

Waterside Health and Wellbeing Centre

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Waterside Health and Wellbeing Centre on September 19th 2017. Overall the practice is rated as Good.

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

- The practice had been managed via a caretaker agreement by Cornerstone Healthcare CIC since October 2016 and this provider was making significant improvement to patient outcomes.
- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety; however photographic identity checks were not always in place

and employment references for locums were not recorded. The locum staff had been employed prior the current provider taking over the contract for the service.

- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with the GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

We saw an area of outstanding practice:

- The practice provided holistic care, treatment and advocacy to vulnerable patients including those with health and spiritual needs for example those living in poverty and experiencing social exclusion. This included funded support from a practice chaplain, a worker supporting asylum seekers and a worker supporting people living in poverty.

The areas where the provider must make improvement are:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvements are:-

- The practice should continue to develop the patient participation group in order to reflect the needs of the community.
- Clinical audits should be further developed and completed to demonstrate quality improvement.
- The protocol to monitor the quality of care delivered and referrals made by GP locums should be fully embedded.
- All staff appraisal documentation should be completed.
- Consider a hearing loop in the reception area.
- The practice should continue to identify and support patients who are also carers.

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 requires improvement for providing safe services.

Requires improvement



- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had defined and embedded systems, processes and practices to minimise risks to patient safety. However some staff files did not include a photographic check of identity and locum GPs did not have references on file. The locum GP's had been employed before Cornerstone took over management of the practice.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. We noted that children on the safeguarding list were not coded as such and children who did not attend appointments were not automatically followed up.
- We saw that there were no systems to log the use of prescription pads.

The practice had adequate arrangements to respond to emergencies and major incidents

Are services effective?

The practice is rated as good for providing effective services.

Good



- The practice had put in place appropriate plans to continue to improve patient outcomes.
- Staff were aware of current evidence based guidance.
- The practice had started two single cycle clinical audits to monitor the quality of care.
- Staff had the skills and knowledge to deliver effective care and treatment. We received evidence 34 days after the inspection that systems to monitor the quality of care provided by locum GPs were established.

Summary of findings

- There was evidence of appraisals and personal development plans for all staff, however the documentation of appraisal discussion was not always completed.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved; however the practice did not provide proactive care to patients by regularly reviewing their needs. The local federation of GPs was currently developing a template for structuring care planning for patients at the end of life.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others within the CCG for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- As part of a Community Interest Company the practice was involved with a number of community based initiatives including the provision of spiritual support and assistance to asylum seekers.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice understood its population profile and had used this understanding to meet the needs of its population. A number of patients had chaotic lifestyles which meant that prebooking appointments led to failures to attend, the practice therefore offered on the day booking for many appointments. Likewise follow up and recall appointments for healthcare reviews were arranged on the day by telephone to try to secure attendance.
- The practice offered support for asylum seekers and had established a diabetic clinic at one of the other practices in the group to which it referred patients with complex needs.
- Patients we spoke with said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. However there was no hearing loop to support patients with a hearing loss.
- Information about how to complain was available in the practice leaflet. Evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

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

Good



- The practice had a clear vision and strategy to deliver high quality, caring & compassionate care with a Christian ethos and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings. A governance framework supported the delivery of the strategy and good quality care, however there were some shortfalls in identifying and managing some risks. We saw significant improvement to systems since Cornerstone Healthcare began caretaking the practice in October 2016.
- The provider was aware of the requirements of the duty of candour and we saw evidence the practice complied with these requirements.
- The GP provider encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice was in the process of developing a patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs in the group who were skilled in specialist areas used their expertise to offer additional services to patients. The lead GP had undertaken leadership training and had developed skills in supporting patients with drug and alcohol related needs.

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

The practice is rated as good for the care of older people.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered same-day appointments at the end of surgeries
- Practice staff contributed to an Integrated Locality Team (ILT) including health, social care and third sector services which identified patients who required a holistic approach. This included the practice following up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs. The ILT met quarterly to discuss the needs of these patients.
- Advanced care planning had been introduced as an option for patients who wished to discuss and record their end of life preferences. An Electronic Palliative Care Coordination plan was under review by the local federation of GPs which could be shared with community colleagues.
- All repeat prescriptions were reviewed annually and as a result of support of the CCG the practice has targeted patients aged 65 and over.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

People with long term conditions

Good



- The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Unvalidated data provided by the practice shows the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64mmol/mol or less in the period October 2016 to March 2017 was 50%. However it represents half year results and many patients had chaotic lifestyles which

Summary of findings

presented an additional challenge. The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- An effective call and recall system had been established since October 2016 which had led to improvements in patient outcomes including a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as good for the care of families, children and young people.:

- From the sample of documented examples we reviewed we found the 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 required improvement.
- Children who were safeguarded were coded on the practice register, however alerts were inconsistent and any failure to attend appointments was not being followed up.
- Immunisation rates were relatively high for all standard childhood immunisations and the practice nurse telephoned all families who did not attend.
- According to unvalidated data in 2016/17 80% of women aged 25-64 were recorded as having had a cervical screening test in the preceding 5 years.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had a policy of seeing children in extra appointments at the end of surgery if there was clinical need or parental anxiety.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics run by the lead GP and regular locums.

Good



Summary of findings

- A relationship worker employed by a voluntary sector agency ran sessions from the practice.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working age people (including those recently retired and students).

- The needs of these populations 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 in the evenings and Saturday appointments.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Results for cervical cytology had been improved by working with the local Primary Care federation to offer out of hours appointments.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability and provided information about accessing better healthcare.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations such as the Age UK 'Here to help@ project' which enabled befriending, telecare and reduction of falls.
- The practice chaplain worked with vulnerable patients and their families to overcome health and social inequalities acting as an advocate where appropriate.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable.

Good



Summary of findings

People experiencing poor mental health (including people with dementia)

Good



- The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).
- Unvalidated data for 2016/17 indicated that 75% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. 92% of patients with mental health conditions had their alcohol consumption recorded in the preceding 12 months.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record in the preceding 12 months.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The GP undertook joint sessions with a drug and alcohol worker and group meetings were held at the surgery.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2017. The results showed the practice was performing in line with local and national averages. 362 survey forms were distributed and 70 were returned. This represented 3.7% of the practice's patient list.

- 75% of patients described the overall experience of this GP practice as good compared with the CCG average of 86% and the national average of 85%.
- 76% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 70% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 79% and the national average of 77%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 35 comment cards which were all positive about the standard of care received. Patients described staff as helpful and caring and the service as excellent.

We spoke with five patients during the inspection. All five patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The friends and family test for the period January-August 2017 showed that 86% of respondents would be extremely likely or likely to recommend the practice to others.

Areas for improvement

Action the service **MUST** take to improve

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

Action the service **SHOULD** take to improve

- The practice should continue to develop the patient participation group in order to reflect the needs of the community.
- Clinical audits should be further developed and completed to demonstrate quality improvement.

- The protocol to monitor the quality of care delivered and referrals made by GP locums should be fully embedded
- All staff appraisal documentation should be completed.
- Consider a hearing loop in the reception area.
- The GP should use prescription pads belonging to this practice.

The practice should continue to identify and support patients who are also carers

Outstanding practice

The practice provided holistic care, treatment and advocacy to vulnerable patients including those with health and spiritual needs for example those living in

poverty and experiencing social exclusion. This included funded support from a practice chaplain, a worker supporting asylum seekers and a worker supporting people living in poverty

Waterside Health and Wellbeing Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser.

Background to Waterside Health and Wellbeing Centre

The Waterside Health and Wellbeing Centre is based in Infirmary Street, Blackburn, BB2 3SF and is part of the Blackburn and Darwen Clinical Commissioning Group (CCG). The practice has 1890 patients on their register. The practice has held a caretaker (APMS) contract with NHS England since October 2016. It is run by Cornerstone Healthcare and is a Community Interest Company (CIC) meaning it is nonprofit making. Cornerstone Healthcare operates three other practices in the local area. There is shared management across all five sites.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to 10 (level one represents the highest levels of deprivation and level 10 the lowest). Life expectancy in the practice geographical area is 73 years for males and 80 years for females both of which are slightly below the England average of 79 years and 83 years respectively. There are 19% of patients with an Asian background; a number of whom do not speak English as a first language. Young people number 95% of the local population and older people 5%.

The service is provided by one male GP and three long term locums, one female and two male. The practice also employs a site manager, one female practice nurse, a male health care assistant (HCA) as well as a team of reception and administrative staff. There are also a team of staff providing support from the Cornerstone Healthcare group including a lead nurse and a quality and integrated care manager.

The practice is based in a purpose built health and wellbeing centre, under contract with NHS Property Services, and hosts a number of services such as an alcohol and drug worker, a listening service run by trained volunteers, a craft group providing art therapy, health and wellbeing workshops and a relationship counsellor. It is fully equipped with facilities for the disabled including disabled parking at the rear of the building, access ramps, double doors, and a disabled toilet; Consulting rooms are on the ground floor and the first floor meeting room is accessible by a lift. Patients benefit from a support worker for the local Asylum Refugee Centre, a Christians Against Poverty worker and a chaplain all employed by the CIC.

The practice is open 8am to 6.30pm on Monday, Wednesday and Friday, 8am to 8pm Tuesday and Thursday and 8am to 12.30pm Saturday. Appointments are available 9.00-12.00 and 2.30 to 5.30pm Monday and Tuesday, 9.15am to 1.30pm and 2.30 to 6pm Wednesday and Thursday with an evening session 6.00 to 7.30pm Thursday, 8.30am to 12.45pm and 2.00 to 5pm Friday and 9.00 to 12.00 Saturday. There is provision for ill children and older people to be seen the same day. When appropriate, patients are redirected to ELMS (East Lancashire Medical Services), the out of hours service or to the 'spoke' clinics

Detailed findings

offered from two or three different locations in Blackburn where patients can access appointments up to 8pm on weekdays and through the day on Saturdays. The Acute Visiting Service (AVS) is also available.

The practice is accredited for training general practitioners and medical students.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Spoke with a range of staff (GP, Quality and Integrated Care manager, site manager, practice nurse, health care assistant and reception staff) and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.

- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of two documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the minutes of protocol meetings evidenced discussions about new guidelines and training in safeguarding and resuscitation.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff within Cornerstone for safeguarding. Children who were safeguarded were coded on the practice register, however alerts were inconsistently used and failure to

attend appointments was not automatically followed up. We were told that a new system had been introduced to improve this and had not been fully embedded. The GP attended safeguarding meetings when possible or provided reports where necessary for other agencies.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. The GP and the practice nurse were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- A lead nurse working across Cornerstone Healthcare was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical

Are services safe?

commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and patient specific prescriptions or directions from a prescriber were produced appropriately.

We reviewed four personnel files and found appropriate recruitment checks had not always been undertaken prior to employment. For example, employment references for locum GPs were not always recorded on staff files and photographic evidence of identity was not always in place when staff were recruited as stated in the recruitment policy. We noted that those staff without employment references had been recruited prior to Cornerstone Healthcare taking over the service. Following the inspection we saw evidence that references for the locum GPs and photographic identification had been obtained. We saw that qualifications, registration with the appropriate professional body and the appropriate checks through the DBS had been done.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out regular fire drills. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.

- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

- The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Unvalidated results provided by the practice for 2016/17 were 98% of the total number of points available. The practice reported an overall exception rate of 10% which had been affected by the team only having the contract for six months of the year. Since April 2017 the robust call & recall system that mirrors systems used for the other Cornerstone primary care contracts had continued and a permanent and regular clinical team treating and reviewing patients was in place. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Unvalidated data from 2016/17 showed:

- The percentage of patients with diabetes in whom the last measure of total cholesterol was 5 mmol/l or less was 80%.
- 75% of patients diagnosed with dementia who had their care reviewed in a face to face meeting in the last 12 months.

- 93% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the preceding 12 months.

An effective call and recall system had been established since October 2016 which had led to improvements in patient outcomes including a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

There was evidence of quality improvement including clinical audit:

- There had been several single cycle clinical audits commenced in the last eleven months, an audit of patients treated with antibiotics for sore throats had been very recently completed. The GP had actioned guidance to all clinicians across the group to revisit the directions for usage of the range of antibiotics to ensure appropriate selection.
- Findings of searches were used by the practice to improve services. For example, recent action taken as a result of a bowel cancer search included promoting the bowel cancer screening kit including the use of leaflets in languages used by the local community. This outcome was shared with the locality meeting.
- The administration team were currently being trained to use the "Workflow" system. The process reduced the time the GP had to spend reading reports and correspondence which could be dealt with at an administrative level. The system is recommended by the GP professional body. The practice has presented the system to the federation who will be monitoring outcomes.
- Cornerstone Healthcare were in the early stages of utilising "GP team net" to collate all staff information such as training schedules, protocols and both national and local guidelines.

Information about patients' outcomes was shared with the GPs and nurses across the Cornerstone group meeting in order to discuss complex cases and share best practise.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

Are services effective?

(for example, treatment is effective)

- Since October 2016 the practice have recruited a lead GP and a part time practice nurse. This has led to continuity of care and a consistent approach to patient reviews in particular for those with chronic disease.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the practice nurse reviewing patients with long-term conditions had attended update training in respiratory disease, diabetes, atrial fibrillation (uneven heart beat) and had received an immunisation and vaccination update.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. We saw that some appraisal documentation was not completed.
- The practice had a protocol to monitor the referrals made by GP locums but were told by staff that in practice the quality of care done by locums was not monitored.
- Staff received training that included: safeguarding, fire safety awareness, and basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- We found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services such as secondary care and retinal screening.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Practice staff contributed to a monthly Integrated Locality Team (ILT) including health, social care and third sector services which identified patients who required a holistic approach. This included the practice following up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs. The ILT met quarterly to discuss the needs of these patients. We saw that minutes contained a clear record of discussions about patients and the action required to meet their 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.

Consent to care and treatment

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

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

Are services effective?

(for example, treatment is effective)

- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted those to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation from the practice team. Patients were signposted to the local pharmacy for support with smoking cessation and to the wellbeing service for advice with diet and exercise.

Unvalidated data for 2016/17 was provided by the practice showed uptake for the cervical screening programme was 80%. The practice was targeting 24-year olds to engage them in the programme as early as possible. There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for breast and bowel screening. Unvalidated data highlighted that 34% of

persons were screened for bowel cancer in the last 30 months; 38% of females aged 50-70 years were screened for breast cancer in the last 36 months. The breast screening programme invited patients on a rolling practice by practice basis. This meant that each practice's patients were called for once every three years. The last round for this practice was in July 2015 with the next round scheduled for July/August 2018. The practice had only been established since October 2016 so this represented figures relating to a six month period. The practice was encouraging its patients to attend national screening programmes for bowel and breast cancer.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to one year olds reached the 90% target, for under two year olds ranged just below the target ranging from 84% to 90% and five year olds from 70% to 87.5%.

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

The practice had recently held a registration promotion event which involved a leaflet drop around the local area. The team wished to promote their holistic approach to care specifically for vulnerable people.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

- During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect. The practice had specific aims to provide “care of the whole person in a clearly Christian environment” which included praying for the community, each other and for patients.
- Curtains were provided in consulting rooms to maintain patients’ privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room or the lowered part of the reception desk to discuss their needs.
- Patients could be treated by a clinician of the same sex.

All of the 35 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

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

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

- 79% of patients 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%.
- 76% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 88% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%.

- 72% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 72% and the national average of 86%.
- 88% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 91%.
- 94% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 92%.
- 92% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 86% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 86% and the national average of 87%.

The practice had taken action in response to the survey results by continuing to engage with Blackburn and Darwen Primary Care Access group to consider alternative approaches to improving patient access including educating patients about self-management, minor illness and reception staff signposting patients to pharmacy advice, and self-referral clinics. The practice continued to promote access to online availability of appointments and was writing an article for the next newsletter on “How to book appointments”. An action plan also included releasing appointments at three points in the day and encouraging completion of the Friends and Family Test for more regular feedback.

Care planning and involvement in decisions about care and treatment

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

Children and young people were treated in an age-appropriate way and recognised as individuals. For example young people were encouraged to use online services when they reached sixteen years.

Are services caring?

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 in line with or slightly below local and national averages. For example:

- 78% of patients 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%.
- 76% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 91% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 90%.
- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format and languages used by the local population.

- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

Patient and carer support to cope emotionally with care and treatment

A wide range of patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 12 patients as carers (0.6% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support and their needs were discussed in multidisciplinary meetings which are attended by staff from Carers Link. If consent was given the carer was introduced to that organisation.

Staff told us that if families had experienced bereavement, the GP contacted them; staff offered to pray for them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Tuesday and Thursday evening until 8.00pm and Saturdays 8.30am to 12.30pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice and appointments were held at the end of surgeries for older patients to attend.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. A palliative care template was currently being updated by the federation in order to improve care planning. The GP felt that the practice could improve its approach to supporting people at the end of life by being more proactive in making regular contact with them.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- A number of patients had chaotic lifestyles which meant that prebooking appointments led to failures to attend, the practice therefore offered on the day booking for many appointments. Likewise follow up and recall appointments for healthcare reviews were done by telephone to ensure continuity of care.
- A relationship worker employed by a voluntary sector agency ran sessions from the practice.
- The practice sent text message reminders of appointments and test results.
- The practice had held planning meetings to coordinate the 2017 flu campaign which included drop in clinics, commissioned a flu champion and sent out invitations to patients on the chronic disease register and children added two and three years.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately/ were referred to other clinics for vaccines available privately.

- There were accessible facilities, which included a lift to the upper floor, and interpretation services were available.
- Patients were referred to the diabetic clinic held monthly at another practice in the Cornerstone group, to the retinal screening clinic and to the education programme held at another Cornerstone practice to help them with self-management.
- The practice supported a local residential care home. Some patients who lived there were not mobile so were accompanied to appointments by practice staff or were visited at home or received a consultation by telephone. The practice nurse undertook vaccination and annual health checks at the facility.
- A practice newsletter provided up to date information about clinics, access to appointments and signposted patients to local support services.
- The practice had considered the NHS England Accessible Information Standard to ensure that disabled patients receive information in formats that they could understand and receive appropriate support to help them to communicate. However there was no hearing loop in the reception area available for people with a hearing loss.

Access to the service

The practice was open 8am to 6.30pm on Monday, Wednesday and Friday, 8am to 8pm Tuesday and Thursday and 8am to 12.30pm Saturday. Appointments were available 9.00-12.00 and 2.30 to 5.30pm Monday and Tuesday, 9.15am to 1.30pm and 2.30 to 6pm Wednesday and Thursday with an evening session 6.00 to 7.30pm Thursday, 8.30am to 12.45pm and 2.00 to 5pm Friday and 9.00 to 12.00 Saturday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable or above local and national averages.

- 80% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 79% and the national average of 76%.

Are services responsive to people's needs?

(for example, to feedback?)

- 83% of patients said they could get through easily to the practice by phone compared to the national average of 71%.
- 81% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 84% and the national average of 84%.
- 87% of patients said their last appointment was convenient compared with the CCG average of 81% and the national average of 81%.
- 76% of patients described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 65% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 61% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

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

The reception team were trained to ask patients for information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where

the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system within the practice information leaflet.

We looked at three complaints received since October 2016 and found they were satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. It is run by Cornerstone Healthcare and is a Community Interest Company (CIC) meaning all profits made go back into serving the health and wellbeing of Blackburn with Darwen residents. Its key aim is to provide excellent, accessible personalised primary care of the whole person.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values which are to provide care in a Christian environment.
- Cornerstone Healthcare had clear plans in place for the future of the practice.

Governance arrangements

- The practice had a governance framework however this was not sufficiently robust to monitor and improve all aspects of quality and identify risk.
- The practice had not completed any two cycle clinical audits although we saw significant improvement to systems since Cornerstone Healthcare CIC began caretaking it in October 2016. For example establishment of a clinical team to provide continuity of care, an effective call and recall system for patients with long term health conditions, the introduction of the workflow system and GP team net.
- A protocol was in place but was not being followed to ensure that the quality of care provided by locum GPs was monitored.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. However documented appraisal were not always complete.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example there was a lead GP in the practice group for safeguarding and for cancer and a lead nurse for infection prevention control.

- Clinical (protocol) meetings and training events were all shared across the Cornerstone group to promote leadership, share skills and specialisms and pool resources.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice team meetings were held weekly which provided an opportunity for staff to learn about the performance of the practice. Locum GPs were paid to attend these meetings to ensure information sharing and learning.

Leadership and culture

The provider told us they prioritised safe, high quality and compassionate care. Staff told us the lead GP was approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The GP encouraged a culture of openness and honesty. From the sample of five documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

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

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- The lead GP had attended a CCG funded leadership programme to gain skills in negotiation, management and procurement.

Are services well-led?

Good 

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

- Staff told us the practice held weekly team meetings although these were not always minuted formally. In addition there were protocol meetings and meetings for nurses to share good practice.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the GP encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG was under development, we saw a poster encouraging recruitment in waiting area, and one member of the PPG had met with the GP and managers to discuss a plan to develop the group and recruit members who could represent the views of the community.
- the NHS Friends and Family test, complaints and compliments received.
- staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice.

- The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area and had joined a newly formed federation of GPs aiming to improve access to services for patients.
- Since October 2016 staffing had increased to include a lead GP, a practice nurse and a practice manager.
- The lead GP was scheduled care lead and sat on the executive board of the CCG to help shape developments in service provision. Another GP for the group was the cancer champion and was cancer lead on the federation board to focus on improving cancer services.
- The practice worked closely with the CCG medicines management team who had trained staff to review prescription requirements and provide information to patients. An action plan had been developed to reduce wastage.

The GP and members of the management team attended locality meetings and the practice manager attended the practice manager forum and monthly federation meetings. The lead practice nurse for Cornerstone attended the practice nurse forum and cascaded information to all of the practice nurses at an internal nurse meeting in order to keep abreast of best practice and institute appropriate improvements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014</p> <p>How the regulation was not being met:</p> <p>There were not sufficient systems or processes in place that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk.</p> <p>In particular:</p> <p>There was incomplete identification of children on the safeguarding register and no evidence of follow up if these children did not attend appointments.</p> <p>Some staff files did not contain evidence of a photographic identity check and some locum GP files did not contain employment references.</p>