Tilehurst Surgery Partnership

Quality Report

Tylers Place
Tilehurst
Reading
Berkshire
RG30 6BW
Tel: 0118 9427528
Website: www.tilehurstsurgery.co.uk

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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

Tilehurst Surgery is located in Reading, Berkshire. It provides primary medical services to approximately 13500 registered patients.

We carried out an announced, comprehensive inspection on 19 November 2014.

We visited the practice location at Tylers Place, Tilehurst, Reading, Berkshire, RG30 6BW.

We found the practice to be good for providing safe, effective, caring, responsive and well led services. Tilehurst Surgery is rated overall as good.

Our key findings were as follows:

- Comprehensive risk management processes were in place to ensure the practice was operating in a safe, clean environment including incident reporting and infection control audits.
- Patients were supported through, for example, care plans, to manage their conditions. Trained staff had development opportunities and had access to resources to improve outcomes for patients.
- Patient feedback from the national GP survey, practice survey and patients we spoke with was very positive about most aspects of the care and treatment they received.
- The practice appointment system was very flexible and there was a range of appointments to suit most patients' needs. However, some patients reported difficulty in obtaining non-urgent appointments with their preferred GP.
- The practice focussed on quality and safety. It had an inclusive approach and welcomed learning from incidents, complaints and constructive challenge to improve the way it provided services.

We saw one area of outstanding practice:

The practice pioneered a web-based approach to care planning to improve the care of patients with diabetes and promote self-management of their condition.

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice, for example, it pioneered diabetes care planning. The GP who led this initiative won four regional and national awards including the NICE shared learning award 2014. 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.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that 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 decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified, for example the practice secured funding to provide extra appointments during the winter months to meet expected demand. Patients said they found it easy to make appointments when they needed to be seen the same day. However, they were less satisfied with obtaining

Summary of findings

non-urgent appointments. 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. Learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The practice had a very active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. All older patients had a named GP. The practice provided a weekly round to two nursing homes and a six monthly review of care. The practice maintained a register of patients with complex needs many of whom were older patients; 336 (100%) of these patients had care plans in place.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. The practice pioneered diabetes care planning and supported the management of diabetic patients with a virtual diabetic clinics and a community diabetic specialist nurse. One of the GPs had a specialist interest in rheumatology and they provided a second opinion for colleagues in the practice. The majority of patients with long term conditions had received annual reviews of their condition: 94% of patients with diabetes, 89% of patients with chronic obstructive pulmonary disease (lung disease), 95% of patients with asthma and 97% patients with high blood pressure. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medicine needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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 and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

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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, flexible and offered continuity of care, for example early morning and late evening appointments were offered. The practice was proactive in providing online services as well as a full range of health promotion and screening that reflects the needs for this age group. For example, travel clinic, acupuncture and a non-obstetric scanning service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. All staff were trained on a national training programme to support victims of domestic violence. Two GPs worked with a local carers support organisation. The practice held a register of patients living in vulnerable circumstances including patients with a learning disability; it had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. 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. One of the GPs was clinical lead for the organisation Identification and Referral to Improve Safety (IRIS) (a national training programme for GP surgeries to support victims of domestic violence) and worked with a local organisation to support victims of domestic abuse and violence.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The number of patients who had received annual health checks was in line with CCG average. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice provided an in-house counselling service and also referred patients to 'Talking Therapies'.

Summary of findings

What people who use the service say

The 2014 national GP survey results for Tilehurst Surgery based on 121 surveys (43%) responses showed the practice was rated above the local average for the number of patients who recommended the surgery. The practice was also rated highly for doctors giving patients enough time and explaining tests and treatment and less well on listening to them. Satisfaction scores for nurses appear less good, but this does not take into account the high number of patients who said the question did not apply to them. The helpfulness of the practice reception staff was also rated above the local clinical commissioning group (CCG) average.

The 2014 practice participation group (PPG) survey of 324 patients explored their views on access to the practice.

Over 80% patients responded they would welcome early morning, late evening and weekend surgery opening times. The practice worked with the PPG and now offers two early morning and two late evening surgeries.

During the inspection on 19 November 2014 we spoke with 12 patients. All the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Four out of 12 patients expressed some dissatisfaction with the time to obtain non-urgent appointments.

We received 35 completed comment cards. The majority were positive about the service experienced. Patients said they felt the practice offered a good or very good service and staff were helpful and caring. Eleven comments related to dissatisfaction with obtaining non-urgent appointments.

Outstanding practice

The practice pioneered a web-based approach to care planning to improve the care of patients with diabetes and promote self-management of their condition.One of the GPs was the diabetes lead across the four federated CCGs of West Berkshire. In 2012 the area identified poor achievement in meeting key aspects of diabetes care. In response the GP led the network of diabetes (Diabetes sans frontier (DSF)). This was a collaborative model of care involving virtual access to a diabetic specialist, patient education programme supported by care plans and a web based system for patients to access their records and results to improve self-management. This had resulted in improved patient outcomes. The practice achievement was above the CCG average for Quality and Outcomes Framework (QOF) diabetes indicators. The GP who had led the work won national recognition and four awards including the NICE shared learning award 2014.

Tilehurst Surgery Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Tilehurst Surgery Partnership

Tilehurst Surgery Partnership is located in an urban area of Berkshire. It holds a primary medical services (PMS) contract to provide primary medical services to approximately 13 500 registered patients.

The practice serves a population which has a similar age profile to the local clinical commissioning group average and is slightly more affluent than the national average.

Care and treatment is delivered by seven GP partners and four salaried GPs: six female and five male. The practice is a training practice, although at the time of inspection no trainee was in post. The practice employs a team of seven nursing staff. GPs and nurses are supported by the two practice managers and a team of reception and administration staff; a total 44 staff.

The practice takes an active role within the North and West Reading Clinical Commissioning Group (CCG), with a number of GPs taking lead roles, for example the senior partner is the CCG clinical lead and another GP is the lead for diabetes across West Berkshire.

The practice has opted out of providing out-of-hours services to its own patients. There are arrangements for patients to access care from an out-of-hours provider, NHS 111.

The CQC intelligent monitoring placed the practice in band six. 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.

The announced, comprehensive inspection at Tilehurst Surgery Partnership, Tylers Place, Tilehurst, Reading, Berkshire, RG30 6BW took place on 19 November 2014.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected before and that was why we included them.

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

Detailed findings

How we carried out this inspection

Prior to the inspection we contacted the North and West Reading Clinical Commissioning Group (CCG), NHS England area team and local Healthwatch to seek their feedback about the service provided by Tilehurst Surgery Partnership. We also spent time reviewing information that we hold about this practice.

The inspection team carried out an announced visit on 19 November 2014. We spoke with 12 patients and 14 staff. We also reviewed 35 comment cards from patients who shared their views and experiences.

As part of the inspection we looked at the management records, policies and procedures, and we observed how staff interacted with patients and talked with them. We interviewed a range of practice staff including GPs, nursing staff, managers and administration and reception staff.

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

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

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

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

The practice serves a population which has a similar age profile to the CCG average and is slightly more affluent than the national average.

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 with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, one reported incident involved a patient being referred for an appointment which was meant for another patient with a similar name.

We reviewed safety records, incident reports and notes of meetings where these were discussed for the previous 18 months. 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 senior GP described a culture of 'Name and Share' to encourage all staff to report incident. 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 previous 18 months and we were able to review these. Significant events reported included clinical incidents for example, delays in handling results or poor communication as well as non-clinical incidents such as an electrical item was not switched off and could have had serious consequence for the practice. Significant incidents were a standing item on the weekly practice business meeting and a dedicated meeting was held every six months to review all significant incidents over the previous six month period. There was evidence that the practice had learned from these incidents and the findings were shared with relevant staff. All staff were aware of how to raise issues and had opportunities to do so.

We reviewed the last two 'Significant Events Summaries' and looked at three incidents in more detail. We saw records of incidents were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, following a medical emergency during a fitting of an intra-uterine contraceptive device (IUCD or coil), the practice had changed its procedures to ensure coil fittings were undertaken with two staff present and in the treatment room. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager to nursing staff. Staff we spoke with were able to give examples of alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at the weekly meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in every consultation room.

One of the GPs was clinical lead for the organisation Identification and Referral to Improve Safety (IRIS) (a national training programme for GP surgeries to support victims of domestic violence) and worked with a local organisation to support victims of domestic abuse and violence.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role (for example, GPs had received level three training in safeguarding children). All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, the practice managers who had also undertaken training were available.

The practice had systems in place to identify and follow up vulnerable patients. For example, children who failed to attend for appointments such as childhood immunisations were alerted to the GP lead for safeguarding children, who followed up individual families as necessary.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Medicines management

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 that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Fridge temperatures were checked, however, readings were regularly omitted for two fridges on a particular day when the staff member whose responsibility it was to check the temperatures was absent.

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 dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw the practice's prescribing data review for the previous year. The practice had taken action to change prescribing and had successfully achieved all six areas in the prescribing scheme. The practice had a designated GP who led on prescribing and was also the prescribing lead for medicines optimisation for the clinical commissioning group.

The nurses and the health care assistants administered vaccines using patient group directions and patient specific directions respectively; these had been produced in line with legal requirements and national guidance. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role from one of the GPs. They also attended update training in the specific clinical areas of expertise for which they prescribed, for example, diabetes.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. A repeat prescription audit had been carried out by the West Berkshire Medicines Optimisation team in September 2014. The audit report included a few recommendations and suggestions for review of the practice repeat prescribing policy. We saw the policy had been promptly reviewed and amended in September 2014. The practice had been providing electronic prescribing for over two years and was now in the second phase of electronic prescribing.

Cleanliness and infection control

We observed the premises to be clean and tidy. Most areas of the practice except for the treatment rooms were carpeted including the 'sluice room'. However, the practice had a plan in place to replace the carpets. All seating in the waiting area was in good condition and clean, although not of an impermeable material. 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.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit in the last year and actions had been taken to make improvements, for example, purchase of new clinical waste bins.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, collection of samples from patients. There was also a policy for needle stick injury,

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Are services safe?

Notices about hand hygiene techniques were displayed in staff and patients' toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had 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 and we saw the 2014 certificate to show all items had been tested and those that had not passed had been replaced. We also saw evidence of checking of fire equipment.

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 checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Staffing levels had been reviewed, for example, following an incident where certain tasks had not been completed promptly due to staff absence.

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 practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at weekly business meetings. The deputy practice manager was the health and safety officer and carried out regular inspections of the workplace to assess environmental risks and take action. We saw the last risk assessment and actions taken and planned.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, patients who attended the accident and emergency department or were discharged from hospital were followed up after three days and at three weeks to monitor their condition. This prevented patients being readmitted to hospital for the same conditions or medical concerns.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. 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). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and appropriate changes had been implemented as a result.

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, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan 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

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Are services safe?

recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and was regularly updated to reflect changing contact details or suppliers.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were not up to date with fire training, however, it was scheduled to take place in the next month.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw notes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in certain areas for example, diabetes and prescribing. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of diabetes. Diabetes was a priority for the practice and local area.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital. Patients were reviewed at three days and three weeks by their GP, according to need.

National data showed that the practice was in line with or had better referral rates to secondary and other community care services for all conditions. We saw notes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 referred on need and that age, sex and race was not taken into account in this decision-making.

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 practice showed us six clinical audits that had been undertaken in the last 18 months. We saw audits were conducted by the majority of GPs. Examples of audits included a review of antipsychotic prescribing in nursing home patients, minor surgery audit and appropriateness of spinal x-ray requests.

The GPs told us clinical audits were often linked to medicines management information or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of antibiotics for urinary tract infections.

The practice had recently implemented a risk rating tool; this was run weekly to identify patients who were in need of close monitoring to ensure their changing needs were met. All these patients had a care plan in place or pending. The practice recalled patients with long term conditions for their annual reviews on their birthdays. Patients who failed to attend their appointments were followed up with a phone call.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The majority of patients with long term conditions had received annual reviews of their condition: 94% of patients with diabetes, 89% of patients with chronic obstructive pulmonary disease (lung disease), 95% of patients with asthma and 97% patients with high blood pressure. The practice met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease, this was reflected in its high QOF achievement of 99%. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a

Good

Are services effective?

(for example, treatment is effective)

group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All results were actioned promptly by the GP or their buddy.

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 annual basic life support. We noted a good skill mix among the GPs with interests in child health, family, rheumatology and diabetes. All GPs were up to date with their yearly continuing professional development requirements and all 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 annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, reception and administration staff had been developed to take on health care assistant duties. The practice was a training practice but currently did not have a trainee in post.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles, for example, diabetes, were also able to demonstrate that they had appropriate training to fulfil these roles. Antibiotic treatment would be discussed with GP. Staff told us very good educational and training support and resources were available to support them.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. 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 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. The GPs worked with the midwifery team to provide antenatal care. A virtual diabetic clinic provided access to a community diabetic consultant and community diabetic specialist nurse.

The GPs and nurses had a scheduled morning break as an opportunity to discuss clinical matters with colleagues if necessary. One of the GPs had a specialist interest in rheumatology and they provided a second opinion for colleagues in the practice. The practice held quarterly, monthly and weekly multidisciplinary team meetings 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, palliative care nurses and decisions about care planning were documented in a shared care record.

The practice was innovative in its approach and one of the GPs was the diabetes lead across the four federated CCGs of West Berkshire. In 2012 the area identified poor achievement in meeting key aspects of diabetes care. In response the GP led the network of diabetes (Diabetes sans frontier (DSF). This was a collaborative model of care involving virtual access to a diabetic specialist, patient education programme supported by care plans and a web based system for patients to access their records and

Good

Are services effective?

(for example, treatment is effective)

results to improve self-management. This had resulted in improved patient outcomes. The GP had won national recognition and four awards including the NICE shared learning award 2014.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 100% of referrals the previous year were made through the Choose and Book system, except for those which needed to meet the national two week targets. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nurses we spoke with understood how the legislation applied to their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes, 336 of these patients were identified. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. GPs and nurses demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, immunisations and for observers (such as medical students), a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice provided medical care to two care homes for patients with dementia. The GPs told us early in the admission process the GP considered do not attempt resuscitation decisions with the families of patients.

Health promotion and prevention

The practice worked closely with the CCG and was active in health promotion and prevention. One of the GPs led on diabetes across the four CCGs in West Berkshire and the practice had pioneered a system to support patients and promote self-management of their condition. Patients with long term conditions had annual reviews, for example, 95% of patients with diabetes and 96% patients with asthma. 100% patients with dementia had an annual review and 94% patients with severe mental health problems had an annual physical health check.

The practice offered NHS Health Checks to all its patients aged 40-75 years. Practice data showed that 73 patients without other diseases had a health check in the previous year and double that number had health checks so far this year.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Patients over the age of 75 years had a named GP to facilitate continuity of care. The practice kept a register of all patients with a learning disability and 100% had an annual review in the last 12 months. The practice had also identified the smoking status of 88% of patients over the age of 16 and 90% had been offered smoking cessation advice.

The practice's performance for cervical smear uptake was 83%, which was above average for the local area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually.

Good

Are services effective?

(for example, treatment is effective)

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

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 the national patient survey and a survey of 324 patients undertaken by the practice's patient participation group (PPG) which focussed on access issues. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated above the local average for the number of patients who recommended the surgery. The practice was also rated highly for GPs giving patients enough time and explaining tests and treatment and less well on listening to them. Satisfaction scores for nurses appear less good, but this does not take into account the high number of patients who said the question did not apply to them. The helpfulness of the practice reception staff was also rated above average.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good or very good service and staff were helpful and caring. They said staff treated them with dignity and respect. Eleven comments related to dissatisfaction with obtaining non-urgent appointments. We also spoke with 12 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. Four out of 12 patients expressed some dissatisfaction with the time to obtain non-urgent appointments.

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

During the inspection we witnessed a number of caring and discreet interactions between staff and patients to preserve their dignity and privacy. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. However, patients' satisfaction with regards to privacy at the reception was rated slightly below the CCG average, in the national patient survey.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 75% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining tests and treatment. Tilehurst Surgery was one of the first practices in the CCG to establish care planning for patients with diabetes.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 86% of respondents to the national GP survey said the GP was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. One bereaved relative was very positive

Good

Are services caring?

about the support they had received during a difficult time. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access 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. One GP and a member of reception staff worked with a local carers support organisation.

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 patients' 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 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). For example, following the 2014 PPG survey the practice began to offer two early morning and two late evening surgeries per week.

The practice provided a number of services in house including physiotherapy, a non-obstetric scanning and acupuncture.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training

The practice provided services to four homes for patients with learning disabilities.

The practice had access to online and telephone translation services and three GPs spoke additional languages: Bengali, German and Italian. The practice website had a function to translate it into different languages.

The patient areas of the practice were all on the ground floor. 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. The reception desk was low to facilitate interaction with patients in wheelchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Bariatric scales were available for use by patients.

Access to the service

The practice had a flexible appointment system to accommodate varying demands of patients, with a focus on seeing patients on the day for urgent appointments. Pre-booked appointments were available up to six weeks in advance. The practice had secured additional funding to provide additional urgent appointments to meet the anticipated increased demand over between November 2014 and March 2015.

The practice's core opening times were 8am to 6.30pm Monday to Friday. It had two early morning days (7.30am start) and two late evenings (8pm finish) to accommodate patients' preferences for pre-booked routine appointments. Early morning, lunchtime and evening appointments were also available. There was a daily weekday 'global clinic' which provided short urgent appointments. Appointments were kept under constant review and adjustments made as necessary. Telephone consultations and home visits were also offered as needed.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to a number of local care homes on a specific day each week, by a named GP and to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, we saw one patient attend the practice requesting an appointment, due to their circumstances they were seen within a very short period of time by the duty doctor. The national patient survey showed the practice performed slightly below the CCG average in the responses. Seventy-two per cent of patients were able to obtain an appointment the last time they tried and 95% of patients said the

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointment was convenient. Feedback from patients we spoke with and comment cards showed a proportion of patients were not satisfied with the wait to obtain non-urgent appointments.

Listening and learning from concerns and complaints

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. There was a designated GP lead responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system by poster in the waiting area and information 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.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. Staff tried to resolve complaints verbally as far as possible if in writing. GP lead complaints took complaints very seriously and were investigated to learn lessons. The latest complaints review showed all complaints had been resolved, most involved a written apology and some had involved a face to face meeting with the patient/ family.

Complaints were discussed and lessons shared amongst staff. Lessons were mainly around reminding staff of the importance of sensitive and appropriate communication with patients.

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. We found details of the vision and practice leaflet values were part of the practice's strategy and two year business plan. These values were clearly displayed in the practice leaflet. The practice vision was 'to deliver first class primary healthcare and care services that are caring, compassionate, inclusive and continually improving and be a well-established forward thinking business and a fulfilling place to work.' The practice charter was in line with NHS charter and was included in the practice leaflet.

The practice had strong representation on the clinical commissioning group (CCG) through the senior partner, who was the clinical lead on the CCG, another GP was lead for diabetes across four CCGs and a third worked with the medicines optimisation team.

The practice was proud of its role in the community through its long history and links to charities. For example, recent charity events included fund raising for the local air ambulance and a coffee morning.

We spoke with 14 members of staff and they all spoke highly of the practice and were consistent in their values for achieving the practice aims.

We saw the practice had regular away days for senior staff to discuss the practice development including succession.

Governance arrangements

Practice had clear leadership and accountability structures. Supportive team environment. Staff handbook.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on the practice intranet. We looked at eight of these policies and procedures, they had all been reviewed annually and were all up to date.

We reviewed 12 notes of meetings including, clinical and reception meetings which had taken place over the last three months. They all contained discussion of issues, decisions and actions and follow up at the next meeting. 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 partner was the lead for safeguarding. We spoke with 14 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. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

We saw a range of clinical audits which had been used to monitor quality and systems to identify where action should be taken. For example, in the areas of prescribing and referrals.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, spillage and fire. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example to reduce trip hazards.

The practice held weekly business meetings. We looked at notes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

The practice demonstrated openness, for example, the waiting area had a large photo board naming every member of staff and all staff wore name badges.

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months with senior staff and sometimes facilitated by an external trainer.

Staff had access to an electronic staff handbook which contained a range of human resource policies and procedures including a whistleblowing policy. Staff we spoke with knew where to find these policies if required. Staff told us they were comfortable to raise issues and

Are services well-led?

Good

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

concerns and were confident they would be listened to and appropriate actions taken if necessary. The senior GP described a culture of 'Name and Share' to encourage learning from incidents.

The practice produced a regular surgery newsletter which was accessible in the practice and the website. We reviewed the September 2014 issue which highlighted the diabetes project, promoted the PPG and on-line booking and informed patients of changes to practice staff.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, thank you cards and letters and complaints received.

The practice had an active patient participation group (PPG), which met monthly. It was not chaired by a patient, but this was the PPG's choice and was under review. The PPG carried out an annual survey. The practice showed us the report of the findings from the national GP survey and 2013 PPG survey. It resulted in an action plan to improve telephone access by promoting online booking and increase receptionist cover at busy times. The PPG survey of 2014 focussed on patients views of extended access. Over 80% of patients responded they would like evening and weekend appointments. The practice had taken action and implemented two early morning and two late evening surgeries.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had a whistleblowing policy which was available to all staff in the staff handbook. 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. All staff said they had regular appraisals and we saw records to confirm this. Staff told us the practice was very supportive of training and where staff had shown interest encouraged them to obtain additional skills, for example, in phlebotomy.

The practice had completed reviews of significant events and complaints and shared learning with staff at meetings and to ensure the practice improved outcomes for patients. For example, reminding staff about the importance of sensitive and appropriate communication with patients

The practice was innovative in its approach and one of the GPs was the diabetes lead across the four federated CCGs of West Berkshire. The GP had won national recognition and four awards including the NICE shared learning award 2014 for his pioneering work in diabetes care planning.