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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Myrtle House Surgery on 19 January 2017. Overall the practice is rated as requires improvement.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, records maintained by the practice did not include sufficient detail to demonstrate improvement actions were monitored and reviewed to ensure they were adequate and effective.
- Risk management activity was not consistently and fully completed. For example risks related to fire and electrical safety had been identified in 2016 but limited action had been taken to mitigate those risks.
- Infection prevention and control (IPC) activity was undertaken within the practice supported by a practice policy and regular audits. However, audit activity was not comprehensive and audit records did not detail sufficient information to demonstrate action was taken when areas for improvement were identified.
- There was limited evidence of IPC training for staff.
- Systems in place to ensure appropriate follow-up action was taken for patients identified as vulnerable within practice records following receipt of notifications were not sufficient.
- Data showed patient outcomes were variable when compared to the national average. However, a good understanding of performance was maintained within the practice and there was evidence of continuing improvement.
- Patient's feedback was generally good and patients said they were treated with compassion, dignity and respect.
- The practice had a number of policies and procedures to govern activity, but we noted compliance with practice policy was not always consistent.

The areas where the provider must make improvements are:

Summary of findings

- Take action to mitigate identified risks and review and improve the governance arrangements for the identification, assessment and management of health and safety risks to ensure they are comprehensive and complete.
- Review the systems in place to ensure appropriate follow-up action is taken for patients identified as vulnerable within practice records following receipt of notifications.

In addition the provider should:

- Implement a revised system to support the completion of staff training and maintenance of associated records.
- Ensure staff have received infection prevention and control training as appropriate to enable them to carry out their individual roles and responsibilities.
- Create and maintain records to support the management of clinical audit activity and that demonstrate the implementation of improvement actions.
- Have a system in place that details the actions taken in response to all alerts issued by external agencies.
- Implement a system to support compliance with practice policies and procedures.
- Consider the installation of a hearing loop and ensure all staff are aware of the availability of translation services within the practice.
- Review the practice Service Continuity plan to ensure it details appropriate direction and information relevant to Myrtle House Surgery.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was a system in place for reporting and recording significant events. However, records maintained by the practice did not include sufficient detail to demonstrate improvement actions were monitored and reviewed to ensure they were adequate and effective.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a verbal or written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse. However, the systems in place to ensure appropriate follow-up action was taken for patients identified as vulnerable within practice records following receipt of notifications were not sufficient.
- Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example risks related to fire and electrical safety had been identified in 2016 but limited action had been taken to mitigate those risks.
- Infection prevention and control responsibilities had been allocated to staff within the practice. However, there was limited evidence of staff training and associated audit activity was not comprehensive or supported by adequate records. For example the sealed floor within a treatment room was in a poor state of repair and this had not been identified as a risk or area for improvement.
- Staff training records were not consistently maintained. For example there was no evidence of safeguarding training completion for two of three GPs that regularly worked within this practice location. We were sent confirmation that the two GPs completed associated training immediately following our inspection visit.

Are services effective?

Good

The practice is rated as good for providing effective services.

Summary of findings

- Data showed patient outcomes were variable when compared to the national average. However, a good understanding of performance was maintained within the practice and there was evidence of continuing improvement.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data showed patient outcomes were variable when compared to the national average. We noted the practice was taking action to improve patient engagement and experience.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible. For example the practice website provided the opportunity for information to be viewed in a wide variety of languages.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example having recognised the limitations of the current practice building the practice was involved in ongoing liaison and planning with NHS England and the CCG to explore options to move to more suitable premises.
- Patients said they found it generally easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had adequate facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about how to complain was available on request and was easy to understand. Evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led.

- The practice told us they had a vision to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management.
- The practice had a number of policies and procedures to govern activity, but it was identified that not all policies were consistently applied.
- The practice had an overarching governance framework but we found evidence that the supporting systems and processes were not consistently applied and/or effective, particularly those related to the management of risk. For example risks identified in June and October 2016 had not been mitigated or managed effectively. In addition although infection prevention and control audit activity was undertaken there were no systems or process in place to ensure the activity was comprehensive or that issues identified were appropriately addressed.

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

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- A practice based community nurse and community healthcare assistant (HCA) supported the practice in the provision of services to older people. As a result of a review the practice had a plan in place for the HCA to make contact and visit older patients that had not attended or contacted the practice for some time.
- Patients were offered an appointment with the practice based pharmacist to discuss any complex medication queries.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was between 50% and 96% and this was lower than the national average range of 70% to 95%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines 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.

Summary of findings

Families, children and young people

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

- Immunisation rates were comparable to local and national levels 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.
- Cervical screening uptake for women aged 25-64 years was 95%, which was higher than the Clinical Commissioning Group average of 83% and national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

- 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.
- A text messaging service was used to remind patients of appointment times and reduce non-attendance.
- Telephone appointments were offered to reduce the need for patients to visit the practice in person.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

The practice held a register of patients living in vulnerable circumstances including those with a learning disability and housebound patients.

Summary of findings

- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed 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.
- Alerts were placed on patient records to enable appropriate support to be given to vulnerable patients. However, we noted that follow-up activity was not consistently recorded for patients identified as vulnerable following receipt of notifications.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for providing safe and well-led services. The concerns which led to these ratings apply to everyone using the practice, including this population group.

However,

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. We were told a practice GP was the locality clinical lead for mental health and learning disabilities that had worked closely with local clinical commissioning groups and had been nominated for various awards during the previous 12 months.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- 75% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was lower than the national average of 84%.
- 67% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive care plan documented in the preceding 12 months, which was lower than the national average of 89%.

Summary of findings

- A record of alcohol consumption was recorded for 67% of patients with mental health related conditions compared to 89% nationally.

Summary of findings

What people who use the service say

The national GP patient survey results were published 7 July 2016. The results showed the practice was generally performing below local and national averages. A total of 285 survey forms were distributed and 110 were returned. This was a response rate of 39% and represented approximately 2% of the practice's patient list.

- 63% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 72% and national average of 73%.
- 81% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 83% and national average of 85%.
- 76% of patients described the overall experience of this GP practice as good compared to the CCG average of 84% and national average of 85%.
- 60% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 76% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 42 comment cards the majority of which were positive about the standard of care received and included praise for staff by name. 10 cards included less positive comments related to access issues and the attitude of some GPs and other staff members.

We spoke with one patient during the inspection and one member of the patient participation group who was also a patient. The two patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

- Take action to mitigate identified risks and review and improve the governance arrangements for the identification, assessment and management of health and safety risks to ensure they are comprehensive and complete.
- Review the systems in place to ensure appropriate follow-up action is taken for patients identified as vulnerable within practice records following receipt of notifications.

Action the service SHOULD take to improve

In addition the provider should:

- Implement a revised system to support the completion of staff training and maintenance of associated records.
- Ensure staff have received infection prevention and control training as appropriate to enable them to carry out their individual roles and responsibilities.
- Create and maintain records to support the management of clinical audit activity and that demonstrate the implementation of improvement actions.
- Have a system in place that details the actions taken in response to all alerts issued by external agencies.
- Implement a system to support compliance with practice policies and procedures.
- Consider the installation of a hearing loop and ensure all staff are aware of the availability of translation services within the practice.
- Review the practice Service Continuity plan to ensure it details appropriate direction and information relevant to Myrtle House Surgery.

Myrtle 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 specialist adviser.

Background to Myrtle House Surgery

Myrtle House surgery (154 Blackburn Road, Accrington, BB5 0AE) is part of the NHS East Lancashire Clinical Commissioning Group (CCG) and provides services to approximately 5000 patients under a General Medical Services contract with NHS England. The surgery building is a converted mid terraced house with limited parking. It has level access and provides patient facilities of a waiting area, treatment room and consulting rooms all on the ground floor. An additional waiting area and treatment/ consultation room is also provided on a lower ground floor that also provides level access externally from the rear of the property. We were told the lower ground floor rooms are not routinely used by the practice but are used by visiting healthcare professionals.

The registered provider, Oswald Medical Centre, also offers services from three other sites under a separate contract with NHS England and in accordance with a separate CQC registration. It is noted Myrtle House Surgery is identified as a branch site of Oswald Medical Centre on the practice website. However, as Myrtle House Surgery operates under a separate contract with NHS England, an independent patient list is maintained and patients are not routinely able to access services at other Oswald Medical Centre sites without prior arrangement.

Information published by Public Health England rates the level of deprivation within the practice population group as level three on a scale of one to 10. Level one represents the highest levels of deprivation and level 10 the lowest. Male and female life expectancy in the practice geographical area is 76 years for males and 81 years for females, both of which are below the England average of 79 years and 83 years respectively. The number of patients in the different age groups on the GP practice register was generally similar to the average GP practice in England.

The practice has a lower percentage (49%) of its population with a long-standing health condition when compared to the England average (53%). The practice percentage (62%) of its population with a working status of being in paid work or in full-time education is similar to the England average (63%). The practice percentage (5%) population with an unemployed status is also similar to the England average (4%).

The practice is staffed by five GP partners (one female and four male) and one salaried GP (female). The GPs are supported by a nurse practitioner, assistant practitioner, a healthcare assistant, a practice based community nurse and a practice based clinical pharmacist. Clinical staff are supported by a senior business manager, a practice manager and 12 administration and support staff.

The practice is open Monday to Friday from 8am to 6.30pm with the exception of Wednesday when the practice closes at 1pm. Appointments are available between 8.30am and 11am Monday to Friday and between 3.30pm and 5.30pm Monday, Tuesday Thursday and Friday. On Wednesday afternoons patients are able to access appointments at a local Oswald Medical Centre site in addition to extended hours appointments at this alternate site on Monday from 6.30pm to 8.30pm.

In addition to pre-bookable appointments that can be booked up to two weeks in advance, urgent appointments

are also available for people that need them. When the practice is closed, Out of Hours services are provided by East Lancashire Medical Services and can be contacted by telephoning NHS 111.

The practice provides online patient access that allows patients to book appointments and order prescriptions.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 January 2017. During our visit we:

- Spoke with a range of staff including GPs, nursing staff, practice management and administrative staff. We also spoke with patients who used the service.
- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We noted that individual records provided summary details of the incident and the action taken. However, the overarching register of incidents maintained by the practice did not include sufficient detail to demonstrate improvement actions were monitored and reviewed to ensure they were adequate and effective.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We were told that lessons were shared and action was taken to improve safety in the practice.

Overview of safety systems and processes

The practice had defined systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and we were told they had all received training on safeguarding children and vulnerable adults relevant to their role. However, there was no evidence of safeguarding training completion for two of three GPs that regularly worked within this practice location. We were sent confirmation that the two GPs completed associated level three training immediately following our inspection visit. GPs were trained to child safeguarding level three and nurses were trained to level two.
- We noted through a sample review of patient records that follow-up activity was not consistently undertaken or recorded for patients identified as vulnerable within practice records, following the receipt of information or notification from external sources. For example there was no evidence within practice records to indicate a child identified as vulnerable had been followed up after the practice was formally notified the individual had not attended a planned appointment at a local hospital.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice healthcare assistant was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and we were told staff had received up to date training although evidence of training completion was not available when requested. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result but the action taken was not formally noted within the audit records.
- We were told no additional training had been given to the IPC lead to support the completion of lead activities. Document templates used by the IPC lead were not sufficiently detailed to provide adequate assurance or

identify areas for improvement in relation to IPC risks. For example the sealed floor within a treatment room was in a poor state of repair and this had not been identified as a risk or an area for improvement.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal).
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of a practice pharmacist and the local CCG pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines against a patient specific direction from a prescriber.
- The practice had a process, supporting documentation and clearly defined responsibilities for monitoring and maintaining medicines carried in GP bags. We were shown records to demonstrate checks had been carried out. However, a physical check of a GP bag revealed it contained two vials of adrenaline that detailed an expiry date of November 2016. Immediate action was taken by practice staff to appropriately dispose of the out of date items and we were told the current process for monitoring bag contents would be reviewed as a matter of priority.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications and the appropriate checks through the Disclosure and Barring Service. One file did not contain evidence of registration with the appropriate professional body and immediate action was taken by the practice to confirm registration and place a record on the associated file. We noted that personnel files were not maintained in a consistent manner and that templates detailed within the practice recruitment policy to support the completion of employment checks had not been used.

Monitoring risks to patients

Risks to patients were identified, assessed and recorded although the management of risk was not always comprehensive, consistent or supported by adequate records.

- There were procedures in place for monitoring and managing risks to patient and staff safety but comprehensive supporting records were not maintained. For example the practice risk register did not include reference to issues identified as a result of a premises fire inspection undertaken 18 May 2016 or the improvement recommendations detailed within the premises electrical installation condition report dated 1 June 2016 that assessed the premises as unsatisfactory.
- The practice told us the report from the fire inspection was not received until 6 October 2016 and an action plan was created following receipt of the report. The fire inspection report included 15 recommendations for improvement and a copy of the action plan supplied by the practice following our inspection identified the practice had taken action in relation to eight of the recommendations. The practice was requested to provide evidence that demonstrated the action plan was regularly monitored and updated but we were told documentary evidence was not available.
- The premises electrical installation condition report dated 1 June 2016 included 11 observations classified as C3 (improvement recommended). Classification C3 indicates non-compliance with the current safety standard which, whilst not presenting immediate or potential danger, would result in significant improvement if remedied. The report had been discussed at practice management meetings during 2016 and remedial action had been agreed. However, an action plan had not been created and not all recommendations had been addressed at the time of our inspection. The practice had received a quote dated 7 January 2017 for the seven remaining recommended improvements and told us arrangements would be made as a matter of priority for the work to be completed following our inspection.

Requires improvement

Are services safe?

- The practice had nominated a member of staff to review and improve systems in place to support fire safety in the practice. We were shown documentation developed by the nominated individual that supported the completion of fire evacuation drills and also included the opportunity for learning from the drills to be recorded and communicated.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. We noted the practice emergency medicines did not include atropine or benzyl penicillin in accordance with recommended best practice and the risks to patients created by the lack of these medicines had not been assessed.
- The practice had a defibrillator available on the premises and oxygen. At the time of our inspection only adult masks were available for use with the oxygen. We were told masks for children would also be made available as a matter of priority following our observation.
- A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. With the exception of two items located in a GP bag all the medicines we checked were in date and stored securely.
- The practice had a generic Oswald Medical Centre Service Continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However, we noted the plan did not include specific reference to Myrtle House Surgery.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- We saw evidence alerts were received and action was taken as required. However, there were no formal systems or processes in place to record alert distribution or confirm appropriate action was taken.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results (2015/16) were 80% of the total number of points available with 8% overall clinical domain exception reporting (exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Practice management told us significant improvement actions were required when the current provider took over the practice in 2014 although we were not provided with evidence to indicate improvement action was formally planned. However, comparison of data indicates performance improvement is ongoing for example total QOF achievement for 2015/16 was 80% compared to 72% in 2014/15.

Data from 2015/16 showed:

- Performance for diabetes related indicators was generally lower when compared to national averages. For example:
  - 96% of patients with diabetes had received an influenza immunisation compared to the national average of 95%.
  - A record of foot examination was present for 63% of patients compared to the national average of 89%.
  - Patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) was within recommended levels was 75% compared to the national average of 91%.
  - Patients with diabetes whose last measured total cholesterol (measured within the preceding 12 months) was within recommended levels was 59% compared to the national average of 80%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months was within recommended levels was 62% compared to the national average of 83%.
- Performance for mental health related indicators was lower when compared to national averages. For example the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record in the preceding 12 months was 67% compared to the national average of 89%.
- The percentage of patients diagnosed with dementia whose care had been reviewed face to face in the preceding 12 months was 75% compared to the national average of 84%.

The practice carried out a variety of audits to inform quality improvement including medication audits aided by the practice pharmacist and the local CCG pharmacy team. For example, as a result of a review of the management of Urinary Tract Infections (UTI) opportunities for improvement were identified related to the use of urine dipsticks as a tool in diagnosis of UTI and reduce prescribing of antibiotics in line with best practice. We were told regular discussions took place to consider audit outcomes and agree future audit areas but records of these discussions and a formal audit plan were not available when requested by a member of the inspection team.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as health and safety and confidentiality. The current induction

Good

Are services effective?

(for example, treatment is effective)

programme did not include formal reference to topics such as safeguarding but we were told training and information was provided to staff. We noted the practice was in the process of implementing a new system to improve staff training records and associated governance in the practice.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Staff were also provided with in-house training that included improving patient experience.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking cessation and alcohol consumption. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 95%, which was higher than the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 51% to 87% and five year olds from 59% to 98%.

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

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard by individuals outside of the clinical areas.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

The majority of the 42 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was generally comparable to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and the national average of 89%.
- 88% of patients said the GP gave them enough time compared to the CCG and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG and the national average of 95%.
- 80% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national average of 85%.
- 89% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and the national average of 91%.
- 78% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

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

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG and the national average of 86%.
- 79% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and the national average of 82%.
- 85% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. However, it was noted that not all clinical staff were aware of the availability of the translation services.

Good

Are services caring?

- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information was also available on the practice website.

The practice's computer system alerted GPs if a patient had or was a carer. The practice had identified 130 patients as being or having a carer (approximately 3% of the practice list). A practice protocol was in place to support the identification and registration of patients and a notice board in the practice was dedicated to providing information to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either 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

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example the practice had recognised the limitations of the current practice building. As a result the practice was in involved in ongoing liaison and planning with NHS England and the CCG in relation to a proposal to amalgamate Myrtle House Surgery and two other Oswald Medical Centre practice sites into a single more suitable building.

- For patients unable to attend the surgery during normal working hours the practice offered extended hours appointments at a local alternative Oswald Medical Centre site on a Monday evening between 6.30pm and 8.30pm.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities and translation services available. However the practice did not have a hearing loop and staff told us they would react to patient needs and provide appropriate support as required.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday with the exception of Wednesday when the practice closed at 1pm. We were told the practice had a plan to open the practice on a Wednesday afternoon in the future but until the plan was implemented patients were offered the opportunity to book appointments at a local alternative Oswald Medical Centre site. Extended hours appointments were also offered on a Monday evening between 6.30pm and 8.30pm at the same local alternative Oswald Medical Centre site. In addition to pre-bookable appointments that could be booked up to two weeks in advance, urgent appointments were also available for people that needed them.

Patients on the practice 'Avoiding Unplanned Admissions Register' were provided with a dedicated telephone number to call to improve patient access and ensure requests for assistance were dealt with as a priority.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was variable when compared to local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared to the CCG average of 75% and the national average of 76%.
- 63% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%. We noted improvements had been made as a result of feedback received that included the installation of digital telephone lines and increasing the number of staff available to answer calls during busy periods.

People told us that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

Practice staff were able to describe the system in place to assess the urgency of need when patients called to make an appointment. Staff were able to offer telephone consultations and would record any requests for a home visit and pass the patient details to a GP. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Its complaints policy and associated guidance for patients 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. However, we noted this information was only available on request from reception staff and there was no information displayed in the waiting area to advise patients of information availability.
- The practice routinely monitored patient comments on the NHS Choices Website and where applicable provided responses that offered the opportunity for individuals to meet with a member of the practice team to discuss any issues or concerns further as required.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled in a timely way. Lessons were learnt from individual concerns and complaints that was shared with staff through staff meetings and we were told action was taken to as a result to improve the quality of care. However, we noted the practice register of complaints did not detail sufficient information to fully support trend analysis or provide details of any improvement action taken.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice told us they had a vision to deliver high quality care and promote good outcomes for patients.

The practice had recognised the limitations of the current practice building and had been liaising and working with NHS England and the clinical commissioning group (CCG) to explore options to relocate the practice to a more suitable building. We were told further meetings were planned with the CCG in 2017 to agree and finalise relocation arrangements.

Governance arrangements

The practice had an overarching governance framework which was intended to support the delivery of the practice vision and good quality care. For example:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Clinical and internal audit was used to monitor quality and to make improvements although we noted clinical audit was not supported by a formal programme.
- Practice specific policies were available to all staff.

However we found evidence to indicate the supporting systems and processes were not consistently applied or effective. For example:

- Documentation held within staff files was not consistent and did not demonstrate compliance with the practice recruitment policy.
- Although infection prevention and control audit activity was undertaken there were no systems or process in place to ensure the activity was comprehensive or that issues identified were appropriately addressed.
- The practice did not maintain adequate records to demonstrate staff had completed required training. However, it was noted the practice was in the process of implementing a new record system that had the potential to improve the management of staff training.
- The system in place to ensure vulnerable patients were followed up was not consistently applied. For example, a sample review of patient records identified there was no evidence to indicate follow up action had been taken when the practice was informed a patient identified as vulnerable had failed to attend a planned appointment at local hospital.
- Risk management activity was not consistent and there was no evidence to indicate all identified risks had been mitigated or managed effectively.
- There were opportunities for improvement in the management of safety alerts. We saw evidence alerts were received and action was taken as required. However, there were no formal systems or processes in place to record alert receipt and distribution or confirm appropriate action was taken.

Leadership and culture

Partners told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

Are services well-led?

Requires improvement

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through surveys, complaints received and monitoring comments uploaded to the NHS Choices website. Improvements had been made as a result of feedback received that included the installation of digital telephone lines and increasing the number of staff available to answer calls during busy periods.
- At the time of our visit the practice was in the process of reorganising the patient participation group (PPG) that included patients from all Oswald Medical Centre sites including Myrtle House Surgery. We were told two members of the PPG were patients at Myrtle House Surgery and work was ongoing to encourage further patient involvement at this practice location.
- The practice had gathered feedback from staff generally through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example the practice had employed a practice based pharmacist as part of a pilot scheme supported by the CCG.

External specialists were regularly invited into the practice to provide information and training to staff during practice meetings.

At the time of our visit we were told the practice was working towards becoming an accredited training practice and that four GP partners were already qualified trainers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users and others. This was in breach of regulation 12.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person did not have systems and processes in place to demonstrate effective governance of the practice. This was in breach of regulation 17.