

Roe Lee Surgery

Quality Report

(Also known as Blakewater Healthcare)

367 Whalley New Road

Blackburn

BB1 9SR

Tel: 01254 618000

Website: www.roeleesurgery.co.uk

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection November 2014 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) – Good

We carried out an announced comprehensive inspection at Roe Lee Surgery on 8 November 2017 as part of our inspection programme to inspect 10% of practices before April 2018 that were rated Good in our previous inspection programme

At this inspection we found:

- The practice ensured that care and treatment was delivered according to evidence- based guidelines and reviewed the effectiveness and appropriateness of the care it provided.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice documented investigations resulting from them and improved their processes. However, documentation did not always clearly identify learning outcomes. While staff demonstrated awareness of recent incidents, we found communication channels to disseminate learning was at times informal.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- Staff felt respected, valued and supported.

Summary of findings

- The practice engaged positively with integrated working alongside other professionals. Regular multidisciplinary team meetings took place to ensure person-centred care was delivered to patients.
- Quality improvement issues were discussed in regular staff meetings. Clinical matters were discussed in weekly meetings although there were no formal minutes kept for these meetings.
- There was a strong focus on continuous learning and improvement at all levels of the organisation. The partners and management team were keen to contribute and add value to the local healthcare economy.

We saw two areas of outstanding practice:

- The practice had developed a care pathway for the management of deep vein thrombosis (DVT; a blood clot that develops within a deep vein in the body, usually in the leg) and delivered this service for all

patients across the clinical commissioning group area. This had streamlined access to services for patients as well as resulting in considerable cost savings over a two year period.

- The practice worked in partnership with a local hospital trust in offering patients access to non-obstetric ultrasound services in the primary care setting, facilitating faster access to diagnostic scans for patients. The practice told us the implementation of this service had reduced waiting times for patients from eight weeks down to two weeks or less.

The areas where the provider **should** make improvements are:

- Consider the improving the recording of incident investigations and formalise communication channels to ensure learning is disseminated effectively.
- Consider the detail of policy and procedure documents, such as that for needlestick injury.

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

Summary of findings

The six population groups and what we found

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

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

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 also included a GP specialist adviser.

Background to Roe Lee Surgery

Roe Lee Surgery (367 Whalley New Road, Blackburn, BB1 9SR) is located in a purpose built, two storey premises on the outskirts of Blackburn. The premises has ample parking spaces, including designated disabled spaces and ramped access to facilitate entry to the building for people experiencing difficulties with mobility.

On 1 October 2017 the practice merged with a neighbouring practice (The Montague Practice) situated in Barbara Castle Way Health Centre, Simmons Street, Blackburn, BB2 1AX. This site is functioning as a branch site, with patients able to access services at either premises. The practice was in the process of updating its registration with CQC at the time of our visit to reflect this change. We visited the Roe Lee site only on this visit.

The practice delivers primary medical services to a patient population of approximately 11,000 people via a general medical services (GMS) contract with NHS England. The practice is part of the NHS Blackburn with Darwen Clinical Commissioning Group (CCG). However, due to the recent takeover of a neighbouring practice, data contained in this report relates only to the approximately 4900 patients registered at the Roe Lee site prior to 1 October 2017 when the practices merged.

The average life expectancy of the practice population is slightly below the national averages (78 years for males and 82 years for females, compared to 79 and 83 years respectively nationally).

The practice patient age distribution is broadly similar to that of the average GP practice in England.

Information also published by Public Health England rates the level of deprivation within the practice population group as four on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The Roe Lee practice is staffed by two GP partners (both male) along with a salaried GP (female). In addition the practice employs two advanced nurse practitioners, a practice nurse and a health care assistant. Clinical staff are supported by a practice manager, assistant practice manager and a team of seven administrative and reception staff.

The practice is open between 8am and 6.30pm each weekday apart from Friday, when extended hours appointments are offered from 6.45 in the morning. Patients are also able to access additional extended hours appointments, which are offered from local spoke clinics (Little Harwood Health Centre and Barbara Castle Way Health Centre) by the local GP federation between 5pm and 9pm on weekday evenings, and between 8:45am and 2:15pm on weekends.

Outside normal surgery hours, patients are advised to contact the out of hour's service by dialling 111, offered locally by the provider East Lancashire Medical Services.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance, with relevant contact numbers displayed in consultation and treatment rooms.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. Most staff had completed equality and diversity training.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was a system to manage infection prevention and control (IPC). Regular IPC audits were completed, the most recent undertaken in November 2016 by the practice manager. One of the GPs was designated as IPC lead for the practice.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. We saw that the practice had been given an award by NHSE for vaccinating all staff against flu.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis, and demonstrated awareness of best practice guidelines.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information and urgent referrals were made in a timely fashion and monitored to ensure that patient appointments were made.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

Are services safe?

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. A member of the clinical commissioning group (CCG) medicines management team attended the practice on a weekly basis in order to support the appropriate prescribing of medicines. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship, for example introducing the use of C-reactive protein testing (as an indicator as to whether antibiotics would be an effective treatment for respiratory tract infections) to ensure antibiotics were being prescribed only when necessary.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- There were adequate systems for reviewing when things went wrong, although we found in some cases the documented investigation lacked detail. For example, there were two recent needlestick injuries documented as significant events. However, in only one case was it documented how the injury had occurred. While appropriate action was taken following these incidents in that blood samples were taken and sent for testing, no other details of investigation were documented. We noted that the needlestick injury section of the IPC policy outlined the employer's responsibilities for protecting employees who use needles as part of their role, but did not document the procedure for safe handling of needles nor the process to follow in the event of an injury.
- We saw evidence that while significant events were formally discussed at team meetings, the regularity of these meetings meant that in some cases substantial time would elapse before this would take place. Staff confirmed that informal discussions took place as an interim measure, and staff were able to discuss examples of these. However, in light of the recent practice merger and the increase in size of the organisation, more formalised communication channels to maximise learning outcomes would further reduce risk of significant events being repeated.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an incident, nursing staff had been asked to contact patients by telephone before flu vaccinations being administered on home visits in order to reiterate the purpose of the appointment and to ensure patients were fully aware and consented.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Prescribing data for the practice for 01/07/2015 to 30/06/2016 showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group was comparable to local and national averages; 1.47, compared to 1.33 locally and 0.98 nationally. (This data is used nationally to analyse practice prescribing and Hypnotics are drugs primarily used to induce sleep.)
- Similar data for the prescribing of antibacterial prescription items showed that practice prescribing was comparable to local and national levels; 1.25 compared to 1.18 locally and 1.01 nationally.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had a patient health monitoring machine in the reception area for patients to take and record their height, weight and blood pressure. This could then be reported to practice staff.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

The practice had developed a care pathway for the management of deep vein thrombosis (DVT; a blood clot that develops within a deep vein in the body, usually in the leg) and delivered this service for all patients across the clinical commissioning group (CCG) area. This service was commissioned following a review by the CCG in 2014 which found that existing DVT pathways in the area were complicated and inconvenient for patients. The community-based DVT assessment and treatment service devised by the practice accepted referrals from other GPs as well as from A&E. Between April 2015 and March 2017 a total of 806 patients were referred into this service, with

97% of these wholly managed within the primary care setting. All patients were offered an appointment on the same day. A total of 185 patients were diagnosed as having DVT and 174 of these were treated without the need to access secondary care. This service streamlined the access to care for patients. Conservative estimates by the practice placed the savings made for the local health economy at approximately £500,000 as a result of this service.

The practice was also working in partnership with a local hospital trust in offering patients access to non-obstetric ultrasound services in the primary care setting, facilitating faster access to diagnostic scans for patients. The practice told us the implementation of this service had reduced waiting times for patients from eight weeks down to two weeks or less.

We reviewed evidence of practice performance against results from the national Quality and Outcomes Framework (QOF) for 2016/17 and looked at how the practice provided care and treatment for patients. (QOF is a system intended to improve the quality of general practice and reward good practice.)

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail were discussed as part of the practice's complex care multidisciplinary team meetings.
- Older patients who were at risk were identified and if necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Joint visits were made to housebound patients approaching the end of life with other professionals such as district nurses. We saw that the practice utilised comprehensive palliative care templates on the patient record to ensure information such as a patient's preferred place of death was recorded accurately.

People with long-term conditions:

Are services effective?

(for example, treatment is effective)

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- The percentage of patients with asthma on the register who had an asthma review in the preceding 12 months that included an appropriate assessment of asthma control was 89%, compared to the CCG average of 79% and national average of 76%. However, exception reporting for this indicator was also higher at 29% (CCG average 10%, national average 8%) (exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).
- Blood measurements for diabetic patients (IFCC-HbA1c of 64 mmol/mol or less in the preceding 12 months) showed that 74% of patients had well controlled blood sugar levels compared with the CCG average of 79% and national average of 80%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Data published for the year 2015/16 by NHS England showed that uptake rates for the vaccines given were mostly in line with CCG/national averages. For example, performance for the vaccines given to under two year olds achieved the 90% target in three of four cases and equated to a score of 9.1 (out of a possible score of 10), compared to the national average of 9.1. The percentage uptake for MMR vaccinations given to five year olds was higher than both local and national averages, and ranged from 92% to 99%, compared to the CCG range of 87% to 95% and nationally 88% to 94%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 82%, which was in line with the 80% coverage target for the national screening programme.
- The practice encouraged patients to attend national cancer screening programmes. There was a large display for this in the patient waiting area.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

People experiencing poor mental health (including people with dementia):

- 89% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was higher than the local average of 85% and national average of 84%.
- 93% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was in line with the local average of 93% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 93%; CCG 94%; national 91%). However, exception reporting for this indicator was higher than local and national rates (practice 34%; CCG 15%; national 10%).

Monitoring care and treatment

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives. We saw that the practice engaged well with the local Quality and Outcomes Enhanced Services Transformation (QOEST) quality improvement programme; a suite of quality improvement plans initiated by the CCG and developed by practices to monitor and improve the quality of clinical care provided to patients, the access to and sustainability of general practice. The practice also worked with members of the CCG pharmacy team to ensure that practice prescribing was carried out in line with local and national recommended guidelines.

The most recent published QOF results for 2016/17 were 98.6% of the total number of points available compared with the CCG average of 98.2% and national average of 95.5%. The overall exception reporting rate was 15.8% compared with the local average of 10.7% and a national average of 9.9%.

The practice demonstrated to us that it was aware of its above average exception reporting rate. The practice manager discussed how it had been identified that previous errors in coding on the patient record had contributed to this high rate. The system for coding exceptions had been updated to ensure they were only coded at year end, ensuring that any patients attending for review after time had elapsed following their invite would still be captured in the practice's QOF submission, rather than excepted as might have previously been the case.

The practice was actively involved in quality improvement activity and used information about care and treatment to make improvements. The practice shared two audits with us that had recently been commenced. One examined the use of calcium and vitamin D3 therapy as an intervention for osteoporosis (a bone condition resulting in increased risk of fractures or breaks) and resulted in a marked improvement in the number of patients being put in calcium and vitamin D3 therapy in line with best practice guidance. The other audit looked at stroke prevention in atrial fibrillation therapy (atrial fibrillation is a heart condition that causes an irregular heart beat). This audit demonstrated that compliance with best practice for stroke prevention for patients with atrial fibrillation increased from 73.91% of cases to 95.65%. Both of these audits had

only recently been initiated and were not yet completed audit cycles, that is, re-audit had not been completed to monitor that the improvements made had been maintained.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with
- We saw systems were in place to ensure staff had access to annual appraisals. The appraisal meetings for this year had not yet taken place at the time of the visit, meaning some staff were slightly overdue. However, this was a conscious decision by the practice in light of the recent merger to ensure the appraisal meetings were as useful as possible. Management staff were in the process of evaluating the skill mix required at each site. Once this was established, the appraisals would be planned and used to ensure staff were best placed to maximise their skill set.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies. For example, the advanced nurse practitioner

Are services effective?

(for example, treatment is effective)

took responsibility for following up patients discharged from hospital with asthma, COPD (Chronic Obstructive Pulmonary Disease; a disorder of the lung function) and diabetes; the patient was contacted to establish whether an appointment was required at the practice to review their health needs.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.
- Patients who were in need of end of life care, as well as those with complex needs were discussed at formal monthly meetings with staff from other appropriate organisations. We saw evidence that the minutes of these meetings were circulated to relevant staff and any actions recorded into the patient records as appropriate.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The number of patients referred under the two-week-wait referral pathway who were diagnosed

with cancer was slightly lower than local and national averages (41% compared to 49% locally and 50% nationally). Clinical staff we spoke to demonstrated awareness of relevant best practice guidance and care pathways around urgent cancer referrals.

- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, by referring patients to a local wellbeing clinic to support smoking cessation and tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private space to discuss their needs.
- Of the 19 patient Care Quality Commission comment cards we received, 17 were wholly positive about the service experienced. The remaining two cards were positive about the care and treatment offered, but raised some concerns around access. Many of the cards described an excellent level of care and compassion, with patients describing staff as being devoted to their 'vocation' of assisting patients. This was in line with the results of other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 331 surveys were sent out and 107 were returned. This represented a response rate of 32% and was approximately 2% of the practice population. The practice was either above or in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 89% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 92% of patients who responded said the GP gave them enough time; CCG - 88%; national average - 86%.
- 93% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 95%; national average - 95%.

- 86% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG - 86%; national average - 86%.
- 92% of patients who responded said the nurse was good at listening to them; CCG - 91%; national average - 91%.
- 96% of patients who responded said the nurse gave them enough time; CCG - 93%; national average - 92%.
- 100% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 95% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 91%; national average - 91%.
- 92% of patients who responded said they found the receptionists at the practice helpful; CCG - 86%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language and patients were directed to multilingual staff where possible. There was also a hearing loop available for patients with hearing difficulties.
- Staff communicated with patients in a way that they could understand.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice identified patients who were carers. It was documented on the practice's computer system to alert GPs if a patient was also a carer. The practice had identified 252 patients as carers (5% of the practice list).

- The practice was recognised as a 'carer friendly practice' by Blackburn with Darwen carers service and a

Are services caring?

certificate acknowledging this was displayed in the waiting area along with relevant literature to support patients in accessing appropriate support services for carers.

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

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 generally higher than local and national averages:

- 91% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 87% and the national average of 86%.

- 83% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 83%; national average - 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 90%; national average - 90%.
- 89% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 86%; national average - 85%.
- 68% of patients who responded felt they were usually able to see or speak to their preferred GP; CCG - 55%; national average - 56%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended hours appointments were offered on a Friday morning from 6.45am and the practice offered online services such as appointment booking and ordering repeat prescriptions.
- The practice improved services where possible in response to unmet needs. For example, developing the community DVT 'one stop shop' service to streamline access to care for these patients, and working in partnership with the local hospital trust to provide community based non-obstetric ultrasound services, reducing waiting times for access to such services from eight to two weeks.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the practice offered longer appointments to patients with complex needs, used interpretation services for patients with English as an additional language and a hearing loop was available for those patients with hearing difficulties.
- The practice offered 15 minute consultation appointments to patients as standard.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours on Friday mornings.
- Extended hours appointments were also available at 'spoke' clinics held at another local surgery until 8pm each weekday and also during the day on weekends which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Patients with complex needs were offered longer appointments.

Are services responsive to people's needs?

(for example, to feedback?)

- There were monthly meetings with other health and social care professionals to discuss the care and treatment of vulnerable patients.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice proactively signposted patients to support organisations for those with mental health needs and those who had recently suffered bereavement.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use. There remained on 'on the day' urgent appointments available late in the afternoon on the day of our inspection visit, while the next available pre-bookable routine appointment with a GP was in two days' time.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was generally higher than local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 84% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.
- 80% of patients who responded said they could get through easily to the practice by phone; CCG – 73%; national average – 71%.
- 90% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG – 84%; national average – 84%.

- 86% of patients who responded said their last appointment was convenient; CCG – 81%; national average – 81%.
- 84% of patients who responded described their experience of making an appointment as good; CCG – 75%; national average – 73%.
- 56% of patients who responded said they don't normally have to wait too long to be seen; CCG – 61%; national average – 68%.
- 59% of patients who responded usually wait 15 minutes or less after their appointment time to be seen; CCG – 70%; national average – 64%.

The practice were aware of its lower than average score for patients waiting beyond their allocated appointment time to be seen, and could demonstrate how it had taken action in an effort to remedy this. For example, for clinicians identified as experiencing difficulty keeping to appointment times, 'catch up' slots were incorporated into their clinic in an effort to ensure patients were not kept waiting.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Ten complaints were received between December 2016 and August 2017. We reviewed two of these complaints in detail and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. A complaints log was maintained for the practice to facilitate the identification of emerging themes so that action could be taken accordingly. We saw that following a complaint it was clarified with staff what information it was appropriate to share with patient's relatives over the telephone.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.

- Leaders and managers told us they would act on behaviour and performance inconsistent with the vision and values if there was need to do so.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Patients were kept informed and offered apologies wherever appropriate. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. The practice's significant events policy documented how the practice would ensure it acted in keeping with the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. All staff received regular annual appraisals. Staff appraisals for the current year were slightly overdue, however this was due to the recent practice merger; the appraisals were planned to be completed once the analysis of required staff skill mix was complete across the two sites. We saw comprehensive appraisal documentation for all staff for previous years. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Most staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

Are services well-led?

Good 

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

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety. However we did note examples where policy documents would benefit from describing procedures in more detail, such as the needlestick injury procedure within the infection control policy.
- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information. We were told that clinical matters were discussed in weekly meetings with clinical staff and that GPs kept their own notes for reference, however, there were no formal minutes of these meetings.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of MHRA alerts, incidents, and complaints. We did however note that some incident investigations lacked detail and the dissemination of learning from these was at times informal.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality, although audit cycles had not been repeated to monitor the ongoing impact these changes to practice had made to patient outcomes.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, following the recent merger with another local practice, all staff across both sites were consulted as to what the new name of the practice organisation should be. The staff member who nominated the winning name, 'Blakewater Healthcare' was given a prize. Results from the national GP patient survey had been used to identify areas for improvement; an action plan had been formulated and action taken to address patient concerns about appointments running to time.

Are services well-led?

Good 

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

- There was an active patient participation group (PPG) who met regularly. The group consisted of 14 members. We saw that the next planned meeting of the PPG was in January 2018.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. We saw examples of innovative practice, such as the community DVT service as well as the non-obstetric ultrasound service. The partners were forward thinking and keen to add value to the local healthcare economy. During our inspection the practice received correspondence that another local clinical commissioning group (CCG) planned to roll out the practice model of DVT service delivery in its own area. The practice manager informed us the practice would consider bidding to be commissioned to provide this service.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had recently merged with another local practice. The partners told us how this was done to ensure the stability of the organisation and felt it would allow for greater flexibility in service provision to best meet patient need.
- The practice was adding to the clinical team as a new advanced nurse practitioner was due to commence employment in January 2018.