Priderm LLP

Blackburn Road Medical Centre

Inspection report

Blackburn Road
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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

Overall summary

This service is rated as Good overall.

The service had previously been inspected in August 2018 and was found to be providing services in accordance with relevant regulations. At that time, independent providers of regulated activities were not rated by the Care Quality Commission.

At this latest inspection the key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Summary of findings

Are services well-led? – Good

We carried out an announced comprehensive inspection at Blackburn Road Medical Centre on 10 June 2019 as part of our inspection programme.

PriDerm LLP Community Dermatology Service (Blackburn Road Medical Centre) provides a medical diagnostic and treatment service for the provision of community based dermatology.

One of the directors is the registered manager. A registered manager is a person who is registered with the

Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Registered persons have legal responsibility for meeting the requirements of the Health and Social Care Act 2008 and associated Regulations about how the service is run.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. There were seven comment cards completed. All these cards contained positive feedback from patients who accessed the diagnostic and screening assessment service.

We also reviewed internal patient satisfaction survey results from surveys completed after their assessments and consultations at the service. We found that these were consistently positive.

Our key findings were:

• There was an effective overarching governance framework which supported strategic objectives, performance management and the delivery of quality care.

• The service provided community based access to specialist dermatology expertise and treatment in a timely manner, including access to consultant dermatologists when required.

• Clear referral, consultation and discharge summaries were in use which ensured consistent communication and information sharing with patients' own GPs.

• There were systems in place to report and record safety incidents or near misses.

• The service undertook relevant quality improvement activity to review and improve the effectiveness of care provided. Care and treatment was delivered in line with current evidence based guidance.

• Patients remained under the care of the service until their condition was resolved, or alternative care and treatment pathways had been established.

• Clinicians were committed to improving the outcomes of patients and delivering quality care.

Dr Rosie Benneyworth BM BS BMedSci MRCGP

Chief Inspector of Primary Medical Services and Integrated Care

Blackburn Road Medical Centre

Detailed findings

Background to this inspection

The inspection team comprised a CQC inspector and a GP specialist adviser.

The service operates from three sites:

1.Blackburn Road Medical Centre, Birstall, WF17 9PL

2.Cleckheaton Group Practice, Church Street, Cleckheaton, BD19 3RQ

3.Calder View Surgery, Wellington Road, Dewsbury, WF13 1HN

We visited the Blackburn Road site during our inspection.

The Wellington Road site operates a service one day per month only. Services offered include treatments for eczema, psoriasis, alopecia (hair loss) and acne. Patients are referred into the service by their own GP to receive treatment. Care is delivered by two male GP partners with special interest (GPwSI) in dermatology who act as directors of the service. They are supported by three additional GPwSI, two male and one female. The clinical team also includes one female specialist nurse.

Additional expertise is provided by two consultant dermatologists, one male and one female, who are able to provide advice and support for more complex dermatological conditions. Each consultant delivers an evening clinic once a month in conjunction with the GPs.

Non-clinical support is provided by a service manager and a small team of administrative and secretarial staff.

The service is open between 8.30am and 4.30pm Monday to Friday, with appointments available up to 7.30pm on some evenings, with Saturday appointments available when required. Patients who have been referred into the service by their own GP are able to opt for a venue and time to suit them via the 'choose and book' service.

There are no restrictions in relation to the age of patients treated by the service.

This service is registered with the CQC under the Health and Social Care Act to provide the following regulated activities:

- Diagnostic and screening procedures
- Treatment of disease, disorder or injury
- Surgical procedures

How we inspected this service

We informed North Kirklees Clinical Commissioning Group that we were inspecting the service. We did not receive any information of concern from them. During the inspection we interviewed staff and reviewed relevant documents and patient records.

We spoke with two patients in the waiting area, and reviewed CQC patient comment cards. In addition, we observed some telephone interaction between staff and patients.

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?

Detailed findings

• Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Good

Are services safe?

Our findings

We rated safe as Good.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

• The provider conducted safety risk assessments. It had appropriate safety policies, which were regularly reviewed and communicated to staff. They outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training. Policies and procedures were accessible to all staff via the service's shared computer system.

• The service had policies in relation to safeguarding information, including local safeguarding teams and other appropriate agencies. All staff had received safeguarding training appropriate to their role.

• Staff were recruited in line with relevant legislation. Appropriate checks were in place, including checking of qualifications and registration with appropriate professional bodies where applicable. Disclosure and Barring Services (DBS) checks were also undertaken. 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 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. We saw that information was available to inform patients that staff could act as chaperones. The provider kept records of when chaperones were used.

• There was an effective system to manage infection prevention and control. This included the management of Legionella and audits in relation to infection prevention and control.

• The provider ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste. We noted the chairs in the waiting area needed a refresh. The host practice showed us an order to replace the chairs had been made.

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 provider regularly monitored the utilisation of staff.

• Arrangements were in place to deal with emergencies and incidents. All staff had received annual basic life support training. Emergency equipment and medicines, held by the host practices, were available at all three sites and we were told that they were accessible to staff in secure areas. We saw records which showed that the appropriate checks of these were in place.

• Vulnerable patients were identified at the time of booking and when required, reasonable adjustments made to meet their specific needs.

• There was an effective induction system for new or agency staff tailored to their role.

• Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention.

• Staff received regular mandatory training in relation to basic life support. We saw evidence that all staff had received Cardiopulmonary resuscitation (CPR) training.

• When there were changes to services or staff, the service assessed and monitored the impact on safety.

• There were appropriate indemnity arrangements in place to cover potential liabilities.

• All screening and test results were reviewed by the attending doctor and accredited scientist.

• Staff had the support of national and regional clinical leads for support when required.

- We saw that staff immunisation status was reviewed in line with Department of Health guidance.

Information to deliver safe care and treatment

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

• The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way. The service made use of electronic clinical

Good

Are services safe?

records which were in line with all referring GPs within the locality. Where full sharing consent had been given by the referring GP, staff had access to the full patient record and clinical system which provided information relating to investigation and test results, advice and treatment plans.

• 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 service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, we saw that reports were available to patients which enabled them to effectively share health assessments with patients' own GP using the 'Transfer of Care Record' best practice guidelines.

• Clinicians took appropriate and timely actions in line with protocols and up to date evidence-based guidance.

Safe and appropriate use of medicines

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

• The systems and arrangements for managing emergency medicines and equipment minimised risks.

• The service had policies for prescribing medicines used to treat skin conditions. All medicines prescribed were recorded appropriately in the patient record, and patient information leaflets were provided in these cases.

• Emergency medicines, held by the host practices, were stored securely.

Track record on safety and incidents

The service had a good safety record.

• Safety alerts were received by individual GPs as part of their role within general practice. Those relevant to dermatology were disseminated to relevant staff and actions taken when required. The service manager was in receipt of such alerts.

• There were comprehensive risk assessments in relation to safety issues.

• The service 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 service learned and made improvements when things went wrong.

• There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses. Managers supported them when they did so. Feedback on the outcome of incidents was always cascaded back to the staff member who raised the issue. A recent incident which involved a religious item of clothing had resulted in diversity training for all staff.

• There were systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service.

• The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents. We spoke with three members of staff who all confirmed that an open and honest culture was demonstrated by all staff at the service.

When there were unexpected or unintended safety incidents:

• The service gave affected people reasonable support, truthful information and a verbal and written apology.

• The service acted on and learned from external safety events, as well as patient and medicine safety alerts. The service had an effective mechanism in place to receive, assess, action and disseminate alerts to all members of the team.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated effective as Good.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence-based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

• The service provided specialised medical diagnostic and management of a range of skin conditions. GPs completed a comprehensive referral form before patients were seen by the service, to ensure that referrals were appropriate, and that all relevant information was available to the service in deciding treatment plans for patients.

• The provider assessed needs and delivered care in line with relevant and current evidence-based guidance and standards such as the National Institute for Health and Care Excellence (NICE) best practice guidelines and the British Association of Dermatologists. In addition, the provider had a training and continuing professional development programme in place for staff. The host practice also had a practice pharmacist who also alerted the team. These alerts were discussed at Local network meetings. The alerts were received by the operations manager and disseminated via the IT system only if appropriate to PriDerm's activities.

• Patients' immediate and ongoing needs were fully assessed. Where appropriate this included their clinical needs and their mental and physical wellbeing.

• We saw no evidence of discrimination when making care and treatment decisions, and there had been no complaints regarding discrimination.

Monitoring care and treatment

The service was involved in quality improvement activity.

• The provider had systems in place to monitor and assess the quality of the service, including the care and treatment provided to patients.

• The service undertook regular audits and quality improvement activity. We reviewed two audits, which showed that medicines were being prescribed in line with up to date guidance, and with the appropriate safety measures and patient checks in place.

For example:-

• The provider had carried out an audit in 2019 that focused on patients that were being prescribed a disease-modifying anti-rheumatic drug (DMARD). A patient record search was made to see how many patients were seen in PriDerm over the previous one year. To see if treatment was initiated in the clinic. The search revealed ten patients on a DMARD that had been seen in the previous one year, an increase in one patient from the previous audit. Of these ten patients, five had a DMARD initiated in a PriDerm clinic. These 10 patients had all been referred to ophthalmology for baseline tests. This was a 100% improvement in the previous 12 months.

• Clinical audits gave assurance to the provider of compliance with standards and operating practices. Other regular audits included those in relation to infection prevention and control and clinical waste.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

• All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

• Relevant professionals were registered with the General Medical Council (GMC) and were up to date with revalidation.

• The provider 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. For example the operations manager was due to start an MBA via the Open University later this year.

• Learning needs of staff were identified through one to one support and appraisals.

• The well-being of staff was supported through access to occupational health when appropriate.

Coordinating patient care and information sharing

Good

Are services effective?

(for example, treatment is effective)

Staff worked together, and with the consent of the patient worked with other organisations, to deliver effective care and treatment.

• Patients received coordinated and person-centred care.

• Patients were referred to the service from GPs within the catchment area for the service. Referral information was detailed, including full medical history, with details of previous and current treatments and medications.

• Following consultation and treatment by the service, the patient's referring GP received full and detailed information, including diagnosis, management plan, any medications which had been prescribed and what, if any, additional appointments the service would provide.

• Care and treatment for patients in vulnerable circumstances was assessed to best meet their needs.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

• Clinicians made use of their general practice expertise to provide opportunistic healthy lifestyle advice where appropriate in the course of consultations with the service.

• Patients were provided with detailed information relating to their treatment plans, including self-help guidance when applicable.

• When clinically indicated, referrals were made to other healthcare providers, and these were completed in a timely manner.

• Risk factors were identified, highlighted to patients and where appropriate, to their normal care provider for additional support.

Consent to care and treatment

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

• Staff understood the requirements of legislation and guidance when considering consent and decision making. We saw that staff had received training in relation to the Mental Capacity Act.

• Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

• The service monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated caring as Good.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

• Feedback from patients was positive about the way staff treated people. CQC comment cards and interview feedback from patients mentioned the expert, friendly and pleasant nature of staff.

• Patient feedback was sought following treatment through patient questionnaires. We saw that in the period 2018 – 2019, of 61 completed questionnaires, 98% of patients rated the understanding and care provided by staff as 'good' or 'very good'.

• Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients. A recent incident which involved a religious item of clothing had resulted in diversity training for all staff.

• The service gave patients timely support and information. For example, a young person had been identified as experiencing low mood. After the service was contacted by their relative, their appointment was brought forward to support their mental health.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

• Interpretation services were available for patients who did not have English as a first language. Information leaflets were clear and easy to understand. A patient recently had a practice leaflet translated to Polish.

• Patients told us through CQC comment cards, that they felt listened to and supported by staff and had good explanations of their condition during consultations. Follow up advice was also fully explained and supported by written information. Recent patient feedback resulted in clear signs being placed around the service to enable patients easier navigation around the building.

• Staff communicated with people in a way that they could understand, for example, via communication aids and services.

• All screening tests and procedures were carried out in consultation with the patient. Comprehensive after care plans were developed in conjunction with patients' own GP.

Privacy and Dignity

The service respected patients' privacy and dignity.

• Staff recognised the importance of people's dignity and respect.

• Curtains were provided in consultation rooms to maintain privacy, and patients were provided with towels, robes and slippers during assessments.

• Consultation room doors were closed during assessments and conversations could not be overheard in these rooms when the doors were closed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated responsive as Good.

Responding to and meeting people's needs

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

• The service had rapid access to more specialised advice and treatment from two consultant dermatologists for more complex dermatological problems.

• Referring GPs received a letter including a detailed discharge/management plan within five days of consultations.

• The provider understood the needs of their patients and improved services in response to those needs and feedback.

• The facilities and premises were appropriate for the services delivered.

• Patients were able to access a range of health assessments and consultations based on their personal needs and preferences. For example, more detailed rheumatology (the study of rheumatism, arthritis, and other disorders of the joints, muscles, and ligaments) checks could be accessed via the normal GP route.

• Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. For example, patients were able to bring carers and translators to appointments to support them.

Timely access to the service

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

• Services were provided at three sites spread throughout the North Kirklees area. Patients could choose to attend the site of their choice.

• Appointments were available between 8am and 6pm Monday to Friday. In addition, patients were able to attend evening appointments with a consultant dermatologist, delivered in conjunction with the GPwSPI. Weekend appointments were also available when required. Appointments were available with male or female clinicians.

• The provider told us that the average wait time from initial referral to first appointment was between two and four weeks.

• Consultations were 20 minutes long for initial appointments, with subsequent appointments 10 minutes long, although individual patient needs were accommodated whenever possible. The provider gave examples where appointments had been offered more urgently when it was felt to be clinically or socially appropriate.

Listening and learning from concerns and complaints

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

• The provider had a complaints policy and procedure. We saw that the policy and procedure was regularly reviewed. There was patient information about how to make a complaint. This informed patients how they could refer their complaint to the Independent Health Care Advisory Service if they were not happy with the outcome or how their complaint had been managed by the provider.

• There was a lead member of staff for managing complaints. This enabled identification of any themes or trends which could be shared across the organisation. The provider told us that there were no emerging themes linked to complaints and historical complaint levels were low.

• We saw there had been two complaints in the preceding 12 months. As a result of one of these complaints and the investigations carried out, the provider had made changes to the information supplied to patients.

• Concerns and complaints were discussed both locally and at an organisational level to monitor the quality of investigation, outcome and identified learning.

• Staff treated patients who made complaints compassionately.

• Information was available on how to make a complaint on the provider's website and in leaflet form within the service premises.

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 well-led as Good.

Leadership capacity and capability

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

• Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them, and had plans to improve the level of service offered to patients who accessed their health assessments and consultations.

• Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. We received positive feedback from staff regarding their relationships with the management team.

• Staff could access support from the wider organisation. For example, they could contact regional and organisational leaders including clinical leads.

• The provider had effective processes to develop leadership capacity and skills.

Vision and strategy

The service 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 service had a realistic strategy and supporting business plans to achieve priorities.

• There was a clear strategy in place. Performance outcome measures were submitted to the commissioners on a regular basis, detailing numbers of patients seen for first or subsequent appointments as well as numbers of patients failing to attend for their appointment. Funding for the service was based on these performance figures.

Culture

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

• Staff informed us that they felt respected, supported and valued. Staff feedback from their internal leadership surveys showed high levels of staff satisfaction.

• Leaders and managers acted on behaviour and performance inconsistent with the vision and values.

• Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.

• Staff were all fully aware of processes and procedures 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 need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. We saw that identified training needs were met and that mandatory training needs were effectively monitored and managed. The operations manager was due to start an MBA via the Open University later this year.

• There was a strong emphasis on the safety and well-being of all staff, and staff had access to a number of in-house benefits.

• The service actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. A recent incident which involved a religious item of clothing had resulted in diversity training for all staff.

• 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.

• The provider had an overarching governance framework which supported strategic objectives, performance management and the delivery of quality care. This encompassed all sites and ensured a consistent and corporate approach. The governance and management processes of the service promoted person-centred care.

• Staff had access to policies and procedures and were kept informed when these had changed or had been updated.

• Staff were clear on their roles and accountabilities

• There was a clear organisational structure and staff were aware of their roles and responsibilities. A range of policies and procedures had been developed.

Are services well-led?

Good

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

• The service told us there was a utilisation of a comprehensive computer based database in which all policies and other service information, such as staff training and appraisal records was stored.

• Systems were in place for monitoring the quality of the service and making improvements. The service directors had oversight of these, and they were discussed and shared with all clinicians working at the service.

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 and patient satisfaction.

• The service had processes to manage current and future performance. The performance of the overall site in general, and the health services in particular, could be demonstrated through audit. Leaders and managers had oversight of safety alerts, incidents, and complaints.

• Clinical audit had a positive impact on quality of care and outcomes for patients.

Appropriate and accurate information

The service acted on appropriate and accurate information.

• 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.

• The service 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 or required improvements.

• There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

• All staff had signed confidentiality agreements as part of their contractual arrangements. We saw evidence of this in the three staff files.

• Information was routinely shared with the patients' referring GP, and with patient consent, with other services such as secondary care.

Engagement with patients, the public, staff and external partners

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

• The service encouraged and heard views and concerns from the patients and staff and acted on them to shape services and culture.

• Staff could describe to us the systems in place to give feedback. We saw evidence of feedback opportunities for staff and how the findings were fed back to staff. We also saw staff engagement in responding to these findings.

• The service was transparent, collaborative and open with stakeholders about performance.

• Patients were actively encouraged to provide feedback on the service they received. This was constantly monitored and action was taken if feedback indicated that the quality of service could be improved.

• The service maintained close relationships with the patient's referring GP in order to support continuity of care for patients.

• Staff opinion was sought through informal contact, one to one meetings and appraisals. Plans were in place to organise staff away days and other team events to facilitate the building of 'one team' approach across all three sites from where services were delivered.

• We also saw that regular minor surgery audits were conducted, evaluating the accuracy of clinical diagnosis in line with histological analysis. We saw that results were discussed within the clinical team to drive forward continuous improvement.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

Are services well-led?

Good

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

• There was strong ethos on teaching and learning in the service. The directors of the service provided educational events for local GPs relating to their area of expertise in dermatology, as well as acting as a resource for advice over the telephone. They were involved in the development of local pathways relating to their area of expertise. Going forward they were looking to develop a service providing remote (skype) consultations with a consultant dermatologist to further improve timely access to specialised advice for more complex dermatological conditions. The organisation participated in regional dermatology networks and 'good skin days' where good practice and innovation was shared.

One of the clinicians had been involved in the training of GPwER in dermatology to two other clinicians. One of the GPs was from Calderdale and was struggling to find clinical experience locally, to enable clinical practice after completing the diploma in dermatology. The service created a poster on behalf of Pennine GP alliance outlining this service that the practice was supporting.

A clinician offered training to GP trainees who wished to gain further expertise in dermatology. A clinician was scheduled to attend a minor surgery clinic on the 28th of June. These educational sessions were provided for the benefit of colleagues without remuneration.

• There was a focus on continuous learning and improvement.

• The service made use of internal 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.

• There were systems to support improvement and innovation work.