

Roe Lee Surgery

Quality Report

367 Whalley New Road
Blackburn
BB19SR
Tel: 01254 618000
Website: www.roe-lee-surgery.co.uk

Date of inspection visit: 11 November 2014
Date of publication: 05/02/2015

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

Ratings

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

Summary of findings

Contents

Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	3
What people who use the service say	5
Areas for improvement	5

Detailed findings from this inspection

Our inspection team	6
Background to Roe Lee Surgery	6
Why we carried out this inspection	6
How we carried out this inspection	6
Detailed findings	8

Overall summary

Letter from the Chief Inspector of General Practice

We inspected Roe Lee Surgery on 11 November 2014 as part of our new comprehensive inspection programme. We looked at how well the practice provided services for all population groups of patients. The inspection took place at the same time as other inspections of GP practices across Blackburn with Darwen Clinical Commissioning Group.

The overall rating for this practice is Good.

Our key findings were as follows:

- Well established systems were in place to ensure information about safety was recorded, monitored, reviewed and actioned.
- Lessons were learned and communicated widely to support improvement.

- Feedback from patients about their care and treatment was consistently positive.
- We found the practice supported a strong team based ethos and this was reflected across all staff.
- Patients with substance misuse problems had access to a weekly drug and alcohol support and treatment clinic.
- The practice provided care and treatment for women who reside in a women's refuge

However there was also an area of practice where the provider needs to make improvements.

The provider should:

- Ensure that enhanced Disclosure and Barring checks are undertaken for clinical staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

The practice had established systems in place to raise concerns and to report incidents and near misses. Staff had a good understanding of their roles and responsibilities, for example in regards to safeguarding patients. Risks to patients were identified, assessed and well managed. There were enough staff to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services.

Data from the Information Centre for Health and Social Care showed patient outcomes were at or above average for the locality. Care was planned and delivered and considered national guidance. Systems were in place to ensure National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely.

Good



Are services caring?

The practice is rated as good for providing caring services.

Data from the National GP Survey showed that patients rated the practice higher than others for several aspects of care. Patients told us they were treated with compassion, dignity and respect. Patients said they were involved in decisions about their care and treatment and that staff, both nurses and GPs, spent time to listen and explain all aspects of care to them.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

It reviewed the needs of its local population and engaged well with the local Clinical Commissioning Group (CCG). The practice had good facilities and was well equipped to treat patients and meet their needs. Most patients reported good access to the practice and were able to make appointments with a named GP. Some patients described waiting a long time once arriving in the surgery, however acknowledged that they then, appreciated how long the GP would then spend with them during the consultation.

Good



Are services well-led?

The practice is rated as good for being well-led.

All staff were well supported by a strong team based ethos. There was a clear leadership structure and all staff told us they felt supported by management. The practice had a number of policies

Good



Summary of findings

and procedures to govern activity and regular practice meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and action was taken. Staff received an appropriate induction, regular on-going training and appraisals

Summary of findings

What people who use the service say

We received 33 completed CQC comment cards and spoke with 14 patients at the time of our visit. We also spoke by telephone, with the Chair of the Patient Participation Group (PPG).

Patients told us that they felt they received good or a very good standard of care from all the doctors and nurses. Patients reported their experiences with staff as excellent or brilliant. These comments were from patients across age, sex and ethnic groups. Only one patient gave negative feedback about their care.

The comments cards also reflected a positive experience of both the nurses and GP's. Patients wrote that they valued the amount of time taken during consultations and how well treatments and other options were explained.

We also reviewed the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England.

80% of respondents describe their overall experience of this surgery as good. (CCG average 86%)

89% of respondents had confidence and trust in the last GP they saw or spoke to at the practice. (CCG average 87%)

89% of respondents said the last nurse they saw or spoke to at the practice was good at treating them with care and concern (CCG average 82%)

The Chair of the PPG commented that the practice responded quickly when any feedback was given on behalf of patients. Although the group was small in numbers, it was acknowledged that the practice was actively encouraging patients across all age groups and backgrounds to join the PPG, to give a representation of the diversity of the patients and varied needs.

Areas for improvement

Action the service **SHOULD** take to improve

Nursing staff only had the standard level of Disclosure and Barring checks prior to employment.

Roe Lee 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 a Specialist advisor with experience as a practice nurse.

Background to Roe Lee Surgery

Roe Lee Surgery provides care under a Personal Medical Services contract with NHS England. The practice is part of the Blackburn with Darwen Clinical Commissioning Group (CCG) and has 5,500 registered patients. The practice is situated in one of the more deprived areas of Blackburn. There is a small branch surgery located at Langho, a village on the outskirts of Blackburn, open twice a week, but patients can access care from either location. We did not visit the branch surgery on this occasion.

Opening times are: Monday to Thursday 8.30 until 1pm. 2pm until 6pm and Friday 6.45-8am then 8.30 until 1pm. 2pm until 6pm.

The practice has two male GP partners and one regular female locum GP. Clinical staff comprise of a nurse practitioner (female), a practice nurse (female) and a health care assistant (female).

The population of the practice is:

aged 0 to 4 years 6.4%

aged 5 to 14 years 13.5%

aged under 18 years 23.8%

aged 65+ years 16.4%

aged 75+ years 7.9%

aged 85+ years 2.45%

The male population, of working age, is slightly higher than the England average and the practice has a slightly lower percentage of patients over the age of 65. The largest group of patients at the practice are between the ages of 0-19 and 35 and 54.

Out of Hours emergency care is provided by East Lancashire Medical Services, based at the local NHS hospital.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people

Detailed findings

- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. No information of concern about Roe Lee Surgery was received. We carried out an announced visit on 11 November 2014. During our visit we spoke with staff including the two partner GPs, one locum

GP, the practice manager, the practice nurse and nurse practitioner, five reception and administration staff and with 14 patients who used the service. We also spoke with a member of the Clinical Commissioning Group medicines management team, who was visiting the practice at the time.

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

Are services safe?

Our findings

Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents were investigated and managed.

We reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the Quality and Outcomes Framework (QOF), which is a national performance measurement tool monitored by the CCG, showed that in 2013-2014 the practice was appropriately identifying and reporting significant events.

The practice used a range of information to identify risks and improve patient safety. These included complaints, findings from clinical audits, significant events and feedback from patients and other health and social care professionals. Staff were clear about their responsibilities in reporting any safety incidents.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. It was clear the practice had an open culture and that staff were encouraged and supported to report any incidents. Weekly staff meetings with reception and administration staff, monthly practice meetings and weekly clinical meetings were used to discuss and communicate learning and improvement from complaints and incidents. Minutes from these meetings were shared by email with all staff and paper copies retained within the practice.

We saw the practice had a system for managing safety alerts from external agencies. For example those from the Medicines and Healthcare products Regulatory Agency (MHRA). These were reviewed by the GPs and practice manager and action was taken as required.

Reliable safety systems and processes including safeguarding

There were systems to manage and review safeguarding 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. One of the GP partners was the identified safeguarding lead for children and adults but both GPs had undertaken level 3 training as required.

When we spoke with both clinical and administration staff, it was clear that they had a good understanding of their responsibilities and staff could articulate the procedures required should any concerns be raised. The GP explained a recent concern and it was clear that action had been taken in a timely manner and shared with the relevant health and social care professionals. GPs told us that attendance at case conferences and serious case reviews was difficult due to the short notice of meetings but that reports were submitted as requested.

The practice had a current chaperone policy in place. We saw evidence that clinical and non-clinical staff had received appropriate training on how to act as a chaperone when requested. Information about requesting a chaperone was displayed in the waiting area.

Staff were familiar with the term whistleblowing. We were told consistently by staff we spoke with that they would have no hesitation about raising any concerns about any member of staff. They were also positive about the support that would be provided if they ever had to raise concerns about a colleague. Staff were aware of external organisations such as the CQC, Nursing and Midwifery Council and the General Medical Council in the event of any professional or clinical concerns.

The practice had systems in place to highlight vulnerable patients and for patients with complex medical conditions. A register was also maintained for patients who were house bound. Action was taken when children and young people were identified with a high number of attendances at the out of hours (OOH) service or the local A&E department. Children who failed to attend for immunisations were identified and action taken to rearrange as soon as possible.

Medicines management

Systems were in place for the management of medicines.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

Are services safe?

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Daily temperature checks were documented.

We saw medicines were in date and robust systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

Appropriate medicines for emergency use were readily available. These included adrenaline (used to treat anaphylactic shock) and benzyl penicillin (used as first line treatment in cases of meningitis).

Prescriptions were reviewed and produced electronically. We were told hand written prescriptions were rarely used. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw evidence of actions taken in response to a review of prescribing data. For example, patterns of prescribing disease-modifying anti-rheumatic drugs (DMARDs), one of the most common, Methotrexate. Warfarin prescribing (used to thin the blood) was robustly monitored and documented on a specific template, in addition to the patient's individual record booklet.

Weekly visits were made by a member of the Clinical Commissioning Group (CCG) medicines management team. When we spoke with a visiting team member no concerns were raised about the practice. We were told that the practice was engaging well with a programme of medicine optimisation. This is to ensure that the right patients get the right choice of medicine, at the right time. It is particularly important when patients are prescribed multiple medicines.

We saw evidence that regular medicine reviews were undertaken. There had been reduction in prescribing medicines such as cortical steroids (used in treating asthma) and Pregablin (used to treat neuropathic pain, anxiety disorder and epilepsy) as a result of medicine reviews and completed audit cycles.

Cleanliness and infection control

We found care and treatment was provided in an environment that was clean and well organised. An infection prevention and control (IPC) policy was in place, with an identified lead but this required review in

September 2014. We raised this with the practice manager who assured us this would be actioned. We saw evidence that staff had attended training in IPC. Reception staff had guidance and appropriate procedures to follow when specimens were handed in by patients to reduce cross infection risks.

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.

There were adequate supplies of personal protective equipment, such as gloves and aprons and hand wash gels and paper towels were available. We saw sharps bins for needles were appropriately dated and stored away from patient access.

The practice undertook minor surgery within one of the treatment rooms and there were procedures in place for the safe handling of instrumentation. Any instruments that were non disposable were sent to the local hospital for appropriate decontamination and sterilisation.

Clinical waste was handled in line with guidelines and was stored in a locked collection bin. A contract was in place with a registered waste collection company.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings).

Equipment

All equipment seen was in good condition and maintained to a good standard. Electrical equipment had been portable appliance tested (PAT) and had labels indicating the next date for testing. Contracts were in place for service and maintenance and calibration of equipment.

A pod for patient use for weight and blood pressure taking was available in a discreet area of the waiting room. Instructions for use were displayed, along with guidance for patients to seek advice from staff if they had any queries or concerns about the results.

Staff told us that they felt they had access to appropriate equipment to carry out care and treatments.

Are services safe?

Staffing and recruitment

The practice was staffed to enable the personal medical service needs of patients to be met. The staff team was well established and most had worked at the practice for many years.

The practice had a contract with an external human resource company, for the provision of employment advice.

We reviewed five personal files for both clinical and non-clinical staff and found these contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We found risk assessments had been completed for all staff to establish the level of checks undertaken. We saw that standard DBS checks had been made when employing nursing staff. We spoke with the practice manager and it was agreed that enhanced level checks should be made for clinical staff.

Systems were in place to check on the registration of nurses with the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) for the GPs in the practice. Checks were also made for professional indemnity of the GPs; however this had not been done for the locum GP. The practice manager was aware that this needed to be undertaken annually.

Monitoring safety and responding to risk

Procedures were in place to deal with any medical emergency. Emergency equipment was readily available. Emergency medicines were checked as required. Staff had received annual training in basic life support.

Accidents were recorded and investigated. Health and safety advice was sought via a contract with an external company. Risk assessments and annual reviews had been undertaken.

The practice had identified a fire marshal and a fire log was maintained. Fire extinguishers and alarms were checked and maintained by an external company.

There were arrangements in place for members of staff, including nursing and administrative staff, to cover each other's annual leave and unexpected absence.

Arrangements to deal with emergencies and major incidents

The practice had a current and comprehensive business continuity plan in place. This gave staff detailed guidance on how to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, 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.

When we spoke with staff they were fully aware of the plan, however we were told this was kept on the ground floor of the building. We discussed the need to have a copy available for the staff who worked predominately on the first floor, which was not a patient area.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Emergency equipment was readily available and included a defibrillator and Oxygen. Checks were undertaken to ensure they were ready for use and in date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems in place to ensure best practice was followed. This was to ensure that people's care, treatment and support achieved good outcomes and was based on the best available evidence. Treatment was based on nationally recognised guidance. These included the National Institute for Health and Care Excellence (NICE).

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible. New patient health checks were carried out by the practice nurses or health care assistant and regular health checks and screenings were on-going in line with national guidance.

We were told from regular review of treatments and prescribing, following any frequent episodes of asthma attacks for example, the practice was able to review medications and stabilise patients based on current guidance and recommendations.

The GPs told us they led in specialist clinical areas and the practice nurse led the chronic disease management for such conditions as diabetes and chronic heart disease. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

Discussion with the GPs, verified that patients were being effectively assessed, diagnosed, treated and supported, whilst considering current guidance.

Management, monitoring and improving outcomes for people

Care plans were in place for patients with complex or multiple health conditions. This enabled the practice to effectively monitor patients at regular intervals. Electronic systems had alerts when patients were due for reviews and ensured they received them in a timely manner, for example, reviews of medicines and management of chronic conditions. The practice had robust systems to follow up and recall patients if they failed to attend appointments, for example, non-attendance at a child vaccination clinic.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included the management of urinary tract infections, based on clinical guidelines and the improved use of a more appropriate antibiotic. Audits had been completed for the improved

management of diabetes to ensure appropriate additional screening for foot and eye care and also for baby development checks, to ensure these are carried out in a timely manner and how non-attenders are managed.

One of the GP partners undertook minor surgical procedures within the practice in line with their registration and NICE guidance.

The practice had a well-established weekly drug and alcohol misuse support service. They worked closely with the community drug team and one of the GP took the lead in this work

Effective staffing

The practice manager maintained a training matrix and this demonstrated that staff received annual mandatory training. This included basic life support, safeguarding, fire and infection control. We saw training certificates to verify that clinical staff had updated training, including dementia, respiratory diseases, sexual health, drug and alcohol awareness and diabetes.

We saw training and competency assessments had been completed to enable the health care assistant to undertake health checks and participate in review of patients with long term conditions.

GPs were up to date with their yearly continuing professional development requirements and 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 NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

We saw annual 360 degree appraisals for all staff. Each staff member contributed to feedback on a variety of areas of performance. Staff confirmed that they were supported in identifying any training needs or personal areas for development.

Patients told us that they felt staff were confident in their roles and that staff seemed knowledgeable when discussing individual conditions or treatments.

Working with colleagues and other services

The practice worked effectively with other health and social care services. We were provided with examples of joint working with midwives, health visitors and school nurses. Blood test results, X ray results, discharge summaries and

Are services effective?

(for example, treatment is effective)

letters received from the local hospital were managed in a timely manner. The GPs were responsible for the amendments to any medications in patient records following hospital admissions.

Information from the out of hours service or when patients attended A&E were received the following day and acted upon appropriately. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The practice had a stamp tracker system and could audit who had dealt with any communication and the action taken. All staff we spoke with understood their roles and felt the system in place worked well.

The practice had regular clinical meetings and the relevant health professional was invited to discuss and manage future care of patients. Palliative care meetings took place monthly to co-ordinate the care of patients coming to the end of their life.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. CQC comments cards also stated that patients felt they had been referred for hospital appointments within an appropriate timescale.

Information sharing

The partner GPs attended CCG meetings and disseminated information in clinical and practice meetings. This kept all staff up to date with current information around enhanced services and requirements in the community. Patients and individual cases were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend meetings as appropriate.

Patient information was updated electronically, with all letters and other relevant patient documentation scanned onto the practice system.

The out of hours services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

Consent to care and treatment

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us that they had received on-line training in regards to consent and the Mental Capacity Act 2005; however there was nothing to verify this is in the staff files we reviewed.

Staff had a good understanding of what was required to determine a patient's best interests and how these were taken into account, if a patient did not have capacity to make a decision. Clinical staff demonstrated an understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

Patients we spoke with and via the completed CQC comment cards said that they were provided with enough information to make a choice and give an informed consent to treatment.

The 2014 national GP patient survey indicated 77% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 85% said the last GP they saw or spoke to was good at treating them with care and concern and 79% had confidence and trust in the last nurse they saw or spoke to.

Health promotion and prevention

New patients when registering with the practice were offered a health check with the health care assistant or practice nurse. The GPs were informed of all health concerns detected and these were followed up in a timely way.

Within the reception area and waiting room there was a large variety of health promotion leaflets. There was information on carer support, self-help groups and signposting to a range of community services.

The practice had a range of enhanced services which included, to prevent illnesses such as, pneumonia and shingles in older patients. A register was maintained of patients who were identified as being at high risk of hospital admission due to long term conditions or who were at end of life.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with 14 patients whilst in the practice and received 33 completed CQC comment cards. Comments we received were positive about how staff treated patients.

Patients told us they felt listened to and were treated respectfully by staff. Some patients in the practice survey had complained about the attitude of the reception staff; however other patients we spoke with told us they had always found the staff helpful and pleasant.

We found there was a strong culture of patient centre care and ensuring a holistic approach to care was delivered by all staff. It was clear staff were motivated to provide the best possible care. One patient explained how staff had gone the extra mile following bereavement. Another patient told us staff were very aware of religious and cultural needs and provided additional support and advice for a trip to Mecca.

Patients said their privacy and dignity was maintained, particularly during physical examinations. All patient appointments were conducted in the privacy of a consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. Staff informed us that there was always a room available if patients or family members requested a private discussion.

The practice had a high percentage of patients who suffered from drug or alcohol misuse. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them frequently diffuse potentially difficult situations.

We were told by the Chair of the Patient Participation Group the practice had taken action from feedback from patients, to ensure that all patients when in the waiting room could be seen by the reception staff and that patients could see them. A large clear glass had been installed between the reception desk and the waiting area.

Care planning and involvement in decisions about care and treatment

Patients we spoke with consistently described their care and treatment to be of a good standard.

Patients said that both GPs and nurses spent time to explain treatments and that they felt involved in the decisions made. Some patients stated they had to wait a long time to see one GP when arriving for their appointment; but acknowledged that this meant that they were given a proportionate amount of time during consultations and time was taken to ensure care and treatment was understood.

Comments we received from patients reflected that practice staff listened to them and felt concerns about their health were taken seriously and acted upon. Additional, written information on health conditions was available in the waiting room.

The most recent GP patient survey reported that 76% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 77% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

We were told by patients that because staff had been at the practice a long time, they felt staff knew them well and understood people's personal needs.

Patients told us they felt safe in the practice and they felt supported when dealing with long term conditions or decisions about care and treatment.

A range of information about how to access support groups and self-help organisations was available and accessible to patients in treatment rooms and reception area.

A counselling support service was also available at the practice to provide emotional support to patients following referral by the GP. A counsellor provided twice weekly clinics at the practice to ensure patients needing emotional support, could access this service in a timely way.

The 2014 GP patient survey reported that 79% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 75% say the last nurse they saw or spoke to at the practice was good at listening to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease were undertaken, with alerts identified on the practice system for when recalls were due.

The NHS England Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and had identified service improvement plans. This had included improving access to the service for patients for appointments. Early extended opening times had been implemented specifically for those patients who worked. On- line and telephone booking had also been introduced.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice. The practice maintained a register of patients who were house bound.

The practice had also implemented suggestions for improvements where possible in response to feedback from the patient participation group (PPG). For example the introduction of the PPG notice board and a new glass window between the reception and waiting room. The Chair of the PPG acknowledged the practice was proactively trying to gain feedback from patients and trying to encourage more patients to join the group in order to determine how to improve and meet the needs of the population it served.

We saw the practice ensured that vulnerable patients were able to attend the drug and alcohol clinic in a discreet manner and they knew the patient's individual complexities, which could prevent them from accessing regular treatments and took appropriate action.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into

account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice had for some time worked closely with the traveller community providing care and treatment for those who were both resident on a local site and those who were frequent transient visitors.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice regularly worked with the local mental health team and other mental health professionals in the case management of people experiencing poor mental health including those with dementia. The practice could refer patients for counselling where appropriate.

An interpreter service was available if required via Language Line; however we were told this was seldom used. One of the GPs spoke several languages, including Urdu, Punjab and Gujarati.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

A triage service was provided to ensure that patients were seen by the most appropriate clinical person. This could be a GP, nurse or health care assistant.

60% of respondents to the 2014 GP patient survey said that the practice was open at times convenient to them. The practice was rated as average for ease of getting through to the practice by telephone.

From the CQC comment cards completed and speaking with patients we were told that it was sometimes difficult to get through by telephone to make an appointment but they always got an emergency appointment or on the same day for children and young people.

Early morning appointments via an extended surgery were available each Friday from 6.45am. These appointments were aimed at patients who struggle to see a doctor due to work commitments. Patients could also pre book appointments.

Are services responsive to people's needs?

(for example, to feedback?)

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties to ensure time was appropriately spent with patients.

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. 11 complaints had been made by patients or family of patients. We found the practice handled and responded to complaints well. Complainants always received acknowledgement of the complaint and complaints were investigated and documented in a timely manner as required.

Investigations addressed the original issues raised and action was taken to rectify problems.

We saw that information was available to help patients understand the complaints system in the form of a summary leaflet and on the practice web site. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

Are services well-led?

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

Our findings

Vision and strategy

Although there was no written strategy it was evident that all staff within the practice worked to the same ethos. Staff had been working at the practice for a number of years and had been part of the development of the service. All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff. We saw evidence that showed the GPs and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

Governance arrangements

There were clear lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff, clinical and practice meetings. We looked at minutes from recent meetings and found that performance, quality and risks had been discussed. The minutes showed meetings how what actions needed to be taken and who was responsible.

It was evident that staff were able to raise concerns in a constructive and fair manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The culture at the practice was open and fair. We saw from minutes that staff meetings were held weekly for reception and administration staff and practice meetings were held monthly. Staff told us they felt comfortable raising any issues or concerns and that they had the opportunity to discuss at these meetings.

The practice had advice from an external human resource company and we found there were policies in place to support staff. Staff we spoke with knew where to find these policies if they were required.

Staff said they were supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries.

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

The practice actively had sought feedback from patients through patient surveys and complaints received. We looked at the results of the 2014 GP patient survey and the last patient survey conducted by the Patient Participation Group (PPG) and published in January 2014. Both surveys reflected high levels of satisfaction with the care, treatment and services provided at Roe Lee Surgery. However where issues were identified action had been taken to address them.

We spoke with the Chair of the PPG who confirmed the practice and the PPG were continually seeking patients to join the PPG. Invitations to join were handed out to patients on their visit to the surgery and there were posters displayed in the waiting area and a message displayed on the patient call system. The group was slowly increasing in numbers and had nine members. Despite many invitations representation was required from patients from ethnic groups, such as Asian and Eastern European. The practice were actively encouraging young members to the group but this had also proved very difficult.

We saw evidence from meeting minutes that the practice did act on feedback and information raised via the PPG.

The practice gathered feedback from all staff grades through meetings and 360 degree appraisals. When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged.

Management lead through learning and improvement

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. Nurses were also registered with the Nursing and Midwifery Council, and as part of this

Are services well-led?

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

annual registration were required to update and maintain clinical skills and knowledge. The GPs were involved in the local clinical meetings. Similarly the practice nurses and practice manager regularly attended their professional forum groups established by the CCG to provide training and support and share good practice.

The practice actively participated in research projects and trials with two local universities. These involved studies on the diagnostic experience of patients with osteoarthritis, early diagnosis of cancer and a study into the diagnosis and treatment options for patients with carpal tunnel syndrome.

The GPs discussed the challenges for services whilst experiencing funding changes, however the practice aimed to be innovative and participate in future locality developments, working closely with other practices and the CCG

The practice completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice learned from and took action, which improved outcomes for patients.