Medicom Limited

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.

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Overall summary

Medicom Limited registered 'The Healthcare Centre' practice with the Care Quality Commission (CQC), as responsible for providing primary care, which includes: access to GPs, family planning, maternity and midwifery services, treatment for disease, disorder and injury and diagnostic and screening services.

The practice team includes the Clinical Director, two associate GP's (One male and one female), as well as two practice managers who job share, two reception staff and a nurse who works twelve hours per week.

The practice provides a service for all population groups safely and effectively. Staff were caring, responsive to the needs of patients and considered care and treatment in line with best practice guidelines.

We spoke to five patients and received nine Care Quality Commission comment cards. Patients were very complimentary about the care and treatment provided. Patients comments included the ease of access for appointments, both routine and urgent, the friendliness of all the staff and the professionalism of the doctors and nurse.

There are some areas for improvement including: staff training, policy development around shared emergency equipment, safe recording of serial numbers on blank prescription sheets and to formalise staff and clinical meetings with minutes.

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 was safe overall. Systems were in place to provide oversight of safety of the patients and environment. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals. Improvement was needed in the safe recording of serial numbers on blank prescription sheets, which immediately following our inspection the practice confirmed they had taken appropriate action and had a policy and process in place.

Are services effective?

The practice was effective. Care and treatment was being delivered in line with current published best practice. Patients needs were consistently met. Referrals to secondary care were made as soon as the need was identified. Consent to treatment was always obtained appropriately. The team used informal staff meetings to assess how well they delivered the service.

Are services caring?

The practice was caring. All the patients who completed our comment cards and those we spoke with during our inspection were very complimentary about the service. They all found the staff to be extremely person-centred and felt they were treated with respect. The results for this practice were amongst the best in the country in the 2013 National GP Patient Survey results.

Are services responsive to people's needs?

The practice was accessible and responsive to patients needs. The practice had a clear complaints policy and had received only one formalised complaint which they responded to appropriately. The practice participated in discussions with local commissioners about how to improve services for patients in the area.

Are services well-led?

The practice was well led and effectively responded to changes. Governance and risk management structures were in place but some were informal and needed to be documented to reduce the risk of communication error. Staff were committed to maintaining and improving standards of care. There was an effective system in place for managing risks and additional attention to the detail in their documentation for example around significant events would further improve the governance arrangements.

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
Staff were knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients health conditions, carers information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

People with long-term conditions
The practice staff were knowledgeable about the number and overall health needs of patients with long term conditions using the service. They co-operated when appropriate to do so with other health services and agencies to provide appropriate support.

Mothers, babies, children and young people
The practice provided services to meet the needs of this population group with childhood developmental checks and had childhood vaccination and immunisation programmes in place which were managed effectively to support patients.

Staff were knowledgeable about child and adult protection and a GP took the lead for safeguarding. The practice staff monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

The working-age population and those recently retired
The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and self-help guidance literature provided both on-line and within the practice to meet the needs of this population group. The practice website also provided information to sign post patients to the most appropriate service during the out of hours periods.

People in vulnerable circumstances who may have poor access to primary care
The practice accepted new patients to their patient list which was accessible to all individuals including patients with no fixed abode and transient population groups.

People experiencing poor mental health
The practice maintained a register of patients who experienced mental health problems. The register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

Summary of findings

What people who use the service say

We spoke with five patients and received nine Care Quality Commission comment cards on the day of our visit. We spoke with men and women, retired people, working people and mothers with pre-school children. All patients were very complimentary about the care provided by the clinical staff and the positive and friendly atmosphere fostered by all staff. They found the doctors and nurses to be professional and knowledgeable about their treatment and care needs. Patients reported that the whole practice staff team treated them with dignity and respect.

The National GP survey results published in December 2013 found that 90.4% would recommend their GP surgery, 90.0% for opening hours; 94.8% of patients rated their ability to get through on the phone as very easy or easy; 92.3% of patients rated their experience of making an appointment as good or very good and 98.8% of patients rated their practice as good or very good. All these figures when compared nationally were amongst the best.

Areas for improvement

Action the service SHOULD take to improve

- Notification of required information to CQC and CCG when appropriate.
- Staff refresher training for all staff to be in line with staffs professional body requirements as well as local and mandatory requirements. To include staff training for Mental Capacity Act and "best interests" decisions and dementia awareness training.
- Review infection prevention and control training and introduce effective monitoring systems of the policy and procedures.
- Formalised staff and clinical meetings with copies of meeting minutes.
- Introduce a written policy for the safe transportation and receipt of patient records.
- Introduce a policy for recording of prescriptions serial number data including home visits
- Introduce protocols regarding shared emergency equipment use and the checks in place
- The revised recruitment policy to include information as specified in Schedule 3 of the Health and Social Care Act (2008) for the purposes of carrying on a regulated activity, and such other information as is appropriate
- Clear recording of the checks undertaken regarding the nurses annual NMC registration and GPs GMC and NHS performers list.
- Capture and engage all patient population groups in providing feedback about the service provided.
- Introduce a robust auditing regime to improve governance arrangements for monitoring and reviews of policies and their effectiveness.

Medicom Limited

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC inspector and the team included a GP, a specialist advisor and an expert by experience.

Background to Medicom Limited

The Healthcare Centre was built in 1993 specifically for family general practice with access and facilities for disabled patients and visitors.

It provides a weekday service for 2138 patients in the Preston area. The practice opens Monday to Friday from 8am and closes at 6pm each week night with the exception of Thursdays when it closes at 1pm. Patient appointments can be made between 8.30am and 11.30am each week day morning and 4pm to 5.30pm each weekday afternoon with the exception of Thursday.

When the practice is closed and in the out of hours periods the practice chose to opt into the out of hours services provided by Preston Primary Care Centre, where patients can receive medical advice and treatment.

The practice team includes; the Clinical Director, two associate GP's (one male and one female), two Practice Managers who job share, two reception/administration support staff and a registered Practice Nurse. The nurse works 12 hours per week spilt over three days; Monday and Wednesday mornings and Friday afternoons. The practice use the same locum GP, when required, for continuity of service and support for their patients. All of the GPs who work at the practice including the locum GP have their professional details available for patients to read on the practice website.

As a small practice the nurse includes any long term condition management clinics into the patients individual review appointment, as opposed to running separate clinics, with the exception of the child immunisation clinic. Long term condition management includes a wide range of conditions, for example; diabetes, heart disease and hypertension (high blood pressure).

Other services run by the practice include child development clinics on Wednesdays 11am to 12pm for childhood development checks and vaccinations. Ante-natal clinics are also held on Wednesdays from 1.30pm to 3pm with the community midwives.

Medicom Limited has a smaller than average patient list size. Although the practice has a lower than average proportion of the population aged less than 39 years old, it has a higher proportion aged greater than 55 years.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward.

This provider had not been inspected before and that was why we included them.

Detailed findings

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced inspection on 8 July 2014 and the inspection team spent eight hours inspecting the surgery. We reviewed all areas of the practice including the administrative areas.

We sought views from patients. We spoke with five patients face-to-face and received nine completed CQC comment cards. The face to face conversations were held with patients of working age, over 75 years old, recently retired and those with young children.

We spoke with the Clinical Director, associate GP, two practice managers, the nurse and two reception staff.

We saw how staff handled patient information received from the out of hours team and patients ringing the service. We saw the ordering of repeat prescriptions, how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

We also talked with family members of patients visiting the practice at the time of our visit.

Are services safe?

Our findings

The practice was safe overall. Systems were in place to provide oversight of safety of the patients and environment. Staff took action to learn from any incidents that occurred within the practice. Staff took action to safeguard patients and when appropriate made safeguarding referrals. Improvement was needed in the safe recording of serial numbers on blank prescription sheets, which immediately following our inspection the practice confirmed they had taken appropriate action and had a policy and process in place.

Safe Patient Care

Information from the General Practice Outcome Standards (GPOS) showed Medicom Limited rated as an achieving practice. The quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting incidents. We reviewed records and for example saw that their Health and Safety policy was reviewed regularly and had been updated in July 2014. When a policy was updated staff received a memo which they signed once read and understood.

In the previous 12 month period there had been three reported significant events, there were no identified themes or patterns to these events, which were all unrelated.

There was a shared awareness of key safety risks with all staff which included for example completion of their accident book in line with their policy; although a recent staff incident had not been recorded it was on the practice managers list for completion. There were informal systems in place for staff to access information regarding any safety alerts such as medical devices and we saw that all staff had been trained to at least a minimum level of basic life support in 2013.

Learning from Incidents

We found that staff actively reported any incidents and viewed this process as a positive way to ensure they provided a high standard of patient care. For example, we found appropriate actions were taken when staff suspected a break in the cold chain storage of vaccines. Staff had reported and acted on information regarding a temperature fault with the fridge, they sought specialist advice from the individual vaccine manufacturers and remedial actions were taken. The nurse was aware of Public Health England's protocol for ordering, storing and handling vaccines. We found that all staff were aware of the actions taken, the outcome and conclusions drawn from this event and the lessons learnt. This demonstrated effective staff communication to ensure safe vaccine practices.

The practice needed to develop more detailed and robust documentation to support the information given verbally. For example the event record noted that all manufacturers where contacted, but did not record specifically the names of the manufacturers or note the specific information given by each, dated, timed and signed. The practice managers assured us that improvements would be made to refine their recording processes and to monitor the improvements made.

We found that changes to national guidelines, practitioner's guidance and any medicines alerts were discussed informally on a one to one basis with no minutes of these discussions made, although all staff met confirmed they took place. The information sharing meant the GPs and nurse were confident that the treatment approaches adopted followed best practice. Having minutes which outlined the content of these meetings would improve their governance mechanisms and minimise the potential of staff misinformation or error.

Medicines Management

Security measures were in place for prescriptions access, such as a lockable room restricted to authorised individuals. Keys or access rights for the rooms were controlled and authorised staff allowed access.

Cleanliness & Infection Control

We spoke with the nurse who we found to be knowledgeable in respect of infection control. We were shown the infection prevention and control policy (IPC) for the practice and the identified IPC lead person was the GP. We found the practice had systems in place for managing and reducing the potential risk of infection. However, the nurse had not completed refresher training in infection control. The practice managers assured the CQC that refresher training would be sourced and completed by the nurse as soon as possible.

We found that staff were aware of where to locate the most recent Control of Substances Hazardous to Health (COSHH) guidance. We saw that a schedule was in place to make

Are services safe?

sure each area was thoroughly cleaned on a regular basis. The practice needed to have a mercury spillage kit in place in the event that the mercury in equipment used to check patients blood pressure should break.

We observed all areas of the practice to be clean, tidy and well maintained. The nurse informed us they would contact the community infection control lead using their electronic systems to source the contact names and numbers for advice should the need arise. Aprons and gloves were available in all treatment areas as was hand sanitizer.

The practice had access to spillage kits to enable staff to appropriately and effectively deal with any spillage of body fluids. Sharps bins were appropriately located, closed and stored after use. We saw that clinical waste such as sharps bins were collected regularly and there were appropriate contracts in place for the safe removal of clinical waste such as needles and sharps. Staff were aware of what to do in the event of a needle stick injury and who to contact for further advice.

Staffing & Recruitment

The practice had a recruitment policy in place and this had been reviewed in the past 12 month period, the practice managers amended this recruitment policy in July 2014. The policy needed further revision to fully reflect the requirements under the Health and Social Care Act 2008.

The practice had a stable staff team with most staff members having worked at the practice for over 10 years and the staff personnel files reviewed reflected this. All staff recalled having had induction training and recalled shadowing senior staff to learn the practice day to day processes on a practical level.

All staff had up to date appraisal documents available in their personnel files. Staff told us the appraisal process was effective in providing a forum for their training and development requirements for their role.

The practice managers had taken full advice from the Local Medical Committee (LMC) in respect of their responsibilities for checks such as Disclosure and Barring Service (DBS) checks for their current staff and followed this guidance. Risk assessments were undertaken in those staff without DBS checks in place. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

The practice managers advised that they were fully staffed with no staff vacancies at the practice at the time of the inspection. There was one practice nurse at the practice who worked 12 hours per week. We were informed the practice were monitoring whether further nurse hours were required and would recruit staff should the need arise

The practice managers were aware of the appropriate pre-employment checks to be completed for any successful applicant before they could start work in the service. The practice managers were aware to obtain health statements/declarations for all new employees so they knew the person was physically and mentally able to perform their role.

We saw that the practice independently checked the suitability of locum doctors as well as reviewing information on the NHS performer's lists. We found the locums had an induction/introduction pack available to them to ensure they were fully orientated into the practice. The practice used the same locum for service continuity and all relevant checks had been conducted prior to the locum working in the practice. The practice managers demonstrated awareness that all relevant checks were to be conducted each time a locum worked in the practice.

The practice managers checked as a routine part of the quality assurance and clinical governance processes the General Medical Council (GMC) and Nursing Midwifery Council (NMC) registration lists each year, to make sure the doctors and nurses were still deemed fit to practice. All clinical staff at the practice were appropriately listed on their applicable register.

The practice managers told us that Medicom Limited sourced human resources advice and information from a specialist company "Peninsular" which included some elements of their induction training and the Local Medical Council (LMC) for information or advice.

Dealing with Emergencies

There were robust business continuity plans in place to deal with emergencies that might interrupt the smooth running of the service such as power cuts, telephone issues and adverse weather conditions.

Are services safe?

Staff knew what to do in event of an emergency evacuation and staff were aware of which staff member was the fire marshal on the day of the visit and who was responsible for health and safety.

We found all staff were trained to a minimum of basic life support to support patients who had an emergency care need. All emergency equipment was regularly checked and readily available for staff to access in an emergency.

We saw that the practice had the 2010 Resuscitation Guidelines in place which are the most current.

Adrenaline, was available as an emergency drug, which if clinically indicated could be administered by appropriately trained staff in the event of patients having an anaphylactic reaction. This was based on the Resuscitation Council (UK) guidelines that patients should expect as a minimum Adrenaline therapy if clinically indicated in a practice setting. The GPs had chosen to stock Adrenalin but not to stock Antihistamines such as Chlorphenamine which are a second line treatment for an anaphylactic reaction as if used alone, they are unlikely to be lifesaving in a true anaphylactic reaction. Or drugs such as Corticosteroids which may help prevent or shorten reactions. In asthma, early corticosteroid treatment is beneficial in adults and children.

GPs at the practice did not carry drugs in their medical bags when attending patients in their own homes or other community settings. The practice had awareness of the Resuscitation Council (UK) Equipment and drug lists guidance for cardiopulmonary resuscitation in Primary Care published November 2013. The nurse and GP informed the CQC that they held medication which would be used in the event of an emergency such as meningitis, and usually had aspirin available to use in the event of an emergency however this was not in stock on the day of our visit. The nurse informed us that this would be quickly remedied.

Equipment

We saw that all of the equipment had been tested and the provider had contracts in place for portable appliance tests (PAT) to be completed on an annual basis and for the routine servicing and calibration, where needed, of equipment..

The building maintenance contracts were held with the GP practice located in the same building including that of gas and boiler maintenance which the practice managers advised they would obtain and hold copies of for their own files in the future.

The practice shared a defibrillator with a GP practice located in the same building. The practice nurse had not received training in its use and the GP would be responsible for the use of the defibrillator. Staff should be regularly trained to ensure they remained competent in its use, which ensured they could respond appropriately if a patient experiences a cardiac arrest.

Emergency equipment including oxygen was readily available for use in the event of a medical emergency. Some of the equipment was checked regularly by staff in the co-located GP practice to ensure it was in working condition. The practice managers agreed they should formalise the use of the shared emergency equipment arrangements they had in place with the GP practice in the same building with written protocols and ensure that all clinical staff received training in the use of the shared defibrillator.

Are services effective?

(for example, treatment is effective)

Our findings

The practice was effective. Care and treatment was being considered in line with current published best practice. Patients' needs were consistently met. Referrals to secondary care were made as soon as the need was identified. Consent to treatment was always obtained appropriately. The team used informal staff meetings to assess how well they delivered the service.

Promoting Best Practice

The practice provides a service for all age groups. GPs, apart from having the overall competence to assess each person attending the service, had particular interest areas. For example one GP, the Clinical Director, had special interests in obstetrics, paediatrics, neurology, medicine in retirement and travel medicine. We saw from records that the practice followed national strategies relating to caring and treating patients. For example they ensured that all people who they treated aged over 75 years of age had a named GP.

The practice was interested in the effectiveness of the urgent suspected cancer referrals two week referral system. The GP completed a clinical audit over a three month period in 2013. A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care and the implementation of change. The results showed that compliance with referral guidance was 67% in that 33 % of the patients referred by the GP during the three month period were not assessed by a consultant within two weeks of the referral being sent. The proportion of patients subsequently diagnosed with cancer was 17%. The conclusions the GP drew from this three month clinical audit was that the predicative power of the referral guidance as a marker for cancer was low, resulting in significant numbers of patients being referred urgently without cancer. This showed us that the practice was both monitoring and also striving for continuous improvement in primary medical services and appropriate timely patient access to hospital and consultant care.

From our discussions we found that the GPs were aware of how to locate best practice guidelines and for example the associate GP was able to describe how they incorporated NICE guidance regarding urinary tract infections into their day-to-day practices.

Management, monitoring and improving outcomes for people

Patients we spoke with and the comments we received demonstrated that they were extremely satisfied with the care and treatment received from the doctors and nurse at the practice. They told us they were involved in the decisions about their care and informed about any treatment choices. Patients were offered health information literature to improve their understanding of their condition or to promote better health.

An example of how the GP monitored the services the practice provides included a review of any inadequate cervical smears conducted over a two year period. The conclusions drawn from the review conducted was that nurses worked within safe limits and were competent practitioners, who had completed appropriate training. The GP advised that performance would continue to be monitored and audited, to maintain and where able improve outcomes for patients.

The practice had agreed with Greater Preston Clinical Commissioning Group (CCG) an improvement action plan in three areas indicated by the data produced from the GPHLI and QOF. An example of one of the improvements was in the percentage of patients aged 15 years and over who are recorded as current smokers, who have a record of an offer of support and treatment within the preceding 27 months at the practice. We saw that this figure had improved from 79.9% to 90%. The practice had already attained the improvement target as agreed by the practice and CCG in their action plan, and continued towards further improvement.

Staffing

The GP held informal one to one meetings with staff in general on a daily basis, which staff found helpful and confirmed took place, but these were not minuted.

The practice managers were aware that clinical staff must maintain their appropriate refresher training in a timely manner, this expectation was in line with national guidance as well as those of the local CCG. As a small staff team the logistics of staff members working set days and/or part time hours meant that external training courses did not always capture all staff, or staff may not be available to attend and some training was therefore provided on-line in the form of E-Learning.

Are services effective?

(for example, treatment is effective)

The practice managers did not have a system in place to easily identify when specific staff training was due to ensure staff could readily update both mandatory and non-mandatory training in a timely manner

Following the inspection the practice manager forwarded a draft of their proposed system to effectively monitor and have oversight of staff training, qualifications and professional registration dates.

We saw that mandatory training for all staff included fire awareness, safeguarding adults and children and basic life support. Reception staff for instance had access to training related to their role for example "Information Governance" and patient confidentiality and the nurse to training such as asthma care. We saw that the basic life support training took place in March 2013. The practice managers confirmed that the refresher training had been booked. We saw that the nurse had not completed recent infection control training or level 2 safeguarding vulnerable adults and children training but had commenced Level 3. Following the inspection the practice managers confirmed they had contacted Greater Preston CCG to arrange infection control training. Training in the Mental Capacity Act (2005) had also not been completed by all staff.

With the exception of the GPs, staff appraisals were completed by the practice managers. These included the individual's review of their own performance, feedback on their performance and planning for future development and training. Staff were given the opportunity to comment on their progress and training needs for the coming year.

The GPs received both internal appraisal and an external professional appraisal. The appraisals involved a 360 degree process, which asks staff to complete a personal reflection on their skills and behaviour. Internal colleagues were also asked to provide open and honest feedback about the appraiser's interpersonal skills and clinical competence.

We noted that the two practice managers completed each other's appraisals which they had found effective. We discussed whether the governance arrangements around their appraisals could be improved with feedback from the Clinical Director or associate GPs.

Two GPs within the practice had completed their revalidation. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practise. Revalidation aims to give extra confidence to patients that their doctor is being regularly checked by their employer and the General Medical Council (GMC).

The practice nurse evidenced that they had maintained their registration with the Nursing and Midwifery Council (NMC) and by doing so assured the NMC that sufficient training had been completed to maintain this registration. We saw that the nurse had successfully completed a modular diabetes course in 2013/14, with diabetes update raining in May 2014 and diabetes insulin medication course in July 2014. This was to ensure that best practice for supporting diabetic patients attending the practice was promoted and maintained.

Working with other services

Medicom Limited was grouped with five other GP practices as a peer group within Greater Preston CCG. When comparing to the other CCG peer groups, this peer group had relatively high overall patient satisfaction levels, which ranged between 85.5% - 99.3%. Greater Preston CCG average is 87% and the National average is 87%.

The practice is co-located in the same building as another GP practice and a dental practice. The practice staff work with the local community nursing team, midwives, health visitors, and for patients with learning disabilities, the community disability team. We found that the clinicians appropriately referred patients to community teams, for example pregnant women were seen for their ante-natal appointments by the community midwives.

We spoke to the practice managers about whether the GPs provided any domiciliary visits to patients in nursing or residential care homes and how the practice worked with the homes staff to provide a seamless service. At the time of the inspection none of their patients were in receipt of care in a nursing or residential care home.

They worked closely with Preston Primary Care Centre who provide their out-of-hours (OOH) service to make sure there was a full exchange of information about patients' needs, which would include any patients receiving palliative care. GP practices who have opted out of OOH services should monitor the quality of the OOH services offered to their patients and report any concerns to NHS England (or as directed by NHS England to the delegated commissioner of OOH services). In monitoring the quality of OOH activity for

Are services effective?

(for example, treatment is effective)

registered patients, practices should have regard to the national quality standards and any reported patient feedback, including reported patient complaints made to practices about the OOH provider.

Greater Preston CCG found Medicom Limited GP OOH attendances in 2012/13 above the CCG average rate and the highest within its peer group, 146.0 attendances per 1000 population, however between November 2013 to June 2014 this had reduced to 115.6 attendances per 1000 population compared to the CCG average of 122.3. Demonstrating that the practice was improving and educating patients in how and when it was to choose to access GP OOH services.

Health Promotion & Prevention

We found that staff proactively gathered information on the types of needs patients had and understood the number and prevalence of different health conditions being managed by the practice. The practice manager and staff could clearly outline the numbers of patients with long-term conditions; what these were; and how the clinicians took action to regularly review their needs. An example of which was 382 patients of the 2138 had raised blood pressure and 89 patients had Coronary Heart Disease (CHD) and these patients attended the practice for regular reviews.

We saw that staff knowledge of patients needs led to targeted services being in place such as immunisation schedules being followed, and long term condition management such as reviews of patients health through for example diabetic and respiratory patient review appointments with the nurse or GP. Public Health England's, Child Health Profile, Lancashire, March 2014 report found that in the year 2012/13 the measles, mumps and rubella (MMR) immunisation by age 2 years compared favourably with the England average. A higher percentage of children (93.8%) had received their first dose of immunisation by the age of two in the Lancashire area as opposed to England's average (92.3%).

The practice had a single piece of apparatus in the waiting room to measure blood pressure, weight and height which they, and their patients, called the Pod. 'The Pod' printed out the patients results and was angled so others in the waiting room could not readily see the readings. Patients at the practice could use the 'Pod' by requesting a token from reception staff, enabling patients to review information about their health at any time the practice was open. They were encouraged to make an appointment with the GP or nurse to discuss the results if outside of their normal range.

We saw that there was a moderate range of health promotion information on display in the waiting areas patients used and leaflets explaining different conditions were also freely available in the treatment rooms of the practice. This meant that preventative work could be completed with all these groups to assist them to improve their health and well being.

A small percentage of patients who attended the practice had a diagnosis of dementia and on discussion with the practice managers they hoped to source dementia care training for their staff.

Are services caring?

Our findings

The practice was caring. All the patients who completed our comment cards and those we spoke with during our inspection were very complimentary about the service. They all found the staff to be extremely person-centred and felt they were treated with respect. The results for this practice were amongst the best

Respect, Dignity, Compassion & Empathy

Patients told us staff were kind and caring, helped them when they needed and treated them with dignity and respect. Nobody had any concerns about their care or treatment and they said if they did they would have no worries about raising them.

All the patients we spoke with told us they were more than satisfied with the approaches adopted by staff and felt clinicians were extremely empathetic and compassionate. Interactions between staff and patients were warm and friendly and we saw that patients were relaxed in the company of the reception staff. We heard how the clinicians were attentive to patients needs and referred them to other services when this was appropriate.

The National GP Patient Survey results 2013 for this practice were amongst the best in the country. This survey asks patients registered at general practices across England for example how easy or difficult it is for them to see or speak to a doctor at their practice. Staff maintained a file which we saw held thank you cards and expressions of gratitude from patients and families.

Staff were familiar with the steps they needed to take to protect people's dignity. Consultations took place in the privacy of the treatment and consultation rooms, purposely designed with an appropriate couch for examinations and screens to maintain privacy and dignity. The nurse confirmed that consultation room doors could be locked when patients were being seen, to ensure patient's dignity was maintained and we saw and heard staff knock and wait for a response prior to entry when doors were closed but not locked.

The practice had a chaperone policy in place which was displayed in the waiting room. This advised patients they may have a chaperone to support them during their consultation if they wished. Staff were clear on their responsibilities should they be asked to chaperone a patient. Some patients we spoke with were unaware of the notice but told us they felt confident if they required the service it would be effective, and professional.

The practice shared the reception room with another GP Practice, which was sited within the waiting room but divided from it by a counter area and glass windows. Inside the reception room the space was arranged so that it was clear that the display screens, documentation and telephones for each practice were placed to minimise the risk of patients information being shared.

We observed that when phoning in, patients would be asked for brief reasons as to why they needed an appointment. We observed that the reception staff treated people with respect and ensured conversations were conducted in a confidential manner. We found the staff dealing with these calls were very knowledgeable about their systems and recognised when an issue was an emergency. All patients with a requirement for an urgent appointment were seen on the same day.

Involvement in decisions and consent

Staff said they had access to interpreter or translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use. The reception staff and GP told us they had yet to use this service as none of their current patients required this assistance.

Staff were aware of how to locate the practice policy which dealt with the Mental Capacity Act (MCA) and best interest decisions but had received no formal training. These pieces of legislation are legal requirements that need to be followed to ensure decisions made about patients who do not have capacity are made in their best interests. They are designed to ensure that patients who are unable to give consent for certain aspects of their care and welfare receive the right type of support to make a decision in their best interest.

We saw that healthcare professionals adhered to the requirements of the Mental Capacity Act 2005 and the Children Act 1989 and 2004. Capacity assessments and Gillick competency of children and young people, which check whether children and young people have the maturity to make decisions about their

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was accessible and responsive to patients' needs. The practice had a clear complaints policy and had received only one formalised complaint. They responded appropriately to complaints about the service. The practice managers agreed that in future they will also record comments made to the service and any improvements or actions taken as a result of any comments, to further demonstrate how they respond to patient's needs.

Responding to and meeting people's needs

The practice staff had a clear understanding of the specific population groups (demographics) located in the area where it provided a primary care service.

We found that the practice had two disabled parking bays, there was a metal ramp entry to the practice from the car park and at ground floor level an accessible disabled toilet facility with wide corridors between the treatment and consulting rooms. Some patients when attending the practice to drop off prescriptions used these bays inappropriately and the practice manager and reception staff were able to monitor this.

The practices electronic system had the facility to record whether staff should be alert to any patient access difficulties or for example have hearing problems or a learning disability so that the GP and staff could make suitable adjustments. Patients aged 75 years or older had a named GP.

The GP met with Greater Preston Clinical Commissioning Group (CCG) where appropriate to do so. The Business Manager told us that more informal communication was maintained by email and telephone conversations with members of staff working for the CCG. This meant that an effective communication was in place between the practice and its commissioners, contributing to effecting changes in patient care when appropriate.

The practice website held information in respect of their services and clinics. This included for example;

Their appointment systems, repeat prescription ordering on line, in person, by telephone, by post and by fax and information about medication reviews and how to register with the practice. It also held information about minor illness and headings such as "Get the Right Treatment" which walked patients through self-care, local pharmacy services, Walk in Centres and Accident Emergency and ambulance services and gave examples for patients of which to use and when.

Patients who did not attend for example where expected for childhood immunisations where followed up by the practice staff to ascertain why and to ensure theirs and their child's needs could be safely met. Children and parents were referred appropriately to attend community clinics such as the Health Visitor clinics and Childhood development clinics and for well-being clinics such as Healthy Child Programmes. Patients had a gender choice regarding their GP appointments, although the female GP only worked on Wednesday afternoons.

Patients did not report any concerns regarding staffing levels or access to the service. One patient of the five spoken with and from the nine comments cards received said as a suggested that the addition of a Thursday afternoon appointment would be beneficial for them.

Staff were responsive to patients needs and patients could phone during the day and they would always be seen on the same day if their condition was urgent to discuss their problem. They could also book face-to-face appointments to see the nurse. The practice actively monitored patients and called them up to make arrangements for them to attend the practice for routine checks, such as for repeat prescription reviews.

Access to the service

We arranged for a Care Quality Commission (CQC) comments box to be placed in the waiting area of the practice several days before our visit and nine patients chose to comment. We reviewed the patients comments and found they were extremely complimentary about the practice, its staff, attitude, skills and responsiveness to their and family's needs and included the excellent staff listening skills and professionalism.

The majority of patients we spoke with thought that access to the appointments system was effective and worked well for them, with only one of the fourteen comments captured either verbally or on comment cards made any suggestions for improvement. This was for staff to consider of opening on a Thursday afternoon.

We spoke with five people who used the service, all those spoken with preferred to use the telephone to access appointments. The majority of patients who made contact

Are services responsive to people's needs?

(for example, to feedback?)

by telephone said they were able to get through to the practice within a reasonable timescale and obtain a non-urgent appointment within two working days. Some patients preferred to wait for an appointment with a GP of their choice.

Patients spoke highly of the urgent appointment system all found they could be seen the same day. Patient's feedback was that they felt listened to and heard and their appointments were not rushed and unless they had been slotted in for an urgent appointment had been seen within 10 minutes of their allocated appointment time.

Urgent same day appointments were made available each day with either the GP or nurse. All of the patients we spoke with thought the system was effective, patients who chose to see the same GP for non-urgent appointments said they were seen within a reasonable timeframe.

When the practice is closed and in the out of hours periods the practice chose to opt into the out of hours services provided by Preston Primary Care Centre, where patients can receive medical advice and treatment. Preston Primary Care Centre contact details are available to patients within the practice brochure and on the surgery answerphone during the out of hours periods and by speaking with staff.

The premises were accessible for patients with limited mobility such as wheelchair users and all patient areas were clean, tidy and well maintained.

Concerns & Complaints

There was a robust complaints procedure in place and a copy was on display in the waiting room area. Patients said they had no complaints about the service provided were confident that if they had cause to complain the staff would action their complaint and investigate accordingly. Patients told us that they felt able to express their views about the service they received which they found to be excellent. We spoke to staff and it was clear they knew how to deal with complaints and would escalate them appropriately. We were shown the complaints procedure which had last been reviewed in the last 12 months. This gave us confidence that the provider ensured it was current and fit for purpose. There had been one formal complaint made in the past 12 months and it was clear that it had been considered in line with their policy.

We saw that action was taken to put measures in place to reduce the risk of the same type of complaint occurring again and patients could expect a full investigation of any complaints made. This low level of complaints was representative of the high level of patient satisfaction with the service as noted from the comment cards, verbal feedback and the National Patient Survey 2013 results. It may also reflect the manner in which patient issues and concerns were dealt with by practice staff before they escalated.

Are services well-led?

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

Our findings

The practice was well led and effectively responded to changes. Governance and risk management structures were in place but some were informal and needed to be documented to reduce the risk of communication error. Staff were committed to maintaining and improving standards of care. There was an effective system in place for managing risks and additional attention to the detail in their documentation for example around significant events would further improve the governance arrangements.

Leadership & Culture

The GPs we spoke with demonstrated an understanding of their area of responsibility and each GP clearly took an active role in ensuring that a high level of service was provided to patients. All the staff we spoke with told us they felt they worked well as a team. Many staff worked part time hours and had set days and it was felt by some staff that regular formalised meetings would enhance the support in place. Formal staff meetings would reduce the risk of error in staff communication, provide clear delegation of actions or tasks and encourage staff ownership of these responsibilities. The practice managers and the GP 360 degree feedback reflected their knowledge of the requests staff made for more formalised whole staff and clinical staff meetings, complete with minutes.

Clinicians were self-governing and we saw that staff critically evaluated the existing service to identify where action could be taken to improve the service. GPs held regular informal meetings to discuss decisions made and treatments prescribed. Examples of this were seen in the practices internal practice review of their patient's accident and emergency attendances in 2013. During the audit it was found that the age group with the highest attendances was between the ages of 25 and 34 which, when analysed, reflected the practice population, as it has a high population within this age group so was not considered to be significant. The practice found from a detailed review of 20 individual cases that the majority of patient attendances to have been genuine and unavoidable.

Governance Arrangements

Clinical staff were responsible for decisions in relation to the provision, safety and quality of care and worked with the practice managers to ensure identified risks were acted upon. GPs engaged with Greater Preston Clinical Commissioning Group to discuss new pathways for care. Clinical staff were aware to

Systems to monitor and improve quality & improvement

The Clinical Director/GP provided the leadership and management structure at the practice and it was clear from the staff we spoke to they knew who to contact for specific advice and support. The practice had a number of clinical protocols in place for example the Resuscitation Council (UK) 2010 guidelines for the treatment of anaphylaxis. There was no formal protocol in place for the shared emergency equipment between Medicom Limited and the other GP practice located at the same address. Devising a protocol would improve the informal systems in place and staff accountability for the monitoring of the equipment. Following the inspection the practice managers confirmed that a protocol for the shared use of the emergency equipment was being devised.

Patient Experience & Involvement

We received nine comment cards and spoke with five patients on the day of the inspection. The patients spoken with were from different age groups, including parents with young children, patients with different physical health care needs and those who had various levels of contact with the practice. All patients were extremely complimentary about the clinical staff and the overall friendliness and approach of the staff team. They all felt the doctors and nurses were extremely competent and knowledgeable about their care and treatment needs. They felt that the service was excellent and found their views were valued by the staff.

The practice did not have a patient participation group (PPG), it had initially looked at setting up a virtual PPG but it had not progressed further. The practice managers said they will be participating in the "Friends and Family" test due to commence in October 2014. The "Friends and Family Test" will be a contractual requirement from October 2014. The test question will be: 'How likely are you to recommend our practice to friends and family if they needed similar care or treatment?' Practices will be required to ask one follow up question of their own choosing, and also provide monthly feedback to NHS England.

Are services well-led?

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

Staff engagement & Involvement

We were told and staff confirmed that brief, informal one to one staff meetings were held with the GP. The practice managers informed us that as a small practice they had not found the need to minute every meeting as communication between the staff team members was very good. However, some staff found as part time workers, communication to catch up on events could be problematic which led them to feel that they were not being as supported as they could be in their role. This would ensure all staff were aware of their delegated responsibilities providing robust governance within the team. Clinical staff told us that they had requested access to refresher training as part of their role but this was not always planned in a timely manner. The practice managers and the GP 360 degree feedback reflected their knowledge of the requests staff made for more formalised whole staff and clinical staff meetings, complete with minutes.

The staff we spoke with discussed how they reflected upon the patient outcomes being achieved and areas where this could be improved. The practice managers and GP were aware that a consistent approach regarding formalised meetings was required for robust and effective communication.

Staff said they could and would openly raise and share concerns about anyone's clinical performance and were aware of Medicom Limited's whistleblowing policy. The nurse was also aware of the Royal College of Nurses whistleblowing procedures .

Staff told us they were encouraged to make suggestions and contribute to improving the way the services were delivered and enjoyed working at the practice.

Learning & Improvement

Staff we spoke with said the GP was very supportive of staff's personal development within their role. The practice had provided staff with extra support to achieve qualifications which would increase the staff member's effectiveness and that of the practice. Staff told us that they were aware of the cost and time implications it had on the practice and they ensured the course requested would benefit patients who attend the practice.

Staff told us about how the practice had learned from a "significant event" such as when the vaccine fridge temperature had risen. The event had produced learning for all staff at the practice in respect of awareness and staff informed us that appropriate remedial actions had taken place. We found that all staff were aware of this event as it had been effectively communicated, new systems had been devised and subsequently reviewed as part of this learning and that further improvements would be made in providing detail in the significant event documentation.

We saw minutes from a meeting held in October 2013 to internally review patient attendance at the accident and emergency department which some of the clinical staff attended with the practice managers.

This review found the majority of patient attendances to have been genuine and unavoidable. The practice reviewed the services and access they provided and ensured that all their GPs were aware of the alternative pathways and services available locally to continue to monitor attendances and provide patient education. This demonstrated that the whole team were focused and very open to exploring how they could improve.

Identification & Management of Risk

Although a system was in place for the recording, investigation and learning from significant events, there was a lack of detail in the documentation and auditing of these events. We discussed this with the practice manager and they agreed that further detailed documentation would improve the governance arrangements in place. They informed the CQC they would monitor any future significant events documentation and provide an annual audit of all significant events, which would be beneficial in identifying any trends and any learning derived from them.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

Staff were knowledgeable about the number and health needs of older patients using the service. They kept up to date registers of patients' health conditions, carers' information and whether patients were housebound. They used this information to provide services in the most appropriate way and in a timely manner.

Medicom Limited had an individual practice initiative which included involvement with the NHS Greater Preston, Primary Care Support Scheme. Once signed up to this scheme the practice identified key actions it hoped to complete by April 2015. This included support for patients over 75 years old by reducing unnecessary admissions to hospitals and to improve the quality of care for patients over 75 years old. To support patients with dementia and co-ordinate with other professionals the care plans of those patients who would benefit from more "active" case management.

The practice had in place a named GP for patients 75 years old and over. Staff at the practice had not attended dementia awareness training and the practice managers following the inspection intended to liaise with the CGG to source applicable external training to support their staff.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice was knowledgeable about the number and overall health needs of patients with long term conditions using the service. They co-operated when appropriate to do so with other health services and agencies to provide appropriate support. For example the nurse and GP were aware that the practice had no current patients in receipt of palliative care.

The Greater Preston CCG suggested as an agreed priority for patients with dementia, longer term support with care closer to home with avoidance of admission to hospital as an agreed priority with their main service providers via the Clinical Senate. The Clinical Senate is a forum where various clinical parties come together and focus on achieving benefits for patients.

We found that the GP had awareness of the CCGs work programmes. Of the patients registered at the practice those diagnosed with dementia represented 0.5%.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice provided services to meet the needs of this population group with childhood developments checks and had childhood vaccination and immunisation programmes in place which were managed effectively to support patients.

Staff were knowledgeable about child and adult protection and a GP took the lead for safeguarding. The practice staff monitored any non-attendance of babies and children at vaccination clinics and worked with the health visiting service to follow up any concerns.

The practice held child development clinics for childhood development checks and vaccinations. Ante-natal clinics were also held with the community midwives. There were baby changing facilities available at the practice.

Parents could access community Health Visitors for advice and support such as those accessing the Healthy Child Programme. The Healthy Child Programme is designed for the child's early life to 5 years old and focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting.

The nurse had completed annual training update in immunisation and vaccinations in July 2013 and basic life support and anaphylaxis training in March 2013 so patients and parents could be assured staff were up to date with any changes and safe practice measures.

During the inspection it was clear that some staff had not been aware to book children and adolescents appointments with the GP regardless of whether they were accompanied by an adult or not. Although staff could not recall any event where this had been required. Immediately following the inspection a policy was devised to ensure all staff were aware that a GP is available to see children and young people on their own if that is what they want. It was devised so that the clinical decisions about a child's competency and understanding would be made by the GP during an appointment and that appointments were accessible to children and adolescents.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and self-help guidance literature provided both on-line and within the practice to meet the needs of this population group. The practice website also provided information to sign post patients to the most appropriate service during the out of hours periods.

The information provided by the Greater Preston CCG for June 2014 indicated that Medicom Limited has a smaller than average patient list size and has a lower than average proportion of the population aged lower than 39 years old and a higher proportion aged greater than 55 years. As a consequence many of the patients on their patient list fell into the working aged and recently retired population group.

The practice provided a range of services for patients to consult with GPs and nurses, including on-line booking and self-help guidance literature provided both on-line and within the practice treatment and waiting rooms. Patients were also able to attend the practice for urgent appointments with the GP or nurse on the same day.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice accepted new patients to their patient list which was accessible to all individuals including patients with no fixed abode and transient population groups.

0.14% of patients registered at the practice had a learning disability and 66% of the 0.14% had other long term conditions. The GP informed us that they were not contracted to provide a Directed Enhanced Service (DES) which incorporates the Learning Disabilities Health Check Scheme, to provide their learning disability patients with annual health checks. Although the practice had not signed up to provide these annual health checks, the nurse told us that their patients had regular follow up reviews for their long term conditions at least annually. The practice managers told us that the community learning disability team liaised with the GPs and that they were involved and informed of any changes in their active care plans.

Staff were knowledgeable about safeguarding vulnerable adults and all staff had completed at least level 1 training. The Clinical Director and GP had completed level 3 training suitable for clinical leads. The nurse had commenced level 3 training and the practice were arranging nurse training using an E-learning program for level 2.

Staff informed us that their patient list was accessible to individuals with no fixed abode and transient population groups.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice staff maintained a register of patients who experienced mental health problems. 0.93% of the patients registered at the practice had a diagnosis of a mental health condition at the time of the inspection and the nurse demonstrated that 55% of these patients had an active care plan agreed. This register supported clinical staff to offer patients an annual appointment for a health check and a medication review.

We read minutes from a clinical meeting held in October 2013. The practice when completing an internal practice review of accident and emergency attendances suggested that where appropriate, patients with mental health and alcohol issues could be further supported with better education in terms of counselling.

They proposed that in order to maintain relatively low accident and emergency attendances the practice would monitor all patient attendances and provide patient education. The practice suggested that accident and emergency could re-direct patients back to the practice, if their attendance in secondary care was inappropriate, with particular attention paid to "frequent flyers? as in regular attenders. At the time of the inspection a further review had not taken place to ascertain if their suggestions had been effective once implemented.

Greater Preston CCG as noted in their Delivery Plan 2013/14 were working with the local mental health NHS Trust to review the current service provision and to identify future patient needs for patients experiencing a mental health problem.

The aim of this review was to provide equitable, efficient, evidence based collaborative primary care mental health service that adopt a recovery based and personalised approach to enable patient to achieve their optimum level of health and wellbeing and in which patients are central to and active participants in their care. They aimed for example to forge links and partnerships with existing community assets. These include third sector providers, volunteers and independent organisations. They were also focusing the commissioning arrangements on improved access and treatment for people with mental health issues. Delivery of Improving Access to Psychological Therapies (IAPT) is variable in terms of referrals into the service against prevalence. As a result of IAPT significant gains have been made in terms of increasing the availability of evidence-based therapeutic interventions for people with common mental health problems.