Croft Medical Centre

Quality Report

Main surgery: Calder Walk, Sydenham, Leamington Spa, Warwickshire, CV31 1SA
Branch surgery: 39 Mallory Road, Bishops Tachbrook, CV33 9QX
Main surgery: 01926 421153
Branch surgery: 01926 451285
Website: www.croftmedical.co.uk/index.aspx

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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

Croft Medical Centre provides primary medical services to people in Leamington Spa and the surrounding areas, with a branch surgery serving people in and around Bishop's Tachbrook. The branch surgery has a dispensary on site to issue prescribed medications to patients. Both surgeries offer consultations on site but doctors also visit patients at home if they need it. At the time of this inspection there were around 11,000 people registered with Croft Medical Centre.

We found that the practice was safe, effective, caring, well led, and responsive. The practice had adequate arrangements to provide healthcare services for older people aged over 75; people with long-term conditions; mothers, babies, children and young people; the working age population and those recently retired (aged up to 74); people in vulnerable circumstances who may have poor access to primary care; and people experiencing a mental health problem.

We spoke with 11 patients during our inspection. They told us that they had positive experiences of the care they had received. Concerns raised were mostly related to the appointment system and access to appointments on the same day. The practice was working with the Patient Participation Group (PPG) to address this issue.

The practice has been recently re-established and financed under new management. The practice management structure ensured the smooth running of the services provided. Staff told us that they felt supported and valued by their managers. There was a systematic approach that identified relevant legislation, latest best practice and evidence-based guidelines and standards, which contributed to effective patient care. The practice had carried out audits to check the quality of clinical care provided and acted on the findings but had not audited again to ensure the improvements made were being sustained.

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. The practice had clear instructions for staff to enable them to provide a safe service and protect patients, including children, from harm. Patients told us that they felt safe when they attended their appointments with the doctors, nurses and other clinical professionals. Staff knew how to respond in a medical emergency.

Clinical and other staff that worked at the practice were suitably qualified, trained and competent to carry out their roles. The practice made appropriate checks when new staff were recruited.

There was an open culture that enabled practice staff to discuss events and incidents that had caused harm or had the potential to cause harm and to learn from them to prevent future occurrences.

Are services effective?

The service was effective. Care and treatment was delivered in line with current best practice standards. The practice had carried out audits to check the quality of clinical care and acted on the findings, but had not audited again to ensure the improvements made were being sustained. The practice provided information on health promotion and prevention, which ensured a proactive approach to care. Patients were referred to other services if they needed specialist care.

There were arrangements to ensure trainee GPs, were supervised and supported, but arrangements for when a trainee GP was the only doctor at the surgery were insufficient.

Are services caring?

The service was caring. Patients told us that staff were kind, considerate and compassionate and that the practice staff treated them with respect and dignity at all times.

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 acted on these needs when they planned and delivered services. Patients were able to make an appointment in a number of ways but the practice reviewed the appointment system frequently to make sure it met patients' needs. Patients told us the system to book an

Summary of findings

appointment was adequate but could be further improved. People's privacy, dignity and right to confidentiality were maintained. The practice had a system to review and look into any concerns or complaints that were raised.	
Are services well-led? The service was well led. The practice management structure ensured the smooth running of services. There was a governance structure in place and all staff were aware of their roles and responsibilities. Staff told us that they felt supported and valued by their managers. There was a patient participation group (PPG) which took an active role in improving patients' experiences of the service. The practice participated in the Quality and Outcomes Framework (QOF), the national data management tool generated from patients' records that provides performance information about primary medical services, which aims to drive the improvement of the quality of patient care across a range of clinical conditions.	

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 operated a system where older people who lived at home or in a care home had regular access to a GP or a nurse. This helped to ensure their health and wellbeing. Care was reviewed regularly and included mental and physical health checks.

People with long-term conditions
The practice had arrangements to care for people with ongoing health problems, for example those with chronic obstructive pulmonary disease (COPD) and diabetes. There were adequate arrangements to ensure the continuity of care for those who needed end-of-life care.

Mothers, babies, children and young people
There were arrangements, in conjunction with the NHS health visiting and midwifery teams, to care for mothers, babies, children and young people. This ensured that there were information leaflets and services for mothers, checks on new babies, and an immunisation programme for the under-fives and for those aged six to 15.

The working-age population and those recently retired
In addition to daytime appointments, the practice offered access to appointments on Monday and Tuesday evenings from 6.30pm to 7.30pm.

People in vulnerable circumstances who may have poor access to primary care
The practice had good links with services such as the NHS, social services and housing services to 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 a mental health problem. Services were offered in conjunction with the NHS mental health team.

Summary of findings

What people who use the service say

Patients we spoke with and those who filled out our comment cards all said they felt the practice met their needs. They also told us that they were treated with respect and dignity at all times. Patients highlighted the need to further improve the appointment system.

We looked at the results of the most recent patient survey. These surveys, which were completed separately for the main and branch surgeries, showed that the majority of 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, those audits had not been repeated to ensure the changes were sustained.
- The appointment system could be changed to make sure it met the continued needs of their patients.
- The supervision and support arrangements for when GP registrars worked as the only doctor at the surgery were insufficient.

Good practice

Our inspection team highlighted the following areas of good practice:

- The care programme provided for substance misusers in conjunction with other local services such as the NHS, social services and housing.
- The medication harms audit that had resulted in the reduction in prescribed medication for people who received multiple medications.

Croft Medical Centre

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, a CQC deputy chief 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 Croft Medical Centre

Croft Medical Centre provides primary medical services to people in Leamington Spa and surrounding areas. The branch surgery, which has a dispensary on site to issue prescribed medications to patients, serves people in and around Bishop's Tachbrook.

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.

Before visiting, 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 14 May 2014. The inspection team visited the provider's main surgery at Calder Walk and the branch surgery at 39 Mallory Road.

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

Detailed findings

We reviewed comment cards patents had completed, and the latest practice commissioned local patient survey.

Are services safe?

Summary of findings

The service was safe. The practice had clear instructions for staff to enable them to provide a safe service and protect patients, including children, from harm. Patients told us that they felt safe when they attended their appointments with the doctors, nurses and other clinical professionals. Staff knew how to respond in a medical emergency.

Clinical and other staff that worked at the practice were suitably qualified, trained and competent to carry out their roles. The practice made appropriate checks when new staff were recruited.

There was an open culture that enabled practice staff to discuss events and incidents that had caused harm or had the potential to cause harm and to learn from them to prevent future occurrences.

Our findings

Safe patient care

Systems in place for reporting risks, significant events and complaints were in line with national and statutory guidance. The practice manager and staff were able to describe their role in the reporting process and knew their responsibility in identifying and acting on risks that affected patient care. Staff we spoke with were clear about whom to approach if they needed further help, advice or support. Patients told us that they felt safe when they attended their appointments and consulted with doctors and nurses.

Learning from incidents

We saw that the practice conducted a significant event audit (SEA) after each safety incident and implemented actions to prevent reoccurrence. All staff we spoke with confirmed SEAs were discussed at clinical practice meetings and we saw evidence to support this. The practice manager showed us an example where, as a result of an SEA, the practice had changed the way it updated contact details so they could communicate test results to patients quickly and safely.

Safeguarding

The practice had a focus on identifying potential or actual abuse early so that patients were protected from harm. This reduced the risk of children and adults experiencing abuse. There was a named GP lead for safeguarding. All 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.

Appropriate checks were carried out when the practice recruited new staff. The practice manager told us that they requested a routine 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 which were in accordance with guidance issued by the previous NHS commissioner. The DBS check is a process of gathering information about an applicant's possible criminal activity and helps determine their suitability to work with vulnerable people. The practice manager however told us that individual

Are services safe?

assessments on the need for a DBS check for non clinical staff were made prior to their appointment and reviewed annually thereafter. There were effective induction programmes for new staff.

Monitoring safety and responding to risk

The registered manager told us that risks to patients were assessed before care and treatment commenced and were reviewed regularly. This ensured safe patient care.

Medicines management

There were clearly defined systems, processes and standard operating procedures for safe medicine management. Systems were in place in the branch surgery which ensured the correct medicines were dispensed to patients. Dispensary staff were appropriately trained. We saw that staff recorded any dispensing errors and these were reviewed by the GP and any actions or changes were discussed with the staff. Medicine stock was checked and used in rotation by date order.

The medication harms audit involved reviewing the patients who received multiple medications. Some reduction in prescribing had occurred as a result of this audit.

The practice had arrangements that made sure temperature sensitive vaccines were transported and stored at the correct temperature. We saw records of temperature checks to ensure the vaccine storage fridge remained within acceptable limits for vaccine safety and potency.

We saw records of checks on the expiry dates and quantities of medicines contained in the bag taken by GPs on home visits to ensure adequate stocks for the doctor.

Cleanliness and infection control

Patients told us that they found the waiting room and the consulting rooms clean. There was a daily cleaning schedule for the premises. The practice manager told us that they visually checked the building for cleanliness every day.

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. Infection control audits of both surgeries had been undertaken with recommendations made for improvements. There were hand washing facilities available with antibacterial hand wash and hand gel.

There were arrangements in place for the safe disposal of clinical and non-clinical waste, including sharps such as needles and disposable instruments used during minor surgery.

Staffing and recruitment

The registered manager told us that they regularly reviewed staffing levels to safely meet patients' needs. Staff told us that duty schedules were planned in advance and reviewed as needed. The practice manager showed us the procedures for obtaining emergency cover for both clinical and non-clinical staff. Patients told us that they were able to see a doctor if they needed a consultation urgently.

Dealing with Emergencies

The practice had an emergency call icon on all computer screens. In the event of an emergency this icon was activated. This alerted staff in other parts of the building to the emergency and requested them to respond to it. We saw that the staff at the practice had received training in medical emergencies such as anaphylaxis and basic life support skills.

The practice had a medical emergency box which contained medicines and equipment for use in an emergency. The practice nurse told us that the equipment and medicines stocked were as recommended by the Resuscitation Council UK. We saw records that showed the medicines and equipment had been checked regularly for function and expiry dates. At the time of our inspection all were fully functional and within their expiry dates.

The practice had a business continuity plan which showed how services would be maintained during an emergency or major incident.

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 had carried out audits to check the quality of clinical care and acted on the findings, but had not audited again to ensure the improvements made were being sustained. The practice provided information on health promotion and prevention, which ensured a proactive approach to care. Patients were referred to other services if they needed specialist care.

There were arrangements to ensure trainee GPs, were supervised and supported, but arrangements for when a trainee GP was the only doctor at the surgery were insufficient.

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 had access to policies, procedures and clinical guidelines via the intranet. There was a nominated doctor who ensured any new guidance received, including those from the National Institute for Health and Care Excellence (NICE), was reviewed for appropriateness, and those relevant were shared with clinical staff.

The practice aspired to deliver high-quality care and participated in the Quality and Outcomes Framework (QOF). The QOF aimed to improve positive outcomes for a range of conditions such as coronary heart disease and high blood pressure. This showed the practice's commitment to provide good quality of care.

The practice undertook minor surgery. There were procedures to obtain informed consent. Patients told us that the doctor usually discussed the benefits and drawbacks of the surgical procedure and, where possible, gave them time to consider alternative options before they obtained their consent to go ahead.

Clinical staff were aware of the requirements of the Mental Capacity Act (MCA) and the registered manager told us that they regularly had training updates on the MCA. The practice manager told us that the practice had recently been involved in making a best interest decision for a person living in a care home.

Management, monitoring and improving outcomes for people

Complete, accurate and timely performance information, including patient outcomes, was available to staff and the public, which included monitoring reports on the Quality and Outcomes Framework (QOF).

The practice reviewed avoidable attendances at the local accident and emergency (A&E) department. Avoidable attendances are those where, if the patient had been seen in the GP practice instead, they could have been assessed and managed by their GP. As a result the practice

Are services effective?

(for example, treatment is effective)

introduced a targeted education programme for this group of patients and clinicians. The practice reported that there had been an apparent reduction in A&E attendances. A re-audit to confirm this reduction has yet to be completed.

The practice audited the prescriptions for drugs that lowered cholesterol levels in blood and, as a result, made changes to reduce inappropriate use of these drugs. A subsequent audit after the changes had been introduced showed that there had been a reduction in prescription of both drugs, which was a goal of the audit.

The GPs told us that they all undertook a clinical audit as part of their revalidation process with the General Medical Council. There were also other clinical audits undertaken by the GP registrars and nurses. However, we did not see a complete listing of the audits undertaken, or whether a repeat audit had been undertaken to check if changes made had brought about the intended improvements. The registered manager agreed that this was an area they would consider for improvement.

Staffing

Staff told us that the practice encouraged and facilitated them to regularly update and maintain their skills and learn new ones. The registered manager told us that they had a programme of appraisals for staff which also identified their learning and development needs.

Croft Medical Centre is an approved teaching practice to train new GPs. Doctors in training had a designated GP who supervised and provided support. The trainee GPs described to us a practice environment, which supported clinical queries and learning. At times, a GP trainee would be on call on a Friday afternoon and could be the only clinician left in the building at the end of the day. In this situation, an experienced clinician was available to supervise and support them by telephone. We did not see evidence of an assessment that showed this arrangement was adequate and safe, and in line with local guidance for training practices.

Working with other services

There was effective communication, information sharing and decision making about a person's care across all of the services involved. Practice staff regularly met with Macmillan nurses to plan, coordinate and deliver effective palliative care. The practice worked with the out-of-hours service so that people who needed end-of-life care had continuity of care.

The practice nurse worked with the local care homes to assess and support people with chronic illness. This included regular home visits if needed. The practices also liaised with the out-of-hours service so they were made aware of any hospital admissions when the practice was closed.

Health, promotion and prevention

The practice proactively identified people who may need ongoing support. This included people who needed support to manage their diabetes, high blood pressure, COPD or mental health issues.

Newly registered patients were offered a mini health check to review and note details of their medical and family histories; medications; social factors, including occupation and lifestyle; and measurements of risk factors.

Information on a range of topics and health promotion literature was up to date and readily available to patients. 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 that staff were kind, considerate and compassionate and that the practice staff treated them with respect and dignity at all times.

Our findings

Respect, dignity, compassion and empathy

Patients told us that staff were kind, considerate and compassionate, and that the practice staff treated them with respect and dignity at all times.

Staff had a person-centred approach and respected people's individual preferences, habits, culture, faith and background. The practice had a large Portuguese population and other patients from diverse ethnic and religious background. The practice offered a telephone interpreting service so consultation could be made in a way that helped patients to communicate in their own language. A GP told us that arranging the telephone interpreting service sometimes caused delays of up to a few days in obtaining a consultation. This meant some people could not have an interpreter if they wanted to see a doctor immediately. The GP told us that they would work with the PPG for ways to improve this service. There were facilities to request a same-sex clinician if the patient wished. Reception staff told us that they accommodated such requests and scheduled appointments accordingly.

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 private consultation rooms. There was a sign in the reception area that gave this information.

There was a chaperone policy. A chaperone is a person who acts 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, were able to make decisions about their care and treatment, and were supported to do so where necessary. Patients told us that the doctor usually discussed the benefits and drawbacks of the treatment proposed and, where possible, gave them time to consider alternative options.

Decisions about, or on behalf of, people lacking mental capacity to consent to what was proposed, were made in

Are services caring?

the person's best interests in accordance with the Mental Capacity Act. 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 acted on these needs when they planned and delivered services. Patients were able to make an appointment in a number of ways but the practice reviewed the appointment system frequently to make sure it met patients' needs. Patients told us the system to book an appointment was adequate but could be further improved. People's privacy, dignity and right to confidentiality were maintained. The practice had a system to review and look into any concerns or complaints that were raised.

Our findings

Responding to and meeting people's needs

The practice provided coordinated and integrated care. The practice had clinics to manage patients with chronic obstructive pulmonary disease (COPD), asthma, heart disease, diabetes, and those that were on blood thinning medication. There were also clinics for child health, family planning, minor surgery and cryotherapy.

The needs and wishes of people with a learning disability or of people who lacked capacity were understood and taken into account. The practice kept a register of those patients who required additional health care and support. These needs were met in conjunction with the NHS learning disability team.

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

The surgery had suitable access and toilet facilities for people with limited mobility.

Access to the service

Patients made appointments for consultation by telephone, in person or online. Patients told us that they had to telephone or attend the surgery at 8am to obtain a same day appointment. The receptionist told us that same day appointments were available between 8am and 9am. Once these appointments were gone, the practice operated a triage system whereby patients that requested a same day appointment were referred to a GP who assessed their clinical need through a telephone consultation. The practice had a number of appointments to accommodate those that needed a face-to-face consultation after triage.

Members of the Patient Participation Group (PPG) told us that getting same day appointments had been a problem in the past but the triage system had greatly improved access to a GP. However, they told us that the practice had not explained the improved process to the practice population; they felt that the reception staff could explain this process better when they told patients that all 8am to 9am appointments were gone.

Are services responsive to people's needs?

(for example, to feedback?)

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 to explain how to make a complaint or raise a concern. The leaflet also gave information on what to expect from the practice and how patients could deal with complaints that were not resolved. Patients could, if they wish, raise a complaint or concern online. The practice had a process to investigate and respond to complaints. We saw evidence of complaints reviews and noted they had been completed appropriately. Staff told us that they were aware and informed of the outcomes of complaints during staff meetings if they were relevant to their role. People told us that apart from the appointment system they found the service good and responsive to their needs.

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. The practice management structure ensured the smooth running of services. There was a governance structure in place and all staff were aware of their roles and responsibilities. Staff told us that they felt supported and valued by their managers. There was a patient participation group (PPG) which took an active role in improving patients' experiences of the service. The practice participated in the Quality and Outcomes Framework (QOF), the national data management tool generated from patients' records that provides performance information about primary medical services, which aims to drive the improvement of the quality of patient care across a range of clinical conditions.

Our findings

Leadership and culture

The practice leadership was focused on the importance of quality. The practice management structure, led by the registered manager and the practice manager, ensured both clinical and non-clinical staff understood their role in providing a compassionate, responsive and effective service. Staff told us that they felt supported and valued by their leaders.

We saw evidence of regular partnership meetings to discuss the day-to-day business of the practice, such as staff recruitments and appointments, skill mix, safety issues, and matters related to the QOF.

There were other regular practice meetings such as the nurses meeting, clinical meetings, and audit meetings. Records showed that care-related matters were discussed during these meetings.

Governance arrangements

The practice had a clinical governance structure with identified roles and responsibilities for each clinician. The registered manager told us that this arrangement was currently under review and will be strengthened.

The practice had a comprehensive intranet that contained policies, procedures and clinical guidelines, including referral criteria and referral forms. All documents had agreed review dates. The registered manager told us that the majority of the documents were under review, these having expired the previous month (April 2014). Staff were updated on any changes to these documents at staff meetings and through email.

A nurse team leader had responsibilities for managing the practice nurses and took a lead role in diabetes care.

GPs from the practice attended local clinical groups that met regularly and reviewed clinical issues.

Systems to monitor and improve quality and improvement

The importance of high quality data and information was recognised by all practice staff. QOF monitoring and audit reports were regularly discussed and actions agreed to

Are services well-led?

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

improve care. For example, we saw evidence of improvements made to diabetic care as a result of monitoring data that indicated the practice was not achieving the right outcomes for patients.

Patient experience and involvement

A full and diverse range of patients' views were encouraged, heard and acted upon. The practice had a Patient Participation Group (PPG), which met monthly. We spoke with a number of members of the group, including the chair person. They told us that their group was supported well by the GPs and practice staff. Their current priority was to help analyse the latest patient survey results and recommend improvements.

A key area for improvement was the appointment system. While the practice had responded by making significant improvements on accessing same-day appointments, further enhancements were needed so patients were able to access forward appointments. Together with the PPG the practice was exploring acceptable solutions.

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

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 operated a system where older people who lived at home or in a care home had regular access to a GP or a nurse. This helped to ensure their health and wellbeing. Care was reviewed regularly and included mental and physical health checks.

Our findings

The practice made annual home visits for those patients who lived in care homes. During this visit clinicians highlighted key health issues to the patient and their carers as required, and advised them on signs that could indicate the need to access medical care. The health needs of anybody new to the care home were assessed by a GP on admission.

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 patients' health needs following such assessments so care could be planned and given in a timely way. Proactive healthcare and advice were given to older people when they received their annual flu vaccinations.

All patients over the age of 75 had a named, accountable GP. Unplanned hospital admissions and readmissions for older people were reviewed so care could be planned to prevent such admissions in the future.

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 to care for people with ongoing health problems, for example those with chronic obstructive pulmonary disease (COPD) and diabetes. There were adequate arrangements to ensure the continuity of care for those who needed end-of-life care.

Our findings

The practice had arrangements to care for people with ongoing health problems and support their carers. There were appropriate links with community nurses and Macmillan nurses.

The practice had clinics to manage patients with COPD, asthma, heart disease prevention, diabetes, and those that were on blood thinning medication.

Unplanned hospital admissions and readmissions for people with long term conditions were regularly reviewed. This review identified patients that needed help in managing COPD and diabetes as the groups most likely to attend hospital unplanned. To help reduce unplanned admissions, the practice had issued patients with COPD rescue packs and information on when and how to use them. The practice is considering a similar service to help patients with diabetes.

The practice regularly met with Macmillan nurses to plan coordinate and deliver effective palliative care. The practice worked with the out-of-hours service so that people who 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

There were arrangements, in conjunction with the NHS health visiting and midwifery teams, to care for mothers, babies, children and young people. This ensured that there were information leaflets and services for mothers, checks on new babies, and an immunisation programme for the under-fives and for those aged six to 15.

Our findings

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

The practice had a focus on identifying potential or actual abuse early so that patients were protected from harm. This reduced the risk of children and adults experiencing abuse. There was a named GP lead for safeguarding. All 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. Clinicians knew the process to assess children and young people on their competency to make decisions about their care and treatment.

The practice held child health clinics, made checks on new babies, and provided an immunisation programme for the under-fives and those aged six to 15.

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

In addition to daytime appointments, the practice offered access to appointments on Monday and Tuesday evenings from 6.30pm to 7.30pm.

Our findings

The practice offered late evening appointments on two days in the week so working age population and those recently retired had access to flexible appointments. Patients could also make appointments online. This flexible approach was being further developed in conjunction with the PPG group. The practice offered phlebotomy (taking blood samples) and routine diagnostic facilities such as blood pressure monitoring at both the main and branch surgeries.

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

Our findings

The needs and wishes of people with a learning disability were understood and taken into account. The practice had a register that identified those patients who required additional health care and support. These needs were met in conjunction with the NHS learning disability team.

The practice liaised with advocates, addiction specialists and the police to meet the needs of other vulnerable people.

The practice provided a care programme for substance misusers in conjunction with other local services such as the NHS, social services and housing. This helped people overcome substance misuse and allowed clinicians to address any other health needs they may have.

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 a mental health problem. Services were offered in conjunction with the NHS mental health team.

Our findings

The practice had a register of patients that suffer with depression. There was also a separate mental health register. Patients were offered an annual physical health assessment, and could access regular meetings with the local psychiatrist and the mental health team if needed. Patients could also contact the local crisis team with any concerns they may have had. Contact telephone numbers were given on the practice's website so patients could have rapid access should they need it. The practice hosted the Improving Access to Psychological Therapies Service (IAPT) once weekly on a Tuesday.