health. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



Summary of findings

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the population group of the working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. Extended hours of opening were available on Wednesday evenings and plans were in place to increase these. The practice was proactive in offering a full range of health promotion and screening which reflected the needs for this age group. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the population group of people whose circumstances may make them vulnerable. The practice had carried out annual health checks for people with learning disabilities and a system was in place to follow up those who did not attend. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. There were no barriers to people in vulnerable circumstances registering with the practice and accessing the services provided. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



People experiencing poor mental health (including people with dementia)

The practice is rated as requires improvement for the population group of people experiencing poor mental health including people with dementia. A system was in place to ensure people experiencing poor mental health had received an annual physical health check. The practice regularly worked with the local mental health team and other mental health professionals in the case management of people experiencing poor mental health including those with dementia. The practice had a system in place to refer patients for counselling. A number of local groups were available to offer support for people with poor mental health. Staff were proactive in promoting these. Improvements around medications management and staffing levels for nurses were required.

Requires improvement



Summary of findings

What people who use the service say

We received 21 completed CQC patient comment cards and spoke with eleven patients at the time of our inspection visit. We spoke with mothers with young children, working age people, older people and people with long term conditions.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice was average or higher than average amongst practices in the area:

79% of respondents found the receptionists at the practice helpful

90% of respondents said the last appointment they got was convenient

89% of respondents said the last GP they saw or spoke to was good at listening to them

90% of respondents described their overall experience of this surgery as good

Areas for improvement

Action the service **MUST** take to improve

- Ensure medication stock is appropriate and well monitored.

Action the service **SHOULD** take to improve

- Ensure the level of nursing support is sufficient to meet the practice needs.

- Review equipment that is no longer used or has not been tested or calibrated.
- Ensure that clinical audit cycles are completed.
- Clarify leadership and the practice vision and embed amongst staff with more support for staff where required.

North Trafford Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice nurse).

Background to North Trafford Group Practice

North Trafford Group Practice has two locations, the main location is on the main A56 Chester Road in Stretford. At the time of this inspection we were informed 10,000 patients were registered with the practice. Three years ago the practice had merged with a smaller practice located within a community health building on Seymour Grove, some two miles away. The second location is based within a building at Seymour Grove which is owned by NHS England property services and the practice maintains a contractual agreement around certain functions such as cleaning and maintenance.

The practice consisted of six GPs (five partners and one salaried GP, three female and three male). These GPs are providing general medical services to registered patients at the practice under a general medical services (GMS) contract. The GPs are supported in providing clinical services by three part time nurses (female), and a part time health care assistant (HCA) (female). Clinical staff are supported by the practice manager and her team who are responsible for the general administration, reception and organisation of systems within the practice.

The practice is part of the North Trafford practice manager's forum which consists of 12 GP practices who regularly meet to share information and identify best practice. The out of hours service is provided by Mastercall.

The CQC intelligent monitoring placed the practice in band 5. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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.

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

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:

Detailed findings

- 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 living in vulnerable circumstances

- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19th January 2015. During our visit we spoke with four GPs, one nurse, the HCA, the practice manager and reception staff. We also spoke with patients who used the service and two members of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at minutes of team meetings and confirmed that these issues were discussed and any learning was put into practice.

The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and sent to the clinical staff for their information. The practice manager told us how they were currently working to improve the accountability for these alerts so that each one was allocated to an individual GP and readily able for review at any time on a new electronic information management system. We saw that alerts were being appropriately progressed and discussed at team meetings, these meetings were recorded and we saw the minutes were clear and concise.

Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Minutes of meetings evidenced that significant events and changes to practice were discussed with practice staff. Action was taken to reduce the risk of recurrence in the future. The GP completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. If it was deemed necessary, events and lessons learned were shared with multi-professional agencies outside the practice, for example Trafford CCG. The Practice Manager told us that regular clinical meetings were held weekly but that full staff

meetings had become much less frequent since the merger with the practice at Seymour Grove, we were told that plans were in place to increase the number of full staff meetings so that they took place monthly.

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. For example we saw that an incident involving a mis-medication had been identified, investigated, reviewed and shared with the appropriate agency. Lessons learned had been implemented; the process had demonstrated that the practice had an open, transparent learning culture. The mistake had also been communicated to the patient with a full explanation and an apology; this demonstrated the practice's commitment to its duty of candour.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3 for children) safeguarding training had been completed by all the GPs. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Staff were also aware of how to raise issues about staff within the practice via the whistleblowing procedure. We noted that the practice whistleblowing policy did not contain the national contact telephone number for staff to use if they wished to raise concerns without informing practice management. The Practice Manager told us that this would be rectified and the update policy made available on the practice computer system, as all practice policies were.

Reception staff and practice nurses were available to chaperone patients who requested this service and information about this service was available in the waiting

Are services safe?

area. Staff had been trained in how to chaperone. When we spoke to reception staff they told us that they were confident in performing a role as a chaperone, and told us that the clinicians would always explain in full to the patient and chaperone what they were doing and why and that they would comply with the wishes of the patient regarding where they should stand in the room whilst any procedure was taking place.

Medicines management

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

Management of medicines was the responsibility of the practice medicines managers. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the practice internal systems. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. A system was in place for monitoring any prescriptions that had not been collected and a written record was kept. Prescription security was well managed by the practice. Any medication errors were treated as significant events.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. At the Chester Road site we saw that the vaccine fridge was fitted with a system to record the temperature when staff were not on premises so that any loss power and subsequent temperature fluctuation could be identified. We saw that the temperature of the fridge had been recently checked. We noted that all vaccines contained in the fridge were within the date for use. We noted that the vaccines fridge was very heavily stocked. This may have an adverse effect on its function. We spoke to the HCA about this and she told us that she had ordered a large supply of medicines as she was unsure of how much was required. There was no system in place to monitor and order stock so that it remained at a level to meet the practice needs.

At the Seymour Grove site the vaccine fridge had a single thermometer, meaning that temperatures were not monitored whilst staff were away from the practice. We saw from records that the fridge temperature was regularly not checked for many days. This meant that if there was a loss of power to the fridge, vaccines could have remained at temperatures above that which they should be stored. We saw that the vaccines within the fridge were in date,

however the boxes in which they were stored had either become wet or subject to something that meant the external date stamps had become invisible and the boxes were stuck together, the HCA could offer no explanation for this. We discussed this with the Practice Manager who told us that more robust systems for checking fridge temperature would be introduced and that that the current stock of vaccines in that fridge would be destroyed. We saw records to show fridge temperatures had been checked, however they was no documented audit of these to ensure staff were making regular checks. The Practice Manager told us that they did examine fridge check sheets to ensure checks were completed; they told us that these audits would be documented in future.

We noted that both fridges used for storing vaccines were hard wired. A cold chain policy was in place to ensure that the drugs requiring storage at particular temperatures were dealt with appropriately. Staff we spoke to told us they were clear on the policy and how to implement it.

We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date.

Cleanliness and infection control

Systems were in place for ensuring the practice was regularly cleaned at both sites. A system was in place for managing infection prevention and control. We saw that a recent audits relating to infection control had been completed by the Practice Manager at the Chester Road site.

We saw at the Seymour Grove site that the privacy curtains in the consulting room were of the re-usable type but there was no date on them to indicate when they had last been cleaned or when they were due to be cleaned. The Practice Manager told us NHS England property services were responsible for cleaning the building and some infection control measures as they owned the building. We were told that practice staff had verbally confirmed with the cleaning contractor that the curtains were within their date for cleaning, we saw no documented proof of this.

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

Are services safe?

were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to staff about handling samples provided by patients, they had a sound knowledge of how to deal with these, however there was no documented protocol in place.

We looked at the treatment rooms used for consultations and minor procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. Appropriate signs were displayed to promote effective hand washing techniques.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed. Sharps boxes were provided for use and were positioned out of the reach of small children.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing (PAT) and calibration of equipment such as fridges and other electrical devices. Documentation evidenced that equipment in use was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Most equipment was single use only and appropriate measures were in place for cleaning equipment that was not single use. We looked at medical equipment that was stored at the Chester Road site in readiness for use and found that it was all within the manufacturers' recommended use by date.

At the Seymour Grove site we found some equipment that the date for use had expired, for example a spirometer (a device for measuring lung capacity) which should have been checked and calibrated in March 2013 and a Smokerlyzer (a device for measuring carbon monoxide in a person's breath) that should have been checked in March 2014. The HCA told us that these instruments were no longer in use. There was a hand held fire extinguisher in the treatment room that had a check date of 2001. In the same room we saw a small wall mounted fridge that had not

been PAT tested since March 2007, there was nothing in the fridge, but it was switched on and operating. We spoke to the Practice Manager about these matters and they assured us that they would be attended to.

Staffing and recruitment

The provider recruitment policy was in place and up to date. We looked at two staff files and saw all of the employment checks that were required to be carried out had been completed. The GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses and reception staff who carried out chaperoning duties also had DBS checks completed.

The practice had encountered staffing problems since the merger with the practice at Seymour Grove, a number of clinical and administrative staff had left for a variety of reasons. The Practice Manager told us that recruiting suitable staff, particularly nurses had been difficult. This had resulted in three part time nurses working a small number of hours totalling 0.95 of a full time position. The practice realised that this was insufficient nursing staff to effectively support the service. Some of the effects of this included the HCA having little clinical support and having their appraisal completed by a non-clinician. We talked to the Practice Manager and four of the GPs about the position and they told us that they intended to make it a priority to recruit additional nursing staff to bring the amount of cover to a more suitable level. The levels of staffing of GPs and administrative/reception staff was sufficient to meet the needs of the practice. Patients we spoke to expressed confidence and admiration for all the staff at the practice.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an

Are services safe?

accident occurred and ensure that it was recorded. The practice had a detailed Health and Safety policy this and all other practice policies were available to all staff at any time via the computer portal.

Arrangements to deal with emergencies and major incidents

Basic life support training was done every year with all staff and this included using a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and the buildings had been surveyed by fire safety professionals to ensure it was safe and suitable measures were in place.

We saw emergency equipment and emergency drugs which were available and staff knew where these could be located. We saw that emergency drugs and equipment were regularly checked by the practice nurses to ensure it

was operative and within the manufacturer's recommended usage date. We did note that emergency drugs were located on the ground floor and none were immediately available on the first floor where the nurses provided immunisations. We discussed the need for emergency equipment to be immediately available for example adrenalin in case of anaphylactic shock, the Practice Manager told us that suitable equipment would be provided on the first floor.

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. The plan was available for all staff. Each member of staff we spoke with was aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and HCA. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance. The practice had a documented system for reviewing patients with specific conditions. The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included cardio pulmonary obstructive disorder (COPD) and asthma. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. These patients were identified using a system called “patient chase” which used data stored on patient records to automatically identify patients with complex conditions. We saw that the practice ensured that checks on patients’ blood were completed before the reviews to ensure the GP had as much information available as possible.

Care Plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma and heart failure. We reviewed a sample of these care plans and saw they were detailed and had been used by other health professionals to make informed decisions, for example one had been used by a paramedic to gather information about whether a patient should be admitted to hospital, it had been helpful in making the decision that this was not necessary on that occasion. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. GPs told us this supported all clinical staff to continually review and discuss new best practice guidelines. The review of the clinical meeting minutes confirmed this had been taking place.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff

meetings and local forums where appropriate. All the GPs at the practice referred to guidance called “map of medicine” as and when they required to. This is a repository of clinical information available on line for clinicians to seek guidance on particular issues.

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. If information was deemed to be particularly significant, it was flagged to appear on the patient’s home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice had a system in place for completing clinical audit cycles; however these were not always completed. The GPs and Practice Manager were aware that further work was required to complete audits so that all the learning possible was available from the process. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice’s engagement with local CCG audits.

We saw no evidence of documented peer review within the practice and we discussed this with the Practice Manager and one of the GPs. They both confirmed that peer review was completed on a regular basis in clinical meeting and by ad hoc discussions; they recognised the need to document reviews and told us that this would be introduced. We were told that the problems caused by the merger had meant that some documentation issues had not been at the forefront of the practice’s priorities, but now that the issues caused by the merger were mostly resolved these areas would receive more focus.

The GPs had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as joint injections, gynaecology and safeguarding patients. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff

Are services effective?

(for example, treatment is effective)

team at the practice. We spoke with two members of patient participation group (PPG) who told us how they both felt that the service delivered by the GPs was very person centred. They told us that the GPs had a very good understanding of the cultural and religious needs of the community that they provided a service to.

Effective staffing

All the staff we spoke to at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice. Most staff were multi-skilled and able to carry out the role of their colleagues at short notice if required. The GPs told us they led in specialist clinical areas such as joint injections, diabetes and gynaecology. The practice had identified that the fact the one of the GPs had a lot of expertise in gynaecology had led the practice making very few referrals to secondary care for issues related to this subject. The HCA we spoke to had previous training and experience in a mental health setting and so was able to offer advice to other patients and other members of staff.

Most staff reception were long serving, nursing staff were relatively new and the one we spoke to had been employed at the practice for eight weeks and was becoming familiar with her roles and responsibilities. Patients we spoke to spoke particularly highly about the patience and professionalism of the reception staff. There was an induction process for any new staff which covered areas such as the practice ethos, introduction to policies and procedures and health and safety issues. We saw that the Office Manager maintained a clear chart documenting staff commitments and how absences would be covered. They told us that this gave them a clear view of staffing requirements and enabled them to advise the Practice Manager on the ability to grant annual leave based on the projected staffing levels.

The GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the general medical council (GMC), that they were up to date and fit to practice. The GPs we spoke to told us they undertook regular clinical appraisals.

All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients.

Information sharing

GPs met regularly with the practice nurses and the Practice Manager. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. Practice meetings for all staff had become less regular since the practices had merged; the Practice Manager told us that these would occur more regularly in future. Regular meetings involving all team members keep staff up to date with current information around enhanced services, requirements in the community and local families or children at risk.

Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Manager regularly attended area Practice Manager meetings, which they formerly chaired, to share information about their role and maintain their professional knowledge.

Are services effective?

(for example, treatment is effective)

There was an informative practice website with information for patients including signposting, the PPG and out of hours contacts. The PPG had become an effective method of communicating information between the patients and practice staff; we saw that results of the PPG survey were available on the practice website in the form of actions and responses from the practice. We talked with two members of the PPG who confirmed that the practice was very responsive to patient feedback. One example provided related to the practice removing the premium rate telephone number after a suggestion from patients. Information leaflets were available within the practice waiting room and notices provided an array of support information. We saw that the results of the patient satisfaction survey were published on the practice website.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers and any other information relating to consent was scanned onto the system and alerts set up to notify clinicians.

GPs and clinicians had received training in the Mental Capacity Act and we saw evidence that patients were supported in their best interests, with the involvement of

other clinicians, families and/or carers where necessary. We looked at a documented example of where one of the GPs had been involved in making a best interest decision for a patient, we saw appropriate people had been consulted and an auditable document trail had been completed.

The 2014 national GP patient survey indicated 84% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 80% said the last GP they saw or spoke to was good at involving them in decision making and 97% had confidence and trust in the last GP they saw or spoke to. These percentages were above the average for the area.

Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse or the HCA. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. We saw that the annual flu vaccination campaign was near completion at the practice.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to 11 patients in person and received feedback from 22 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was offered. Staff had received training on how to be an effective chaperone.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in confidentiality, bullying and harassment, data protection and information governance. We also noted that there were practice policies to cover all these areas.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 85% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 95% of respondents said the last nurse they saw or spoke to was good at listening to them. These percentages were higher than those for most other practices in the area.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best for their health. Patients told us that clinical staff were very patient and took time in ensuring that they understood treatments and medications before they left the consultation.

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

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients. Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2014 GP patient survey reported that 80% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 89% of respondents said the last nurse they saw or spoke to at the practice was good at explaining tests and treatments. These percentages were higher than most other practices in the area.

Patient/carers support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

The practice had a palliative care register and held regular multidisciplinary meetings with community healthcare staff to discuss the care plans and support needs of patients and their families. We saw evidence of these meetings minutes. Patient care plans and supportive information informed out of hours services of any particular needs of patients who were coming towards the end of their lives.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patients' needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular commissioning group meetings, practice manager meetings, primary health care team meetings and meetings with community matrons and district nurses.

Patients were able to access appointments with a named doctor where possible. Patients told us that reception staff were very flexible in trying to ensure they saw their preferred GP. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews. The practice worked closely with a local alcohol support organisation called Phoenix Futures and told us how patients needing support were encouraged to use the service.

North Trafford Group Practice had a reception area at both sites and sufficient consultation and treatment rooms. There were also facilities to support the administrative needs of the practice (including reception offices, practice manager's office and meeting rooms). Both buildings were easily accessible to patients including those with a disability.

The practice had an effective and active PPG and we saw that information about the PPG was displayed around the reception area. A section of the practice website provided information about the PPG and how it responded to patient needs and suggestions. We looked at the both the 2012/13 and 2013/14 patient questionnaire action plan and saw it contained information on the issues raised and how they would be addressed. The information in the PPG section included data about the age and ethnicity profile of the practice and the PPG itself. The latest survey had involved sending 175 surveys out with 129 responding, giving a response rate of 74%.

Tackling inequity and promoting equality

The practice had taken steps 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 a care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. We saw that some information displayed at the practice had also been provided in easy read format, for example how to make a complaint, making it more accessible for people with learning disabilities.

We saw that a number of asylum seekers were registered at the practice and seen by clinicians so as to meet their needs. Their details were recorded on a separate register and translation facilities were available to all staff should they be required. There were good communication links with the local homeless and vulnerable people service, who were able to provide information on the medical requirements of this group of people.

Access to the service

There were no negative comments about being able to access the services at the practice. We also looked the results of the 2014 GP survey 79% of respondents found the

Are services responsive to people's needs?

(for example, to feedback?)

receptionists at the practice helpful, 90% of respondents said the last appointment they got was convenient and 90% of respondents described their overall experience of this surgery as good. These percentages were average or above when compared with other practices in the area.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday 8.30am to 6.30pm. Extended hours were operated on Wednesdays until 8.10pm to provide service for people who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances

GP appointments were provided in ten minute time slots and were pre bookable, longer appointments were available for patients with more than one issue for discussion. Urgent appointment slots were kept available throughout the day with one appointment always available for children under three years of age. Telephone consultations were used when appropriate. Three female and three male GPs were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this. The practice manager told us that they were constantly reviewing patient demand and responding to it by altering the patients booking system to ensure it was always effective. Saturday morning flu clinics had been introduced as a way of making the service more accessible to patients.

The practice used an electronic messaging system to aid communication between administration staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service.

The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where the GP used the electronic messaging system to prompt reception staff to create an appropriate appointment based on patient choice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system both within the practice information book and leaflets as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. One of the patients spoken with had a minor complaint to make, but had never felt strong enough to air their views. They knew the process for doing so had they wished to.

We looked at several complaints received in the last twelve months. In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review and identify any trends.

Are services well-led?

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

Our findings

Vision and strategy

There was a new leadership structure at the practice and staff were clearly adjusting to this and the merger between Chester Road and Seymour Grove. We spoke to the Practice Manager about the vision and values of the practice. They were clear that communication between GPs, clinical staff, management, reception staff, patients and partner groups was essential. They recognised that this had deteriorated since the merger of the practices and problems with recruiting nursing staff. They recognised that team meetings involving all staff and appraisals were not being completed as regularly as they would have liked.

We saw that the practice had a documented statement of purpose and included in their aims and objectives 'to be committed to our patient's needs', 'to provide the highest quality NHS general medical services available' and to 'understand and meet the needs of our patients'. These high level statements were not known to staff when we asked them. When we asked about the "vision" of the practice some staff were unable to tell us about this. We spoke to the GPs and Practice Manager about the practice vision; they told us that they wished to embed this into the whole practice and aimed to do this through regular meetings with all staff and by appropriate personal objectives within staff appraisals. We saw from information in the practice leaflet that patients were provided with a practice charter which outlined some of the levels of service they could expect.

Governance arrangements

The practice held regular documented meetings for clinicians and management. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were

produced to maintain or improve outcomes. We saw evidence that showed the GP and practice manager met with the (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

The practice had a system in place for clinical audit cycles, some of these had been started but not completed and GPs told us they were aware that final reviews of data were required to complete the audit cycle, they said these would be completed as soon as possible. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk assessments which addressed a wide range of potential issues, such as environment and infection prevention. We saw that the risks were regularly discussed at clinician team meetings and updated in a timely way.

Leadership, openness and transparency

Staff told us that felt valued and generally well supported and knew who to go to in the practice with any concerns. The reception team had worked together for many years, the nursing team had been through a great deal of change recently as some nurses had left due to the merger and recruiting suitable replacements had been difficult. The HCA told us that clinical support had been lacking and that they sometimes sought advice outside the practice. The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw some staff undertook annual appraisals and that some were overdue. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. We discussed the potential for documented supervision meetings between appraisals as a method of evidencing staff support. The practice manager agreed that together with the open door policy and strong informal communications between staff and management, this would be a good idea.

Are services well-led?

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example bullying and harassment and equal opportunities, which were in place to support staff. We were shown the staff induction handbook that was available to all staff which included sections on equality and confidentiality. Staff we spoke with knew where to find these policies if they required them for review.

We were told that support for learning, development was very good. Documented peer review was not evident. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be made to the practice manager. Staff told us that practice meetings were not as regular as they would like. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the 2014 GP patient survey and the survey conducted by the practice in 2013 and 2014. Both surveys reflected high levels of satisfaction with the care, treatment and services provided at North Trafford Group Practice.

The practice had an active patient participation group (PPG) which was representative of the patient group it's ethnic diversity. The PPG contained representatives from various population groups. We spoke to two member of the PPG who said that it worked effectively and was an excellent way of patients influencing the way the practice was run.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development. Staff we spoke to had not been asked to complete any staff satisfaction surveys.

GPs were supported to obtain the evidence and information required for their professional revalidation. Every GP is appraised annually and every five years undergoes a process called revalidation. When revalidation has been confirmed by the General Medical Council the GP's licence to practice is renewed which allows them to continue to practice and remain on the National Performers List held by NHS England. Clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with clinical staff during meetings to ensure outcomes for patients improved. Where appropriate significant events had been notified to the CCG in order that learning on a wider area base could be achieved. We noted that the practice was very open and transparent in sharing any errors.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person must ensure that care and treatment is provided in a safe way for service users, including the proper and safe management of medicines.