Eagle House Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Eagle House Surgery on 10 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive and safe services. It was also good for providing services for older people, people with long term conditions, working age and recently retired people, families, children and young people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were generally assessed and well managed. The fire risk assessment identified actions to ensure fire safety that had not been completed in full.
- 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.
- The practice carried out home visits for over 75 year old health checks to identify issues that may have an impact on their health and wellbeing
- 94.7% of patients described their experience of making an appointment as good compared to the clinical commissioning group average of 81.9% and national average of 73.8%.
- 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 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.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

However there were areas of practice where the provider needs to make improvements:

Importantly the provider should

- The provider should ensure that all actions required from the fire risk assessment in February 2014 have been completed to improve the fire safety at the 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. 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. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' 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.

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 Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a 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. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

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 patient participation group was active. 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 people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, patients deemed at risk were on proactive care programmes. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice carried out home visits for over 75 year old health checks to identify issues that may have an impact on their health and wellbeing. There was a carer identification process in place and the practice ensured that this group were informed about support, both financial and practical which was available to support them.

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.The practice had a consistent approach to patients with chronic disease through close working between GPs and the practice nurse team. Clinic sessions were offered at varying times, to enable patients to attend and patients were involved in drawing up and agreeing their care plans.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 medicine 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.

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. We saw good examples of joint working with midwifery and health visitor teams and monthly multi-disciplinary meetings were held to discuss children on a protection plan, children in need and families of concern.

The practice offered a full range of childhood immunisations in line with national guidance. Children and young people were treated in

Summary of findings

an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

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. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability and offered longer appointments for people within these population groups.

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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice signposted patients experiencing poor mental health to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

We reviewed 30 CQC patient comment cards which had been completed in the two weeks prior to our visit. During our visit we spoke with five patients. We also looked at results from the GP national patient survey and results of the practice's patient survey. Information from all these sources indicated that overall patients were satisfied with the service provided.

National patient survey results showed that 95.4% of respondents described the experience of the practice as good. Other areas where the practice scored well included:

- 90.1% found it easy to contact the practice by phone.
- 96.15% were able to get an appointment to see or speak to someone the last time they tried.
- 88.2% usually waited 15 minutes or less after their appointment time to be seen.

The majority of comments on the comments cards were positive, apart from three which showed dissatisfaction with the amount of time patients had to wait for their appointment, once at the practice. We saw that the average wait time after the schedules appointment was given as 30 minutes.

Areas for improvement

Action the service SHOULD take to improve

- The provider should ensure that all actions required from the fire risk assessment in February 2014 have been completed to improve the fire safety at the practice.

Eagle House Surgery

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 and practice manager specialist advisor.

Background to Eagle House Surgery

Eagle House Surgery is situated in the semi-rural area of Blandford, Dorset. The practice holds a general medical services contract.

The practice has approximately 8500 patients on its register. The practice also provides a service to the local army camp and can usually care for up to 1000 patients above their permanent practice population. We inspected the main practice of Eagle House Surgery. The practice's demographics are in line with national averages, but there are a higher number of male patients in the 65-69 age group. There are also higher numbers of children under four who are registered.

The practice has five GP partners and one salaried GP. There are three female GPs and two male GPs. The practice has a team of three practice nurses and three health care assistants. The clinical team is supported by a practice manager, a reception team leader, five receptionists; a prescription administrator; a practice secretary and a medical records summariser. The practice is open between 8am and 6.30pm Monday to Friday. Appointments are available between these times and extended hours are offered on Mondays, Tuesdays and Thursdays between 6.30pm to 7.30pm.

When the practice is closed patients are advised to use the out of hours service provided by South West Ambulance service via the 111 service.

We inspected the main surgery:Eagle House Surgery, White Cliff Mill Street, Blandford Forum, Dorset. DT11 7DQ.

The branch surgery address is:

Families Medical Centre, Blandford Camp, Blandford Forum, Dorset. DT11 8RH.

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.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 10 June 2015 at Eagle House Surgery. During our visit we spoke with a range of

Detailed findings

staff which included GPs, nurses and reception staff. We spoke with patients who used the service. We reviewed 30 comment cards where patients and members of the public shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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 we reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 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.

The practice had a specific form for recording significant events which were collated by the practice manager for action. When needed incidents were reported to the clinical commission group. There was also a system in place to act on national alerts such as those from the National Patient Safety Advice and medicine alerts.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. Learning from these events was shared with relevant staff and the practice planned to include other staff groups. One example of a significant event occurred when a patient was prescribed an antibiotic by the hospital that they were allergic to. The practice provided the prescription and the patient collected the medicine to take and noted that they were allergic to this particular medicine. The patient did not take any of the medicine and alerted the practice and a suitable alternative was prescribed. As a result of this incident the practice changed its prescribing policy to ensure that all new medicines a patient needed were only prescribed by a GP.

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.

The practice had a dedicated GP partner and practice nurse as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All GPs had been trained or were being trained to level three safeguarding for children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. Contact details for relevant agencies were available in the reception area, as well as on the computer system.

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; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Chaperones were usually nurses or health care assistants. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

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 checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Practice staff monitored the refrigerator temperatures and appropriate actions had been taken when the

temperatures were outside the recommended ranges. When vaccines were transported to the branch location, a specific cool bag was used to ensure the temperature of the vaccines was maintained during transit.

The nurses used Patient Group Directions to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw examples of these directives and found they were in date and current.

A designated member of staff was responsible for managing repeat prescriptions requests. We found that there was a safe system in place to ensure repeat medicines were not prescribed beyond the review date and a GP review was requested. In addition, early requests for repeat prescriptions were flagged up and a GP would review the request. The member of staff was able to explain to us the system they used and demonstrated their thorough understanding of safeguards in place, for example they gave examples of medicines which were not on repeat prescriptions, such as controlled medicines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescriptions for use in printers and those for hand written prescriptions were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying medicines, which included regular monitoring. Appropriate action was taken based on the results. We looked at prescribing data from the Quality and Outcomes Framework (QOF) and saw the practice was in line or below the national prescribing pattern for antibiotic, hypnotics and anti-inflammatory medicines. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures).

Cleanliness and infection control

We observed 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.

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 and aprons 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We looked at the policy and found it complied with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. The practice had nominated infection control leads who linked with the infection control lead for the clinical commissioning group (CCG) for advice and support.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand cleansing gel and hand towel dispensers were available in treatment and consulting rooms. We saw that hand cleansing gel was also available at the reception.

Suitable arrangements were in place for handling and disposing of clinical waste in line with current guidance. The practice had arrangements in place to manage clinical waste, non-hazardous waste and used needles and medicines which were in line with national guidance and regulations. We saw clinical rooms had colour coded waste bags and sharps containers to ensure waste was appropriately segregated prior to disposal. Where disposable privacy curtains were used these were changed at least every six months, or sooner if needed.

The practice had a policy in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A legionella risk assessment had been undertaken and legionella testing had been carried out.

Equipment

Staff said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We looked at records for equipment testing and calibration. (Calibration is where pieces of equipment such as weighing scales and thermometers are tested to ensure they provide accurate measurements). We found that all equipment was tested and maintained. All portable electrical equipment was routinely tested and displayed

stickers indicating the last testing date which was in January 2015. There was an annual maintenance schedule in place for equipment such as emergency lighting, alarms systems and servicing of the gas boiler.

Liquid nitrogen which was used for treatment was stored in in an external ventilated cupboard and an up to date risk assessment was in place for its use.

Staffing and recruitment

The practice had a recruitment policy that set out its standards when recruiting clinical and non-clinical staff. We saw that a list of checks that was carried out before a person was employed, these included evidence of conduct in previous employment in the form of references, proof of qualifications and registration with the appropriate professional body. The list included completing a criminal records check via the Disclosure and Barring Service (DBS) on clinical members of staff.

We looked at a sample of staff recruitment files which included those for GPs, nurses and administration staff. We found that all had evidence of satisfactory conduct in previous employment, a full employment history and when needed evidence of criminal records checks carried out via the Disclosure and Barring Service (DBS). The recruitment process was carried out in line with their practice policy. When needed checks with professionals bodies such as the Nursing and Midwifery Council were made to ensure that nurses were registered to practice. The GP performers list was also checked when a new GP was recruited.

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 checks of the environment to ensure it was hazard free, medicines management, staffing, dealing with emergencies and equipment, for example portable appliance testing. We found that the risk assessments in place were comprehensive and were rated as to the likelihood and potential impact that could occur if issues arose.

There was a health and safety policy in place and all staff we spoke with were aware of the policy. The policy covered use of visual display screen equipment, moving and handling, disposal of clinical waste and control of substances hazardous to health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were 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. Mitigating actions were 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. For example, contact details of a heating company to contact if the heating system failed.

Records showed that staff were up to date with fire training and that they practised regular fire drills. We viewed fire safety maintenance records and found that fire extinguishers had been tested in November 2014 and six monthly fire evacuations were carried out.

The practice had carried out a fire risk assessment in February 2014, that included actions required to maintain fire safety, these actions had not been fully completed. We found that an area of risk related to the storage of paper records in the loft, this was deemed to be a medium risk. The practice had not taken any steps to minimise this risk, but said that the door leading to the loft was a fire door. Another recommendation was training of more staff to be fire wardens. At the time of our inspection one member of staff had received the fire warden training.

Good

Are services safe?

We also saw a computer server was placed on a carpet on a first floor landing of the practice. This area lacked ventilation and also the server was not secured, which posed a risk to patients.

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. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. For example NICE guidance on the use of aspirin for patients with atrial fibrillation, an irregular heartbeat, which was not recommended. The practice had conducted a search for these patients and reviewed the treatment to ensure they were not taking aspirin.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and 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. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice had a health care assistant who was responsible for carrying out health checks for the over 75's. They showed us a patient passport which contained details of the patient's gender, age, current medication and any allergies. The health care assistant said that they used a specific template to assess a patients physical health and when needed referred them to a GP for further assessment and treatment, for example if the patient's blood pressure was high.

Discrimination was avoided 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

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99.8% of the total QOF target in 2015, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- The dementia diagnosis rate was comparable to the national average

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 a sample of clinical audits that had been undertaken in the last three years and their plan for audits to be undertaken over the next year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. Examples of audits included one on use of specific antibiotics to ensure they were necessary. Results from this audit showed that these antibiotics were being used appropriately and were needed to provide effective treatment for the patients concerned.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). The practice 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. As a consequence of a patient who was terminally ill not receiving the best possible care, the practice had introduced a 'just in case box' which contained medicine for pain relief, protective personal equipment, such as gloves and aprons and mouth care equipment.

Good

Are services effective?

(for example, treatment is effective)

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example, those with learning disabilities. Structured annual reviews were also offered undertaken for patients with long term conditions, such as heart failure or diabetes.

GPs in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and keep up to date. They also regularly carried out clinical audits on their results and used this in their learning.

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 courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either 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 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 basic life support, fire training and confidentiality.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles which included seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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 these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. We found that in all cases results had been dealt with promptly and letters that had been received had been reviewed. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Information sharing

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, 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. Staff felt this system worked well.

Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. 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 and their duties in fulfilling it. All the staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Training had been provided on the Mental Capacity Act and Deprivation of Liberty Safeguards for staff. All clinical staff demonstrated a clear understanding of the Gillick

Good

Are services effective?

(for example, treatment is effective)

competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

Health promotion and prevention

The practice's performance for the cervical screening programme was 81.79%, which was at the national average of 81.89%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 varied when compared with national averages for the majority of immunisations where comparative data was available.

For example:

- Flu vaccination rates for the over 65s were 71%, and at risk groups 65%. These were below national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 96% to 99.2% and five year olds from 97.7% to 99.2%. These were above to CCG averages.

Patients over the age of 75 years were offered a health check at home, which was carried out by a designated healthcare assistant. We spoke with this member of staff and they showed us a leaflet which they gave to patient's once their check was completed. The leaflet included contact details for the practice and a record of their blood pressure, pulse and body mass index. It also had recorded alcohol intake and areas for patients to comment on their social and emotional health. The back page had a section for a patient to record their health aims.

The practice had a booklet for parents aimed at helping them support their children to navigate through adolescence. The booklet had information on risky behaviours that teenagers may participate in, such as drug taking and self-harm, and provided contact details for further support and information. The practice had a rigorous system to follow up missed immunisations and also contacted 16 year olds with no immunisation history, advising them of the impact of this and offered them a catch up programme. In addition, travel advice and immunisations were provided for all travellers.

The practice also provided information via its website or in the form of leaflets at the practice on men's' health, memory clinics, falls prevention and support agency that patients could access, such as debt counselling.

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 January 2015 and comment cards completed by patients.

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 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92.4% said the GP was good at listening to them compared to the CCG average of 89.7% and national average of 87.2%.
- 88.5% said the GP gave them enough time compared to the CCG average of 88.1% and national average of 85.3%.
- 95.3% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.9% and national average of 92.2%.

Additionally, 88.9% said they found the receptionists at the practice helpful compared to the CCG average of 89.6% and national average of 86.9%.

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.

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:

- 88.7% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.1% and national average of 82%.
- 77.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77.4% and national average of 74.6%.

The healthcare assistant responsible for over 75s health checks said that they visited patients in their own homes to carry out assessments. This allowed potentially upsetting conversations to be held privately, for example discussion about power of attorney and their wishes in the event a patient was no longer able to live at home.

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 patient 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:

- 89.4% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85.9% and national average of 82.7%.
- 85.3% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 79.2% and national average of 78%.

The practice had a designated member of staff who was responsible for supporting patients who were also carers. They showed us an information pack which included details on a male carers group, young carers and activity schemes for cares. There were also contact numbers for further advice and support, which included financial assistance and equipment loan or hire. Carers were contacted annually or more frequently if needed by the practice and an alert was placed on their record to indicate they were a carer or cared for. 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

Good

Are services caring?

organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients were asked if they were carers or were cared for, when registering with the practice and at their health checks.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was sometimes followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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. For example, personal lists were held for patients who misused drugs and the practice worked with other services to provide home detoxification programmes. The practice worked with the military welfare department to provide care and treatment for military families.

GPs and nurses offered opportunistic health checks during their routine appointments. Midwifery clinics were held twice weekly at the practice and copies of referral letters were sent to health visitors when pregnant women first booked in.

Tackling inequity and promoting equality

Patients who were of no fixed abode were able to register as temporary patients with the practice. Flexible appointments were offered for patients who were members of travelling communities and immunisations for children were accommodated within routine appointment times, instead of at the specific clinics held. There were separate waiting rooms for the GPs and nurses, both of which had sufficient space for wheelchairs and prams. There were accessible toilet facilities for patients with limited mobility. Consulting rooms were on the ground and first floor and when needed patients were seen on the ground floor if they had limited mobility. The practice was able to access translation services when needed and main parts of the website could be translated using Google translate.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. Appointments were available from 8am to 6.30pm on weekdays. Extended hours appointments were available on Monday, Tuesday and Thursday evenings from 6.30pm to 7.30pm. Same day urgent appointments and telephone consultations were available on request. Extended appointments were offered for patients when needed, for example those with long term conditions or those who had a number of diagnoses.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 77.3% were satisfied with the practice's opening hours compared to the CCG average of 77.8% and national average of 75.5%.
- 94.7% described their experience of making an appointment as good compared to the CCG average of 81.9% and national average of 73.8%.
- 88.2% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67.8% and national average of 65.2%.
- 90.1% said they could get through easily to the practice by phone compared to the CCG average of 81.7% and national average of 71.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice.

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 responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the form of leaflets and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. All of the patients we spoke with said they had never needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found these were dealt with in a timely manner and when needed a full and unreserved apology provided. Correspondence showed that concerns were investigated thoroughly and resolved as far as practicably possible to the complainant's satisfaction. For example, one patient complained about a delayed diagnosis and we saw the practice carried out a full investigation and provided a full honest and open response. Measures had been put into place to prevent reoccurrence, such as regular reviews of all referrals required, to ensure they had been sent.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We found that letters did not always contain information on other agencies to contact if the complainant was not satisfied with the response, but this information was included in the complaints leaflet and on the practice website. Learning from complaints was in place and we found that themes were identified and there were records of who information had been shared with and whether actions taken were effective.

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

Eagle House Surgery aimed to work in partnership with wider healthcare professionals and the local community to provide medical care for patients and temporary residents visiting the area. Patients were encouraged to self-manage their lifestyles to prevent illness and promote good health. The practice's mission statement was to improve the health and wellbeing and lives of the patient population. The aims and objectives detailed in their statement of purpose included:

- To provide a high standard of service for patients within a confidential and safe environment
- To show courtesy and respect at all times irrespective of ethnic origin, religious belief, personal attributes or the nature of the health problem
- To involve patients in decisions regarding their individual treatment
- To promote good health and well-being to for patients through education and information
- To work collaboratively with allied healthcare professionals in the care of patients
- To encourage patients to participate in practice developments through participation and reference groups.
- To ensure that all members of the team have the right skills and training to carry out their duties competently

All staff we spoke with were aware of the vision and values and demonstrated them in their practice. Staff considered that the practice offered a traditional cradle to grave service, where the emphasis was on meeting patients' needs and caring for families as a whole. Work on cultures and values had been carried out with the patient participation group, partners and staff to produce the mission statement and underlying values. These aspirations were documented and available to staff to reference.

Governance arrangements

We spoke with 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. Policies and procedures which governed activity were reviewed and updated regularly. Staff said that when a policy was updated they were informed by a monthly leaflet which told them of the changes, they said they were required to record that they had read the updated policy and noted its contents when needed.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using 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.

The practice had a system in place for clinical audits and we saw that these had been planned for the forthcoming year. A work plan was in place which covered environmental, clinical and staffing needs. For example, there was an ongoing redecoration and refurbishment programme and employment procedures had been reviewed and updated when needed. The practice manager was in the process of completing a training needs analysis to ensure all training undertaken had been captured and suitable arrangements were in place to meet staffs training needs and continual professional development requirements.

Practice staff were aware of the need to protect patient information and computer systems were password protected and staff were only able to access the system by using a smart care. Training on information governance had been planned for all staff in August 2015. We saw records which confirmed this.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

The partners, practice manager and staff members had worked on business continuity and resilience. In the previous months prior to the inspection there had been changes to the partners and new ways of working had been introduced. For example, nurse prescribers had been employed and a new nurse team leader was identified.

Are services well-led?

Good

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

We saw from minutes that team meetings were held regularly for all staff groups. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners and managers in the practice.

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

We met with members of the patient participation group (PPG) and they told us about the work they carried out to support the practice. The PPG meet monthly and also linked with other PPGs in the area and the clinical commissioning group. There was also a virtual patient participation group which consisted of 3% of the practice population. The practice carried out a continuous survey of patient views, which the PPG reviewed quarterly.

The members considered that they were a critical friend to the practice and worked in collaboration with them to improve the patient experience. Examples of how this had been achieved included making early evening appointments available for cervical cytology screening and liaising with a local pharmacy to address concerns about prescriptions not being received. The PPG said that they continued to activity recruit new members and would attend flu clinics, visit local schools and mother and baby groups to raise awareness of the group and hopefully recruit new members. The PPG considered that the practice was responsive and listened to their views and their meetings were always attended by the practice manager and a GP.

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 files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training where guest speakers and trainers attended. The practice also had a policy to develop and upskill staff, for example a member of the administration team was responsible for carers and a health care assistant was responsible for the over 75 year olds health checks. The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.