clarendon lodge medical centreClarendon Lodge Medical Practice

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.

Summary of findings

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Summary of findings

Overall summary

Clarendon Lodge Medical Practice provides primary medical services to people in North Leamington Spa and the surrounding areas. There is a branch at Bubbenhall Village Hall which is open on alternate Friday mornings.

At the time of this inspection there were around 12800 people registered with Clarendon Lodge Medical Practice. Consultations took place in the two surgeries but sometimes doctors visited patients at home. This depended on the circumstance of their illness. Access to a GP outside of surgery hours was arranged through the NHS 111 service.

We found that the practice was safe, effective, caring, well led, and responsive. The practice had adequate arrangements to provide health care services for the population served.

During this inspection we spoke with 15 patients. They were complementary about the care they had received and found the practice caring and friendly. They felt the service provided were somewhat restricted by space and the age of the practice building. The practice was working with partner agencies such as the NHS and the local authority to address this issue.

We found the health care team at Clarendon Lodge Medical Practice, approachable and helpful when they cared for their patients. There was a commitment to continuous learning, professional development and good communication. The practice had a management structure that ensured the smooth running of the services provided. In spite of the physical restraints they worked under the practice had made good use of available space to ensure safe and optimum patient care.

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 service was safe. Staff understood how to safeguard adults and children from harm. Patients told us that they felt safe when they attended their appointments with doctors, nurses and other clinical professionals. There were systems in place to make sure that practice staff learnt from events such as accidents and incidents, complaints and concerns. Staff knew how to respond in the event of a medical emergency.

Despite the physical restraints of space and the age of the building they worked in, the practice had made good use of available space which ensured an environment for safe patient care.

Are services effective?

The service was effective. Care and treatment was delivered in line with current best practice standards. The practice proactively promoted health and well-being and the prevention of illness. Patients told us that the GP and other clinical staff listened to them and that they received appropriate care.

Clinical and other staff that worked at the practice were suitably qualified, trained and competent to carry out their roles.

Are services caring?

The service was caring. Patients told us they were treated with dignity and respect and confidentiality was maintained. They also told us that staff were kind considerate and compassionate. Patients were given enough information and support to make decisions about their health.

Are services responsive to people's needs?

The practice was responsive to people's needs. The practice understood the different needs of the population and planned and delivered services to meet those needs. Appointments could be made in a number of ways with evening and Saturday appointments available for people who were not able to attend during the day. The practice operated a system of prioritising patients that needed to see a doctor the same day. A clear complaints procedure existed in the practice. There was a system to review and look into any concerns or complaints people had raised and learn from these.

Are services well-led?

The service was well led. There was evidence of good leadership. Clarendon Lodge Medical Practice is a training practice for new GPs. The practice management was supportive and had a governance

Summary of findings

structure with defined roles and responsibilities for each staff member. There was a patient participation group (PPG) which through active interaction with the GPs and practice staff had made useful contributions that had improved patient's care experience. There was good communication and team work with regular team meetings, partners meetings and staff away days that facilitated a positive patient experience.

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 provided a range of services that managed the health of older people who lived at home or in a care home. Clarendon Lodge Medical Practice had adopted the concept of the 'virtual ward'. This is a system that helped the practice identify patients in care homes who were at high-risk of future hospital admissions; so they were offered extra care and support which helped avoid potential emergency hospital admissions. Care was reviewed regularly and included mental and physical health checks.

People with long-term conditions
The practice had arrangements that identified and offered support and care for patients with long term conditions. The practice operated a recall system for specialised clinics such as those for chronic obstructive pulmonary disease (COPD) and diabetes. There were sufficient arrangements to ensure the continuity of care for those who needed end of life care.

Mothers, babies, children and young people
The practice offered services for mothers babies and children in conjunction with the NHS health visiting and midwifery teams. The service provided included checks on new babies as well as an immunisation programme for the under five year olds and for those aged six to 15 years. The practice provided contraceptive treatments and family planning advice for young people.

The working-age population and those recently retired
There was flexible access to the surgery appointments that included on-line booking. Patients could access evening appointments. Appointments for standard health checks were available on Saturday mornings. The practice offered vaccinations to protect adults (and some children) at risk of flu and its complications.

People in vulnerable circumstances who may have poor access to primary care
The practice had a lead GP who in conjunction with the NHS learning disability team oversaw services for people with a learning disability that lived in the community. There were regular health checks and reviews of their care.

Summary of findings

The practice had good links with services such as the NHS, social services and housing. This helped them provide for the needs of people in vulnerable circumstances who may have poor access to primary care.	
People experiencing poor mental health The practice had a system to identify and provide care for people experiencing mental health problems. Services were offered in conjunction with the NHS mental health team. Where appropriate patients were referred to specialist services.	

Summary of findings

What people who use the service say

Before we inspected we asked patients that used the surgery to tell us what they thought of the service. 14 people had completed a comment card. Patients commented how accessible the service was and noted that GPs nurses and other staff were kind caring and compassionate. Patients commented that the services provided would be further enhanced if the surgery was successful in obtaining more spacious premises. Patients noted that the recent improvements to the appointment system had made getting appointments easier.

We looked at the results of the most recent patient survey. This showed that overall patients were satisfied with the care they had experienced.

Areas for improvement

Action the service COULD take to improve

- While audit results had been analysed and changes implemented and audited again to check changes made had been sustained, the practice could change the way competed audits were recorded so staff had an appreciation of all the clinical audits that was undertaken.
- While new staff had appropriate induction, records did not reflect the nature of induction they had undertaken. A recording system could capture the totality of the induction undertaken by new staff.
- The decision not to carry out Disclosure and Barring (DBS) checks on non-clinical staff had not been risk assessed
- The practice could review the security of the location of the main computer server, and the arrangements for the safe storage of back-up data from the main server.

Good practice

Our inspection team highlighted the following areas of good practice:

- The care programme provided by the practice for people who were dependent on drugs and or alcohol in conjunction with other local services such as the NHS, social services and housing.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and a GP. The team also included a second CQC inspector and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to clarendon lodge medical centre

Clarendon Lodge Medical Practice provides primary medical services to people in north Leamington Spa and the surrounding areas. There is a branch at Bubbenhall Village Hall where consultations are held on alternate Friday mornings. The practice has seven GP partners, three registered nurses, two health care assistant and several members of reception and administration team.

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.

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 a mental health problem.

Detailed findings

Before inspecting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We did this to identify any areas of risk that may be relevant to the five key questions. We carried out an announced inspection on 21 May 2014. The team inspected the provider's main surgery at 16 Clarendon Street, Leamington Spa.

During our inspection we spoke with a range of people who worked at the surgery such as GPs, the practice manager, practice nurses and reception staff. We spoke with patients and members of the Patient Participation Group (PPG).

We reviewed our comment cards that patents had completed and left for us, and the latest practice commissioned local patient survey.

Are services safe?

Summary of findings

The service was safe. Staff understood how to safeguard adults and children from harm. Patients told us that they felt safe when they attended their appointments with doctors, nurses and other clinical professionals. There were systems in place to make sure that practice staff learnt from events such as accidents and incidents, complaints and concerns. Staff knew how to respond in the event of a medical emergency.

Despite the physical restraints of space and the age of the building they worked in, the practice had made good use of available space which ensured an environment for safe patient care.

Our findings

Safe patient care

There were arrangements for reporting safety incidents which were in line with national and statutory guidance and staff we spoke with were aware of these arrangements. The practice regularly communicated to staff any emerging risks to patient care and staff were also encouraged and supported to contribute to this process. This demonstrated that the practice acted safely and had a commitment to perform consistently in reducing risks to patients and providing safe care. Patients told us that they received safe and attentive care when they attended their appointments and consulted with doctors and nurses.

The practice used several information sources to improve care and patient experience. This included lessons learnt from patient safety incidents, complaints, clinical audits which measure clinical practice against agreed performance and feedback from people who used the service and from other professionals. For example a clinical audit of repeat prescribing had resulted in the reduction in use of a particular medication.

The practice had an intranet which gave practice staff access to policies procedures and clinical guidelines. This supported the safe and effective delivery of care in line with national and professional guidance.

The main server that provided the electronic information flow to all the computers in the practice was placed along the landing on the public stairway on the third floor. The backup tapes for this electronic data flow were stored in a safe that was not fixed to a secure point. There were no risk assessments that confirmed the safety and security of this storage arrangement taking account of any implications for patient information data security.

Learning from incidents

We saw that the practice conducted a significant event audit (SEA) after each safety incident and implemented actions to prevent reoccurrence. An SEA is process that reflects on and learns from individual incidents to improve quality of care overall. The practice manager and staff were able to describe their role in the incident reporting process. There were regular meetings that discussed significant events. These meetings were attended by clinical and non clinical staff including receptionists and administrative personnel. Where learning points were identified these

Are services safe?

were communicated to all relevant staff and noted. The community liaison nurse described a recent significant event audit in which she was involved and felt well supported by the GPs and her mentor.

Safeguarding

There was a named GP lead for safeguarding and practice staff had received training relevant to their role. Effective safeguarding policies and procedures were in place and staff demonstrated that they understood and implemented them. Information about the local authority's safeguarding procedures was accessible to staff. Staff we spoke with knew how to seek further advice or to report a safeguarding concern.

We saw information which showed that practice staff were aware of the implications of domestic abuse on families. Practice staff described strong links with the local social care teams to safeguard children and vulnerable adults. Where children were subject to a child protection plan there was a marker on their records to alert staff to this fact. Safeguarding was a standing item on the weekly meeting of the practice team, so that information about risks were shared and updated.

Appropriate checks were carried out when the practice recruited new staff. The practice manager told us that they requested a Disclosure and Barring Service (DBS) check previously called the Criminal Records Bureau (CRB) check for clinical staff only as non clinical staff did not engage in regulated activities. The DBS check provides information about an applicant's police record and may be used to determine their suitability to work with vulnerable people. However there were no individual risk assessments to show why the DBS check was not made or needed for non-clinical staff. The practice manager told us that the decision not to request a DBS check was based on previous advice but they would consider changing their recruitment processes to include an individual risk assessment for non-clinical staff.

There were effective induction programmes for new staff. The induction programme was in two parts. All employees attended the first part which covered policies, procedures and basic training such as health and safety, fire precautions and information security. The second part was specific to the department where the new employee worked and facilitated by the relevant department head.

While we saw documented evidence of the successful completion of the first part, we did not see a record of the induction covered within the department. This was an area in which the practice may wish to make improvements.

Monitoring safety and responding to risk

Adequate staffing levels and skill-mix were evident during our inspection. Staffing was reviewed regularly by the practice manager which ensured enough suitably skilled staff were available to maintain the continuity of a safe service. The practice had procedures which ensured emergency cover for both clinical and non clinical staff. Patients told us that they were able to see a GP if they needed to consult urgently.

Medicines management

We looked at the storage of medicines and equipment in the practice. Medicines and medical gases were monitored for their safety and continued effectiveness from their arrival at the practice through to use in patient care. The practice had arrangements that made sure temperature sensitive vaccines and medicines were transported and stored at the correct temperature. We saw records of checks which ensured the temperature of the vaccine storage fridge remained within acceptable limits to ensure vaccine safety. On the day we inspected we saw that the practice had set aside a batch of vaccines and not used them when it became evident that the fridge where this was stored had not maintained the safe storage temperature. This ensured vaccine and medicine safety and their potency.

No controlled drugs were stored at the practice. There were records of regular checks on all medicines and equipment to ensure that stock was 'in date'.

Regular checks were also made on medicines contained in the bag taken by GPs on home visits. This made sure the medicines were in date and adequate stocks were available to the doctor.

Cleanliness and infection control

On the day of our inspection the premises were visibly clean. Patients told us that they found the waiting room and the consulting rooms clean. There was a daily cleaning schedule for the premises.

Are services safe?

The practice had policies and procedures for infection control and staff we spoke with were aware of these. The practice had a lead person for infection control. There were hand washing facilities available with antibacterial hand wash and hand gel.

There were arrangements for the safe disposal of clinical and non clinical waste which included sharps such as injection needles.

Dealing with Emergencies

The practice had a protocol for resuscitation and managing medical emergencies. Practice staff had received training in medical emergencies such as anaphylaxis and basic life support skills. Staff we spoke with were knowledgeable about their role in medical emergencies. We saw that a defibrillator and oxygen were kept appropriately where they could be accessed by staff. The practice had a medical emergency bag which contained medicines and equipment for use in an emergency. The contents of the bag were replenished after every use. We saw records that showed the medicines and equipment had been checked regularly.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was delivered in line with current best practice standards. The practice proactively promoted health and well-being and the prevention of illness. Patients told us that the GP and other clinical staff listened to them and that they received appropriate care.

Clinical and other staff that worked at the practice were suitably qualified, trained and competent to carry out their roles.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was a systematic approach to identifying relevant legislation, latest best practice and evidence based guidelines and standards. Clinical staff told us that they could access policies procedures and clinical guidelines via the intranet.

A GP was nominated to ensure any new guidance received including those from the National Institute for Health and Care Excellence (NICE) was reviewed and where relevant shared with clinical staff.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive patient outcomes for a range of conditions such as coronary heart disease and high blood pressure. The practice served a large elderly population and prioritised QOF targets for this group. This sometimes impacted on other QOF targets. For example the practice had not fully met some targets related to working age population, such as the measurement of blood pressure of patients aged 45 and over, and the measurement of total cholesterol of patients with a stroke or similar.

Patients told us that they were supported to understand their diagnosis and treatment options. One patient for whom English was not their first language told us that the GPs and other staff were clear in their communication. Two parents of young children said that they had received helpful advice information and care throughout their pregnancies. Three patients of working age told us that the practice had provided them with excellent, thorough care and that doctors had consistently discussed options and test outcomes with them.

Clinical staff were aware of the requirements of legislation about mental capacity. A GP described to us how they had been involved in a best interest meeting for a patient who lacked capacity to make a decision about their treatment in accordance with the Mental Capacity Act 2005.

Management, monitoring and improving outcomes for people

Complete, accurate and timely performance information, including patient outcomes, was available. These included performance information against the Quality and

Are services effective?

(for example, treatment is effective)

Outcomes Framework (QOF), clinical audits and other monitoring reports. Practice staff and the Patient Participation Group (PPG) where appropriate proactively used this information to improve clinical care.

There was evidence that the performance of the practice was monitored and where changes were required action was taken in a timely manner. We saw three examples of clinical audit cycles. These showed that the practice had checked their performance on infections following minor surgery, repeat prescriptions and effects of long term use of certain drugs. They had made changes and checked again to see if the improvements made had been effective and sustained.

The registered manager told us that the practice did many more audits but these were held within the personal records of individual GPs as part of their revalidation process. The practice may wish to review their recording system so all clinical staff could have an appreciation of audits being undertaken practice wide.

Staffing

Staff told us that the practice encouraged and facilitated them to regularly update and maintain their skills and learn new ones. We saw evidence of training for clinical staff on managing minor illnesses, prescribing and managing smoking cessation. All doctors had been revalidated by the General Medical Council (GMC) which confirmed the doctors had met all the training and development criteria for safe medical practice. The practice manager told us that they had a programme of appraisals for staff which identified their learning and development needs.

Clarendon Lodge Medical Practice is an approved teaching practice to train new GPs. These doctors in training had a designated doctor who supervised and provided support. A GP in training told us that they received very good support from a team who had current clinical knowledge across the general practice spectrum.

Working with other services

There was effective communication, information sharing and decision-making about a person's care across all of the services involved. There were meetings which aimed to provide coordinated patient-centred care for all patients approaching the end of life. The practice worked with the out of hours service so that people that needed end of life care had continuity of care.

The practice had a community liaison nurse who coordinated the care of older people who lived in care homes. This included regular home visits if needed.

The practice liaised with the out of hours service so the practice was made aware of any hospital admission when they were was closed.

Health, promotion and prevention

The practice proactively identified people who may need on-going support. This included people who needed support to manage their diabetes, high blood pressure, chronic obstructive pulmonary disease (COPD) or mental health issues.

Information on a range of topics and health promotion literature was readily available to patients and was up to date. Information available included advice on smoking cessation, family planning childhood illness, and flu vaccination.

Are services caring?

Summary of findings

The service was caring. Patients told us they were treated with dignity and respect and confidentiality was maintained. They also told us that staff were kind considerate and compassionate. Patients were given enough information and support to make decisions about their health.

Our findings

Respect, dignity, compassion and empathy

People and those close to them were treated with respect. Patients told us that staff treated them with respect and dignity at all times. Many patients highlighted to us the caring and compassionate attitude of staff. We spent time in the patients' waiting room and saw that staff interacted with patients in a professional and caring way.

Staff showed respect for people's individual preferences, habits, culture, faith and background. We saw that information for patients was available in a range of languages relevant to the location. Some information was available on audio disc for patients who preferred to listen to rather than read information. There were facilities to request a same sex clinician if the patient wished. Reception staff told us that they would accommodate such requests and schedule appointments accordingly.

We saw that staff spent enough time when they talked with patients, or those close to them. Patients told us that staff communicated well with them and listened and respected their views.

Confidentiality was respected at all times. We saw patients talk in confidence with reception staff and where applicable patients were offered the opportunity to discuss personal details in consultation rooms that were private.

The care and treatment given to all patients who had died was reviewed by the multi-disciplinary team. This allowed them to learn about the quality of the service given and the level of adherence to the person's wishes and make changes if needed.

There was a chaperone policy. A chaperone is a person who may provide support for a patient or act as a witness for a patient and a clinician during a personal medical examination. Staff were aware of the policy. On the day of our inspection we did not see anyone requesting a chaperone.

Involvement in decisions and consent

People who used the service felt involved in planning their care. They told us they were supported to make decisions about their care and treatment. Patients told us that clinical staff usually discussed the benefits and drawbacks of the treatment proposed and where possible gave them time to consider alternative options.

Are services caring?

Decisions about or on behalf of people lacking mental capacity to consent to their care were made in the person's best interests in accordance with the Mental Capacity Act 2005. Clinicians were aware of the need to record best interest decisions if patients in care homes were unable to consent to treatment.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to people's needs. The practice understood the different needs of the population and planned and delivered services to meet those needs. Appointments could be made in a number of ways with evening and Saturday appointments available for people who were not able to attend during the day. The practice operated a system of prioritising patients that needed to see a doctor the same day. A clear complaints procedure existed in the practice. There was a system to review and look into any concerns or complaints people had raised and learn from these.

Our findings

Responding to and meeting people's needs

The practice provided services that promoted good health and wellbeing. There were clinics to manage patients with chronic obstructive pulmonary disease asthma, heart disease, diabetes. There were also clinics for child health, family planning and minor surgery.

The practice had a register to easily identify those patients with a learning disability or of people who lacked capacity so they could be supported appropriately.

Doctors told us about the end of life care they provided for their patients. Every person who received a diagnosis of a terminal illness received a call from the practice and was put in touch with appropriate support services, including Macmillan nurses. Their care was reviewed every six weeks by the multi-disciplinary team, to ensure the best possible care.

There were arrangements to refer or transfer patients to another service so patient's needs were met at the right time. The practice had referral criteria that helped clinicians to make appropriate referrals after relevant investigations and tests had been performed.

Patient consultation rooms were situated on the ground and first floors. There was a room set aside on the ground floor for any person with limited mobility or those that could not manage the stairs. The practice had access to the language line so people whose first language was not English could be offered a translation service to communicate effectively.

Access to the service

The practice offered a well-organised appointments system which patients found accessible and which staff found manageable. The patients we spoke with were satisfied with the system. They told us that they had found it easy to get an appointment.

The practice offered appointments between 8am and 6 pm on three days each week and between 8am and 7.30pm on two days. There were appointments available on a Saturday morning for specific NHS checks. The spread of available appointments enabled working people and people with caring responsibilities to see a doctor at a time

Are services responsive to people's needs?

(for example, to feedback?)

which suited them. Patients could book appointments up to eight weeks ahead. This was particularly helpful for people with long-term conditions who valued continuity of care.

Many patients told us that they were happy to come to the practice when it opened and wait for an available appointment. They told us that this system suited them, even if it meant not seeing their preferred doctor on the day. Some of the appointments were with a duty doctor who made an initial assessment of the patients' needs by telephone and arranged appropriate follow up, usually a surgery appointment on that day or a home visit by a doctor.

There were facilities to request prescriptions in person, online, by fax, through a pharmacy or in writing.

The practice' website gave information about the practice and the services offered.

Concerns and complaints

The complaints procedure and ways to give feedback were easy to use. The practice had a complaints leaflet which explained how to make a complaint or raise a concern. The leaflet also gave information on what the practice would do in response and how patients could proceed with complaints that were not resolved by the practice. Patients could if they wished raise a complaint or concern online. The practice had a process to investigate and respond to complaints. The practice manager told us that any learning from complaints was discussed during staff meetings. They however could not recall any recent learning points.

Are services well-led?

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

Summary of findings

The service was well led. There was evidence of clear leadership. Clarendon Lodge Medical Practice is a training practice for new GPs. The practice management was supportive and had a governance structure with defined roles and responsibilities for each staff member. There was a patient participation group (PPG) which through active interaction with the GPs and practice staff had made useful contributions that had improved patient's care experience. Regular team meetings, partners meetings and staff away days facilitated a positive patient experience.

Our findings

Leadership and culture

The practice team has an ethos of continuous learning, professional development and good communication. The practice management structure ensured both clinical and non clinical staff understood their role in providing a compassionate, responsive and effective care. Staff told us that they felt involved included and valued which had helped them become more effective and efficient in their work.

There were weekly practice team meetings, other professional clinical meetings such as the Palliative Gold standard Framework meetings which aimed to provide coordinated patient-centred care for all patients approaching the end of life and audit meetings, and other staff meetings. Records showed that care related matters were discussed during these meetings.

There were regular partnership meetings. Records showed that day to day business of the practice such as staff recruitments and appointments, skill mix, safety issues, and matters related to the Quality and Outcome Framework (QOF) which aimed to improve positive patient outcomes for a range of conditions such as coronary heart disease and high blood pressure were discussed during these meetings.

Governance arrangements

The practice had a clinical governance structure with identified roles and responsibilities for each clinician. This structure through identified responsibilities ensured the care provided continuously improved by working to and safeguarding high standards of care.

The practice had a comprehensive intranet that contained policies procedures and clinical guidelines including referral criteria and referral forms. The documents we saw were current and had agreed review dates.

A Nursing Team Manager had been appointed recently who had responsibilities for managing the practice nurses.

A GP from the practice attended the Clinical Commissioning Group (CCG) which met regularly and reviewed clinical issues. Another GP attended locality

Are services well-led?

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

meetings with other primary care providers in the area. These meetings provided an opportunity to evaluate the primary care health needs of the local population and act on it collectively with other services.

Systems to monitor and improve quality and improvement

The importance of high quality data and information was recognised by all practice staff. Quality and Outcome Framework (QOF) monitoring and audit reports were discussed during the practice team meetings and partners meetings and actions agreed to improve care. For example we saw that the practice participated in the CCG generated primary care comparative dash board. This is a listing of the performance of local GP practices against agreed indicators such as those for investigations requests for scans and blood tests, unplanned chronic obstructive pulmonary disease (COPD) admissions, and referrals for ophthalmology. The registered manager explained that the CCG encouraged local review of the dashboard and had a buddy system whereby practices used qualitative information to compare performance and learn from each other to improve performance.

Patient experience and involvement

A full and diverse range of peoples' views were encouraged, heard and acted upon. The practice had a Patient Participation Group (PPG) which met monthly. The PPG through active interaction with the GPs and practice staff sought to make useful contributions to improve patient care experience. We spoke with a number of members of the group including the chair person. They told us that their group was supported by the GPs and practice staff.

The chair of the group and other members told us that they could not fault the services provided. It was evident the practice valued and had involved the PPG in the way the service was provided. The practice had involved the PPG in discussions with the commissioners about exploring future options for the premises.

The practice conducted an annual patient survey. Overall, patients rated their experience of the care received very positively. The survey results and the PPG meetings notes were available on the practice web site.

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.

Summary of findings

The practice provided a range of services that managed the health of older people who lived at home or in a care home. Clarendon Lodge Medical Practice had adopted the concept of the 'virtual ward'. This is a system that helped the practice identify patients in care homes who were at high-risk of future hospital admissions; so they were offered extra care and support which helped avoid potential emergency hospital admissions. Care was reviewed regularly and included mental and physical health checks.

Our findings

All patients over the age of 75 had a named accountable GP. The practice offered dementia screening and INR (international normalised ratio) blood tests at home that checked the clotting tendency of blood so patients received the correct dosage of blood thinning medication.

The practice has a contract with the CCG to provide GP services to people that lived in five care homes in South Warwickshire. This service was further enhanced by a practice employed community liaison nurse who coordinated their care needs in conjunction with other health and social care professionals.

Older people with complex needs who lived at home had regular assessments which included mental and physical health checks. The practice had a list which highlighted patient's health needs following such assessments so care could be planned and given in a timely way. The practice acted opportunistically when older people received their annual flu vaccinations and reviewed their other health needs.

There were services for patients who needed end of life care. Every person who was diagnosed with a terminal illness received a call from the practice and was put in touch with appropriate support services, including Macmillan nurses for palliative care. Their care was reviewed every six weeks by the multi-disciplinary team, which facilitated the provision of best possible care.

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).

Summary of findings

The practice had arrangements that identified and offered support and care for patients with long term conditions. The practice operated a recall system for specialised clinics such as those for chronic obstructive pulmonary disease (COPD) and diabetes. There were sufficient arrangements to ensure the continuity of care for those who needed end of life care.

Our findings

The practice employed nurses who specialised in diabetes, respiratory illnesses and heart disease. This enabled the practice to provide effective support to patients with these conditions. The team was linked to a local forum where the management of long-term conditions was reviewed and learning shared.

The practice had clinics to manage chronic obstructive pulmonary disease (COPD), asthma, heart disease prevention, blood pressure, diabetes, and those patients who were on blood thinning medication.

There were effective links with community nurses and Macmillan nurses to plan coordinate and deliver effective palliative care. The practice worked with the out of hours service so that people that needed end of life care had continuity of care.

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.

Summary of findings

The practice offered services for mothers babies and children in conjunction with the NHS health visiting and midwifery teams. The service provided included checks on new babies as well as an immunisation programme for the under five year olds and for those aged six to 15 years. The practice provided contraceptive treatments and family planning advice for young people.

Our findings

The practice in conjunction with the NHS health visiting and midwifery teams provided care for Mothers, babies and children. There was a range of information available for new and expectant mothers, and on the care of a new baby.

The practice held child health clinics, made checks on new babies and provided an immunisation programme for under five year olds and those aged six to 15 years.

There was a contraceptive implant service for young people and others.

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.

Summary of findings

There was flexible access to the surgery appointments that included on-line booking. Patients could access evening appointments. Appointments for standard health checks were available on Saturday mornings. The practice offered vaccinations to protect adults (and some children) at risk of flu and its complications.

Our findings

The practice offered NHS health checks and flu vaccinations. Patients who could not attend during daytime surgery hours could access appointments on Monday and Thursday evenings and on Saturday mornings. Where appropriate the practice offered telephone consultation. There were on line services for patients that included repeat prescriptions requests.

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).

Summary of findings

The practice had a lead GP who in conjunction with the NHS learning disability team oversaw services for people with a learning disability that lived in the community. There were regular health checks and reviews of their care.

The practice had good links with services such as the NHS, social services and housing. This helped them provide for the needs of people in vulnerable circumstances who may have poor access to primary care.

Our findings

The practice in conjunction with other local services such as the NHS, social services and housing provided medical consultations for patients that needed help to manage their alcohol and or substance misuse. This not only helped them overcome their substance misuse but also allowed clinicians to address any other health needs of this population at the same time.

The practice in conjunction with the NHS learning disability team offered support and care for people with a learning disability that lived in the community. The practice had a learning disability register that identified the specific needs of this group.

The practice supported a local food bank.

The practice catchment area had traditionally low or no homeless and travelling patients, but practice staff told us that people in vulnerable circumstances could access their services in the same way as their registered patients.

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.

Summary of findings

The practice had a system to identify and provide care for people experiencing mental health problems. Services were offered in conjunction with the NHS mental health team. Where appropriate patients were referred to specialist services.

Our findings

The practice had links with local mental health services which included access to crisis care for those whose needed support with their worsening mental or emotional state, and to acute services and counselling.

The practice worked with the local NHS team to prevent admissions to hospital. Patients who had a mental health issue were offered a review at least once every year. Those patients were also offered an annual physical health assessment.

Where appropriate patients were referred to the NHS mental health team or the Improving Access to Psychological Service (IAPT) for further assessment, treatment and care.