Manor Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Manor Practice on 10 November and 26 November 2014. The inspection team was led by a CQC inspector and included a GP specialist advisor. We rated the practice as 'Good' for the service being safe, effective, caring, responsive to people's needs and well-led. We rated the practice as 'Good' for the care provided to older people and people with long term conditions and 'Good' for the care provided to, families, children and young people, working age people (including those recently retired and students), people living in vulnerable circumstances and people experiencing poor mental health (including people with dementia).

We gave the practice an overall rating of 'Good'

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it then acted on.

There was one area of practice where the provider could make an improvement.

Summary of findings

The provider should:

Continue to monitor and review the appointment times for patients who are unable to attend the practice during the day to work commitments.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Procedures were in place to ensure incidents and significant events were reported, analysed and learning shared. Safeguarding procedures were in place to protect children and vulnerable adults from harm. Staff had received training and knew who to report to with any concerns. Medicines were managed safely and infection control procedures adhered to. Appropriate pre-employment checks had been carried out on staff before they started working at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to ensure that liaison with other health care professionals took place.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a very active patient participation group (PPG).

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify children who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. According to NHS England data for 2013/14 the percentage of children receiving a vaccination in all of the age categories was above the CCG area for the majority of vaccinations.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible. As a result of patient surveys a need had been identified for a further extension of evening appointments.

Summary of findings

The practice had considered this information but due to the practice size was not currently in the position to change appointment times. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of patients in this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. Translation services were available for patients whose first language was not English to help them with their communication needs. People with drug and alcohol issues were signposted to local support services.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). People experiencing poor mental health all had an agreed comprehensive care plan in their records. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had participated in a CCG led audit into the records of people with mental ill health. The aim of which was to look at GP patient consultation records and ensure that patients received appropriate advice and treatment.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. People were encouraged to take responsibility for their mental health and were directed to websites which would enable them to read and learn about mental health issues and develop their own action plans.

Summary of findings

What people who use the service say

We spoke with three patients during the course of our inspection. We reviewed the results of the practices' most recent patient experience survey and the 2014 national GP patient survey. We reviewed 24 Care Quality Commission (CQC) comment cards where patients and members of the public had shared their views and experiences of the service.

The three patients we spoke with commented that they were satisfied with the care they received at the practice. Patients commented that their GP understood their medical needs and that access to appointments was good. One patient said that they had been able to book an emergency appointment when they needed one. Another patient told us they had been referred to an awareness and self-management course for their condition. This was to help them reduce their medicines, and they were pleased with this support. Two comments that were not so positive were about arranging a convenient appointment and the 'turnover' of GPs at the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider should continue to monitor and review the appointment times for patients who are unable to attend the practice during the day to work commitments.

Manor Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector, and included a GP who was granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Manor Practice

Manor Practice provides NHS primary medical services from Manor Practice, Boston Manor Road, Brentford, Middlesex TW8 8DS. The practice provides primary medical services through a General Medical Services (GMS) contract to approximately 2,100 patients in the local community. The practice is part of Greenbook Healthcare (Hounslow) a provider of primary medical care operating within the Hounslow Clinical Commissioning Group (CCG) area, which is made up of 52 GP practices. Greenbrook Healthcare (Hounslow) was providing five GP practices and five NHS Urgent Care Centres in the West London area.

Three GPs were employed to work at the practice, two female and one male. One GP was designated as the lead GP and was responsible for clinical governance. The practice manager working at Manor Practice also had management responsibility for four other Greenbrook Healthcare practices in the Hounslow locality. The team also comprised of two practices nurses, one healthcare assistant, a phlebotomist and two reception staff.

A GP Medical Director and a quality and governance lead were employed by Greenbrook Healthcare (Hounslow) and were involved in the management of Manor Practice and the other practices provided by Greenbrook Healthcare (Hounslow), in the locality.

The practice offers a range of services including clinics for patients with long-term conditions, blood pressure monitoring, family planning, cervical smears, flu clinics, health checks, child immunisations and a phlebotomy service. The practice opening hours are between 8am and 6.30pm Monday to Friday. The practice has opted out of providing out-of-hours services to its patients and refers patients to the 111 out-of-hours service.

The practice's patient age distribution was predominantly within the 26 – 45 age group with 39% of patients in this age range The practice was located in an ethnically diverse area with 15% of patients from an Asian community.

The service is registered with the Care Quality Commission to provide the regulated activities of

diagnostic and screening procedures, treatment of disease, disorder and injury, family planning and maternity and midwifery services.

The practice was located in a purpose built Health Centre with two other GP practices. Each practice had a designated reception area. The waiting area for patients was shared, with seating arranged adjacent to each practice reception desk. The Health Centre also accommodated the district nursing service and palliative care team. Building maintenance and health and safety were managed by an external contractor employed by Hounslow and Richmond Community Healthcare.

The CQC intelligent monitoring placed the practice in band 6. 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,

Detailed findings

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 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.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 November and 26 November 2014. During our visit we spoke with a range of staff including the practice manager, two GPs, two practice nurses, the health care assistant, phlebotomist and reception staff.

We spoke with three patients who used the service and looked at the minutes of Patient Participation Group (PPG) meetings. A PPG is a group of volunteer patients who meet with practice staff to discuss the services provided at the practice.

We observed how patients were being spoken with and spoke with three patients. We reviewed CQC patient comments cards where patients had shared their views and experiences of the service with us.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, as a result of a recorded incident the staff team met in November 2014 to discuss the process to be followed to ensure patient correspondence was allocated when a named GP was on leave.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We were shown the system used to manage and monitor incidents. The provider had appointed a Quality and Governance manager who was responsible for staff learning from incidents and complaints and implementing change. The quality and governance manager and GP Medical Director for the provider monitored safety incidents and learning points, which were recorded on a central spreadsheet. The spreadsheet recorded the action which was taken as a result of an incident. For example we saw how the practice had identified a risk in relation to a difficulty recruiting practice nurses, this was then recorded on the risk register. As an outcome of this risk two nurses were eventually recruited and a training plan was organised for them in practice nursing skills.

A clinical risk meeting was held monthly for the providers Hounslow practices. The meeting was chaired by the Medical Director. The GP lead, practice manager and a practice nurse from each practice attended the meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a designated lead at the practice for child protection and safeguarding adults. In addition to this a separate safeguarding lead was responsible for all of the GP practices' managed by the provider. There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. GPs submitted reports to safeguarding meetings and told us that in the event of a complex or serious case review being held by the lead safeguarding agency regarding a patient, they would prioritised this and a GP from the practice would attend.

Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. Clinical staff had received child protection training to Level 3 and non-clinical staff to Level 1. All staff had completed training in safeguarding vulnerable adults. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were displayed in the reception area and were easily accessible for staff to view.

A chaperone policy was in place and was displayed in the waiting room and in consulting rooms. Chaperone training had been undertaken by the practice nurse and health care assistants. Non-clinical staff did not act as chaperones. All clinical staff who chaperoned had criminal record checks via the Disclosure and Barring Service (DBS).

Medicines management

The lead GP had overall responsibility for the safety of medicines management. They attended medicines management meetings arranged and held by Hounslow

Good

Are services safe?

CCG. Prescribing budgets and prescribing pathways were discussed at this meeting. The CCG lead pharmacist attended these meetings and was available to give advice and direction.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff. Vaccines were stored securely in the medicines refrigerator. We saw that there was a system in place for checking fridge temperatures daily and records evidenced this was adhered. Staff were able to describe the action to be taken in the event of refrigeration failure. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry date. Expired and unwanted medicines were disposed of in line with relevant regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Flu vaccines were administered by the healthcare assistant using patient specific directives which were signed by the GP. The health care assistant was only authorised to administer flu vaccines. The healthcare assistant received peer supervision and commented they felt supported in their role.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. This helped to ensure that patients repeat prescriptions were still appropriate and necessary. The prescribing policy was reviewed every two years and was due to be reviewed in 2015. Repeat prescriptions were issued for a period of six months only; a request was then made for the patient to attend a medication review with their GP.

Receptionists handled repeat prescriptions in accordance with the policy and had received training for this task. Receptionists only issued authorised prescriptions, unauthorised prescriptions were forwarded to the GP for approval. There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

Cleanliness and infection control

We found the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Contractors were employed to clean and maintain the Health Centre. One the first day of the inspection we met with the site manager to look at the cleaning and maintenance contract. Documentation was in place to show that a cleaning risk assessment had been completed in 2014 and there was a cleaning schedule of tasks and frequencies. We saw a Control of Substances Hazardous to Health COSHH risk assessment had been completed and information was available on the safe use of cleaning chemicals.

The practice nurse was designated lead for infection control and was responsible for ensuring infection control standards were adhered to in the practice. All clinical staff had received training about infection control during 2014.

We saw evidence that two complete audit cycles had been carried out by the practice over the last year. Areas for improvement had been identified and improvements made as a result.

An infection control policy was available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use. We saw that personal protective equipment was accessible for clinical staff.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms and hand sanitizers were available throughout the practice. A flow chart was on display of the action to be taken in the event of exposure to blood or body fluids.

A clear and secure system was in place for stock control and the disposal of out of date phlebotomy equipment. A contract was in place for the management of clinical waste. Records seen evidenced the periodic collection of clinical waste. We saw waste was separated and securely disposed of in colour coded designated containers, such as ‘sharps’ bins for used needles.

Good

Are services safe?

We found appropriate health and safety risk assessments were in place for example risk assessments for legionella bacteria and infection control.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested. Portable Electrical Appliance (PAT) testing had been carried out in March 2014. A schedule of medical equipment testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, the fridge thermometer and blood pressure monitors.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records check for clinical staff via the Disclosure and Barring Service. All staff had a Disclosure and Baring Service check.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. A specific recruitment policy was in place for the recruitment of bank GPs who applied to work with the provider. The policy covered the steps to be taken to check prospective GPs were up to date with their training and appraisal, were registered with the General Medical Council (GMC) and had received the required immunisations. A record template was available for interviewing candidates and requesting references.

Bank GPs recruited and by the provider were available to cover the absence of salaried GPs when the need arose. We were informed that staff from other practices managed by the provider were available to cover for each other. For example, in the event of a receptionist being unavailable due to sickness a receptionist from practice would cover the position.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The site manager for the Health Centre was responsible for monitoring the safety of the building.

They organised health and safety tests and we saw records confirming this. A fire risk assessment was conducted in 2012. Fire alarms were tested weekly and the fire alarm system was serviced in 2014. A fire drill and full evacuation of the health centre took place on the first day of our inspection. A Fire Marshall from each practice was nominated to carry out essential duties in case of fire.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. The majority of staff had received this training in December 2013, with one member of staff being trained in May 2014. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency).

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A disaster handling and business continuity plan dated December 2013 was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, unplanned sickness, loss of IT function resulting in staff not being able to access patient records, and restricted access to the building. The document also contained relevant contact details for staff to refer to. For example, details of the relevant gas and electricity companies to contact in the event of a failure. Arrangements were in place to direct patients to alternative local practices managed by the provider in the case of emergency or adverse weather conditions.

Good

Are services safe?

Staff told us the protocol had been used during a recent power failure. The practice had experienced a problem with the phone provider forwarding calls after the incident. We discussed this incident with the practice manager who said assured us this would be addressed with the phone company.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. GPs at the practice received information on updated NICE guidelines by email and had access to the guidance on the CCG website. The use of NICE guidance shaped practice, for example the practice had audited the use of the medicine Orlistat (prescribed for the treatment of obesity) in line with NICE guidance. As a result of this review prescribing patterns were assessed and changed. We found from our discussion with the GPs that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, dementia and sexual health and that the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. The GP with a special interest in dementia was proactive in dementia screening and signposting patients to community resources for support.

Referrals to secondary care were made to the Referral Facilitation Service (RFS) for NHS Hounslow CCG. The RFS was the first point of call for GPs and hospital consultants when making an outpatient referral. National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions.

We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff. We looked at the practice referral monitoring data which was audited monthly. This data covered GP referrals to secondary care, elective admissions to hospital and unscheduled attendance at the Accident and Emergency Department. This information was used to audit patient care with the aim of improving practice. For example, gynaecological referrals were noted to be high. A meeting was held at the practice whereby GPs peer reviewed practice referrals and referral correspondence in conjunction with CCG and NICE guidance. Changes were made to referral patterns and on the re audit of this information it was found that subsequent referral numbers had decreased.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audits. The practice showed us four clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the practice received pathology results on Radioallergosorbent testing (RAST). This is a test used to determine substances patients are allergic to. The practice looked at outliers such as high request rates. RAST testing was found to be high and a clinical meeting was held to discuss the role of allergy testing in line with best practice.

The practice had carried out an audit on insulin prescribing. Hounslow CCG had been identified as the highest prescriber in London of long term insulin analogues. Insulin prescribing at the practice was then reviewed in line with NICE guidance and prescribing trends. The main learning outcome for the practice was that prescribing had been carried out as defined by NICE guidelines. As a result of this audit further improvements were identified. For example, protected training time had been identified for GP training and a 'buddy system' was planned with another GP practice in the locality for the support of patients with unstable insulin management.

Good

Are services effective?

(for example, treatment is effective)

An audit cycle had been carried out to determine the number of inadequate smear results. No further action had been identified as the number of inadequate smears stood at 1% with the national target being set at 2% of inadequate smear results needing recall.

An audit had been completed in 2014 on the physical health needs and level of engagement regarding patients who had mental ill health. Hounslow CCG had requested practices undertake this audit to assess the service needs of patients within the Hounslow locality.

Patient records had been reviewed for the number of GP consultations they had attended for physical health checks, for example blood pressure monitoring. Lifestyle factors such as exercise were looked at, and the number of appointments patients had not attended with either their GP or the outpatient department was reviewed. The outcome of the audit of patient records showed that clinical staff encouraged patients to undertake meaningful activities. Patients were referred to the 'Living life to Fullness' website. This is a website aimed at self-help and promoting mental wellbeing.

The practice ensured patients with mental ill health had access to a Community Psychiatric Nurse (CPN) and other agencies who would be able to offer support. For example, housing, financial advice and debt management. At the time of the inspection the final results of this audit were not available from the CCG.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as safeguarding children and vulnerable adults, infection control, basic life support, fire safety and information governance. We spoke with one member of clinical staff who had recently joined the practice, they confirmed they had received appropriate induction training and had received regular supervision. The new member of staff said induction training had taken place over a period of four weeks and this included shadowing the lead nurse for the providers, Hounslow services.

The healthcare assistant at the practice conducted the INR (anticoagulant medicines) clinic. The health care assistant said they were supervised by and reported to a GP at the practice. They felt supported in their work and said protected time was available to discuss the INR clinic with a GP. Practice nurses and healthcare assistants attended monthly meetings with colleagues from other practices for peer support and clinical development.

We were informed of a pilot scheme which was due to take place to offer quarterly group supervision sessions for combined groups of staff including GPs, nurses and healthcare assistants. At the time of the inspection facilitators had been trained to lead the groups. The aim of these sessions was to examine practice themes, for example safeguarding, and learning from incidents. Staff meetings at the practice took place every four to six weeks. Staff we spoke with confirmed their attendance at staff meetings.

All GPs were up to date with their yearly continuing professional development requirements and all have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook an annual appraisal that identified learning needs from which action plans were documented. We saw records to confirm that they had either received their annual appraisal or a date was identified for appraisal. The provider had a GP appraisal format which incorporated a patient record analysis of GP consultations. The aim of this was to ensure effective prescribing, documentation quality and appropriate examinations. Clinical and non clinical staff we spoke with confirmed they had received an annual appraisal.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they

Good

Are services effective?

(for example, treatment is effective)

were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

GPs at the practice attended monthly Hounslow CCG clinical meetings. A lead from each practice attended these monthly meetings which were held with other practices from the Brentford and Isleworth area. Practices' identified case studies for presentation, for example, caring for patients who required palliative care or cancer treatment. We were informed that a specialist would be invited to the CCG clinical meeting if a number of practices had identified the same medical conditions for discussion.

The practice was commissioned for enhanced services and had a process in place to follow up patients discharged from hospital (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). The practice was commissioned to provide an outreach wound care service for people in the locality. The practice also provided enhanced service for alcohol screening and dementia screening.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, and palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. The practice nurse worked with the district nurse team if there was an identified concern with a particular patient.

Information sharing

The practice had electronic systems to communicate with other health care services and provide staff with the information they needed. An electronic patient record system was used by all staff to coordinate, document and manage patients care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Procedures were in place to ensure information received electronically such as blood test results and discharge summaries were actioned within two days. Information was communicated with out of hour's services via fax or by letter including special notes for patients with complex needs. Patient records were available to other health care providers within the Hounslow CCG area.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties under this legislation. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice, for example, when making best interest decisions for those patients who lacked capacity.

GPs we spoke with had a clear understanding of Gillick competencies to obtain consent from children, (these help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). Written consent was sought for intimate examinations.

Health promotion and prevention

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant and practice nurse. An area for improvement identified by the practice was to increase the number of annual health checks provided to patients between 40 and 75. The practice had previously found it difficult to recruit a practice nurse although at the time of the inspection a practice nurse had been recruited and was undergoing induction training. The practice envisaged the capacity to increase health checks would significantly increase once the nurse was fully operational. A nurse from another of practice managed by the provider had been covering some of the nurse led clinics at Manor Practice.

The practice's performance for cervical smear uptake was 79% which was in line with others in the CCG area.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. According to NHS England data for 2013/14 the percentage of children receiving a vaccination in all of the age categories was above the CCG area for the majority of vaccinations.

Good

Are services effective?

(for example, treatment is effective)

The practice adjusted clinics and surgery opening times during October of each year to cater for patients requiring flu vaccinations. Where patients were housebound arrangements were made for GPs to visit them in their home.

Hounslow CCG had initiated Out of Hospital services within the locality. This meant that instead of patients being referred to hospital for treatment, such as diabetes, a practice within the locality would be identified to provide this service. This meant that patients were able to receive this treatment locally and within a primary care setting.

Patients with long-term conditions, for example diabetes, or patients who had been identified as vulnerable, had a care plan. The care plan was reviewed annually or more often if the patient's condition changed or deteriorated. We saw that the care plan was prepared on a template attached to the electronic patient record. Information on the patients' medical diagnosis, treatment and needs were also available for the Out of Hours provider.

The practice had a high prevalence of patients with mental ill health at 1.3% as compared with 0.8% nationally. Patients who approached their GP for support with stress, anxiety, or who needed emotional support for their psychological wellbeing were referred to IAPT (Improving access to psychological services). Patients were usually assessed by the short treatment team within four weeks of a referral. Staff at the practice informed us the demand for this service outweighed availability, and there was often a waiting list for this service. In addition to being referred to IAPT GPs encouraged patients to look at self-help material. For example, patients were directed to websites which would provide them with the relevant literature for the area of support they needed. Patients were also made aware of a website with an on line Cognitive Behaviour Therapy CBT module.

Patients who were being supported with obesity management were referred by GPs to an NHS weight loss programme. Patients requiring help with smoking cessation were referred to the 'stop smoking service' which was held in the same building at the health centre. The practice could also refer patients to the respiratory service situated in the health centre.

The practice provided a wide range of information on health issues. This included information on sexual health services, healthy living, smoking and cancer so patients could make informed decisions about their health and lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from a survey of patients undertaken by the practice's patient participation group (PPG) in 2014. The evidence showed patients were satisfied with how they were treated, and that this was with compassion, dignity and respect. According to the 2014 National GP survey 82% of patients said that the last GP they saw or spoke to was good at treating them with care and concern.

Patients at the practice had completed the 'Friends and Family Test' and the practice had analysed the survey results. The results for May 2014 indicated that 83% of patients would recommend the practice to friends and family, and 91% responded that they found the practice excellent and staff were polite, caring and kind. We were informed that reception staff had recently undertaken training in ensuring a quality patient service.

The provider had carried out an analysis of the feedback from the five practices in the Hounslow area, and had developed an action plan for each. The identified theme for Manor Practice corresponded with the PPG survey results. The survey results indicated that some patients would like to see further improvement regarding the availability of evening appointments, to enable them to book an appointment after work.

Patients completed CQC patient comment cards to tell us what they thought about the practice. We received 24 completed cards and the majority were positive about the service they had experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Patients commented that the service at the practice was efficient. The majority of patients were able to book an appointment when they needed one and repeat prescriptions were ready on time. Positive comments were received about individual members of staff, the comments told us that staff listened, they were friendly and caring and that some staff went out of their way to help. One comment card was less positive about the availability of convenient on line appointments and the information the patient received when they had attended a clinic for a health condition.

We also spoke with three patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

Care planning and involvement in decisions about care and treatment

Patients we spoke with responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. The CQC patient comment cards we received informed us that patients received a personal service; clinicians listened to them, gave clear information and discussed their treatment with them. Seventy two per cent of respondents in the National GP survey 2014 said the doctor involved them in their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language, to ensure they could understand treatment options available and give informed consent to care. Language line was used by the practice when patients required interpretation services.

Patient/carer support to cope emotionally with care and treatment

Patients we spoke to said they were happy with the emotional support provided by staff at the practice. They said staff were there to support them. Carers were signposted to support agencies such as age concern to ensure they received the support they needed. When patients needed additional emotional support, this was coded on the patient electronic record. This enabled reception staff to be aware of their condition.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) survey conducted for the practice over the last two years.

The patient survey initiated by the practice for 2012/2013 identified that patients wished to receive better information on alternative out of hour's services such as Walk-in-Centres, Urgent Care Centres and the Accident and Emergency Department. Information on these services was now advertised at the practice. Patients had also requested early morning and evening appointment slots. The practice had extended GP consultations to 6.30 pm.

The survey conducted for 2013/2014 indicated that patients had requested evening opening times to accommodate people who were at work during the day. The practice action plan for the survey stated that this would be kept under review. The practice had identified and acknowledged this as an area for development. We were informed that due to the small patient list size and financial restraints the practice was not able to offer further evening appointments.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The premises and services had been adapted to meet the needs of patients with disabilities. The Health Centre within which the practice was accommodated was on ground level. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice was open from 8am to 6.30 pm Monday to Friday. The practice was part of a 'locality hub' which offered improved access to a local GP at weekends. The practice participated in a rota of GPs who would open at weekends to provide a service for all patients in the Hounslow area.

Staff at the practice said they aimed to offer patients an appointment within 48 hours of their initial request. In the case of a request for an emergency appointment patients were referred to a GP for telephone consultation and initial assessment of their medical condition. As a result of the telephone consultation service some patients had been identified by a GP for a same day appointment. Other patients were identified on the electronic patient record for a same day appointment; these were children under the age of five and patients who had a care plan for chronic disease management.

Patients were generally satisfied with the appointments system. CQC patient comment cards informed us that the majority of patients were able to book an appointment when they needed one. One patient commented that they were able to book an emergency appointment easily. One patient however felt it was difficult to book a convenient appointment using the on line booking system. Eighty two per cent of respondents to the National GP survey said it was easy to get through on the phone compared to the CCG average of 72%. Sixty one percent of respondents said they usually waited 15 minutes of less when they arrived for their appointment.

Appointments were bookable either by telephone, online via the practice website or in person. Telephone advice and home visits to those patients who were housebound were available. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by the 111 out-of-hour's service and was advertised on the practice website and in the practice information leaflet.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Its 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. The practice published the complaints procedure in the waiting area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at eight complaints received in the last 12 months and found these were handled satisfactorily and dealt with in a timely way.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review of complaints and no themes had been identified. The complaints record identified areas of concern reported by patients and the outcome of the complaints investigation. Complaints were discussed by the staff team in the monthly practice meetings and if a complaint related to clinical practice this was placed on the risk register and discussed at the monthly clinical risk meeting.

We saw evidence that the practice had reviewed four comments made on the NHS choices website. As a result of this an action plan had been developed and a poster made available for patients. The poster gave information on ways in which patients may give feedback, including the email address of the practice manager.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. This vision and values included offering quality NHS healthcare and putting patients first'. Manor Practice aimed to give this service by offering a safe service, communicating clearly, respecting patients and good team work. When we spoke with staff they knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at approximately five of these policies. Policies we reviewed were diverse and included dementia screening, safeguarding and recruitment of staff and locum GPs.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the designated lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards.

The lead nurse for the provider informed us that clinicians would be shortly participating in multidisciplinary supervision sessions. At the time of the inspection these arrangements were at the planning stage and the facilitator for this group was receiving training.

The practice had an ongoing programme of clinical audits which was used to monitor quality and systems to identify where action should be taken to improve services. The practice referred to NICE guidelines to ensure they were operating within the framework of best practice and had identified additional training for clinicians to improve patient care.

The practice had arrangements for identifying, recording and managing risks. All significant events and complaints were reviewed and where a clinical risk had been identified this was included on the practice risk register which was discussed at monthly meetings. A monthly risk meeting was held by the provider for all their practices in the Hounslow area.

The practice participated in a local peer review system with other practices in the Hounslow CCG locality. Topics discussed included clinical best practice and data such as referrals and prescribing. We were informed that GPs had protected management time, within their contract, to attend meetings.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example, the Medical Director was the clinical lead for the Hounslow services and the quality and governance lead was responsible for collating all incidents and complaints for the practices' and identifying areas for improvement. The practice manager was responsible for the day to day management of the practice and the lead GP had the overall responsibility for monitoring clinical practice. We spoke with four members of staff and they were all clear about their own roles and responsibilities. They all told us that they were valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had gathered feedback from patients through online surveys, questionnaires made available in the waiting room, the patient participation group (PPG) and complaints. The practice had developed action plans as a result of feedback and made improvements to the service. For example, the PPG developed the patient survey for 2013/2014. The questions focused on surgery opening hours. Forty nine patients were surveyed over a two week period in February 2014. The survey results indicated that 63% were satisfied with opening hours and 57% wished to see extended opening hours. The practice was now offering late appointments between 17.00 and 18.30 during the working week.

The practice had reviewed and recorded the how the PPG represented different groups of patients within the community. For example, employed or retired patients,

Are services well-led?

Good

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

patients who were identified as carers, and patients who had a long term condition. Where the practice had identified a lack of representation steps had been taken to promote the PPG. This was advertised in the waiting room and invitations of interest where added to repeat prescription forms.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff records and saw that annual appraisals took place which included a personal development plan detailing staff training needs and timelines for completion. Staff told us that the practice was supportive of their training.

The practice had completed reviews of significant events and other incidents and shared lessons learnt with staff via meetings to ensure the practice improved outcomes for patients.