Awburn House Medical Practice

Quality Report

Awburn House Medical Practice
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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

Awburn House Medical Practice provides care for 7200 patients in Mottram, Hyde in Cheshire. The practice provides placements for General Practitioner trainees.

During our visit we spoke with General Practitioners (GPs), the Practice Manager, the Practice Nurse, administration staff and five patients.

All the patients we spoke with were very complimentary about the service they received. We reviewed the results of a recent patient questionnaire and patient comment cards and there provided positive feedback on the service.

The GPs at the practice are accessible to patients during regular working hours and there was an out of hour's service provided by Go to Doc when the practice was closed. Staff found the management team of the practice to be very approachable.

Clinical decisions followed best practice guidelines.

The leadership team are approachable and visible. There are appropriate governance and risk management measures in place.

The practice is registered with the Care Quality Commission to deliver care under the following regulated activities: Diagnostic and screening procedures, family planning, maternity and midwifery services and treatment of disease and disorder.

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 management of the service had ensured that there were safeguarding procedures in place and had taken steps to ensure that staff followed these. All staff had received training in safeguarding children and vulnerable adults. There were safe medicines management processes in place, arrangements in place to deal with foreseeable emergences and equipment was checked and maintained which ensured that patients were kept safe and protected from avoidable harm.

Are services effective?

The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. There was a comprehensive schedule of internal audits. There were enough qualified, skilled and experienced staff to meet patient's needs to ensure that the health care needs of patients were consistently delivered to a good standard.

Are services caring?

The service was caring. All the patients we spoke to during our inspection were very complimentary about the service and said they were treated with dignity and respect. They also told us they were involved in decisions about their treatment and care and were always asked for consent.

Are services responsive to people's needs?

The service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The provider participated actively in discussions with commissioners and patients about how to improve services for patients in the area ensuring that the provider was always helpful and sensitive towards patients' needs.

Are services well-led?

The service was very well led. There was a strong and visible leadership team with a clear vision and purpose. Governance structures were in place and there was robust system in place for managing risks to demonstrate that the provider had an open and inclusive approach which enabled them to provide a good level of service to its population groups.

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
We found that services provided for this population group were safe, effective, caring, responsive and well led. We found that treatment and care was delivered in line with the patients' needs and circumstances, including their personal expectations, values and choices.

People with long-term conditions
We found that services provided for this population group were safe, effective, caring, responsive and well led. The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed.

Mothers, babies, children and young people
We found that services provided for this population group were safe, effective, caring, responsive and well led. A variety of services and clinics were in place to ensure that the diverse and specialist needs of this population group were being met.

The working-age population and those recently retired
We found that services provided for this population group were safe, effective, caring, responsive and well led. The appointments system was regularly reviewed to try to maximise timely access to services for this population group.

People in vulnerable circumstances who may have poor access to primary care
We found that services provided for this population group were safe, effective, caring, responsive and well led. During out inspection we did not encounter any barriers to access for this population group.

People experiencing poor mental health
We found that services provided for this population group were safe, effective, caring, responsive and well led. During out inspection we did not encounter any barriers to access for this population group. There were systems in place to enable timely and appropriate referrals to be made to mental health services for patients if needed.

Summary of findings

What people who use the service say

We spoke to 5 patients, reviewed the patient questionnaire summary from year 2013/14 from the practice and the information written on the comment cards.

Patients who used the services commented that they had always been treated with dignity and respect by staff including the doctors, nurses and receptionists. They said they always felt listened to and that staff were always professional, caring, polite, helpful and informative. Patients also commented that the environment has always been clean and hygienic. In particular patients commented that they really liked that they could walk into the practice in the mornings for the open surgery and wait for an appointment without having to pre book. All the patients we spoke with said they had no reason to complain about the service provided.

Awburn House Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector accompanied by a specialist adviser who was a GP.

Background to Awburn House Medical Practice

Awburn House Medical Practice is housed in purpose built accommodation and has access for disabled visitors including wheelchair users.

NHS Tameside and Glossop Clinical Commissioning Group (CCG) is responsible for commissioning health services for the 240,300 people registered with their 42 member GP practices. Awburn House Medical Practice has approximately 7,200 patients registered.

The CCG works in five geographical localities: Ashton, Hyde, Stalybridge, Denton and Glossop. Four of the localities are within Tameside Metropolitan Borough, and Glossop lies within Derbyshire being served by Derbyshire County Council and High Peak Borough Council. Awburn House Medical Practice is within Hyde, Tameside.

Tameside is a borough of Greater Manchester in North West England. It borders Derbyshire to the east, the borough of Oldham to the north, the borough of Stockport to the south and the City of Manchester to the west.

Census data shows an increasing population and a lower than average proportion of Black and Ethnic Minority residents in Tameside.

Life expectancy is 10.4 years lower for men and 8.8 years lower for women in the most deprived areas of Tameside than in the least deprived areas. This is based on the national average of life expectancy.

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 previously inspected by the Care Quality Commission.

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

Detailed findings

- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting and during the visit, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service.

We carried out an announced visit on 14 May 2014. During our visit we spoke with a range of staff (GPs, practice manager, practice nurse, note summariser and reception staff) and spoke with patients who used the service.

We observed how people were being treated and cared for. We reviewed CQC comment cards where patients and members of the public shared their views and experiences of the service with us.

Are services safe?

Summary of findings

The service was safe. The management of the service had ensured that there were safeguarding procedures in place and had taken steps to ensure that staff followed these. All staff had received training in safeguarding children and vulnerable adults. There were safe medicines management processes in place, arrangements in place to deal with foreseeable emergences and equipment was checked and maintained which ensured that patients were kept safe and protected from avoidable harm.

Our findings

Safe patient care

We saw evidence that the provider had a good record on safety and where concerns had arisen they had been addressed in a timely way. We also saw that there were effective arrangements in place for reporting safety incidents and allegations of abuse which were in line with national and statutory guidance. There were clear accountabilities for incident reporting and staff were encouraged to report. When safety alerts came in they were reviewed by the practice manager then passed on to the appropriate staff member as necessary. This could be a doctor or the practice nurse or dealt with by the practice manager and would be discussed and actioned if necessary at the regular practice meetings.

Learning from incidents

We saw that there was continuous learning when things went wrong and that full investigations took place when a significant event had occurred. Staff told us they were involved in investigations when necessary. We reviewed the significant event file and this demonstrated involvement of staff and patients as required. The significant event record included information about the incident itself, a description of what went well, what could have been done better and any learning and development needs. We saw that all events had been brought to a satisfactory conclusion. For example we saw that some work had been done about advanced care planning and end of life care in response to a patient that had died in their own home which showed the provider had taken into account learning from significant events to improve the services for patients

Safeguarding

The practice was able to identify the things that were most important to protect people from abuse and to promote safety. Safeguarding policies and procedures were in place and were understood and consistently implemented by staff. The safeguarding children and vulnerable adults' policies had been reviewed recently. We saw that relevant safeguarding information and contacts from the local authority were available for staff. The staff we spoke with were aware of these. We also saw that staff had attended safeguarding vulnerable adults and children training, and that future training was planned and due to be delivered through the Clinical Commissioning Group (CCG). We

Are services safe?

observed safe records management by staff in the practice. Patient records were only accessible to those who needed to use them and information held on desktop computers could not be overlooked by people in the reception area.

Monitoring safety and responding to risk

The practice had developed clear lines of accountability for all aspects of patient care and treatment. The GPs and nurses had lead roles such as safeguarding, mental health and infection control lead. Each clinical lead had systems for monitoring their areas of responsibility, such as routine checks to ensure staff were using the latest guidance and protocols.

Medicines management

The practice nurse was responsible for the management of medicines in the service. There were up to date medicines management policies and staff we spoke with were familiar with them. Medicines for use in the practice were kept securely in the practice nurse's room and access to them was strictly controlled. There were medicine and equipment bags for doctors to take on home visits. We saw evidence that the bags were regularly checked to ensure that the contents were intact and in date. We also saw that fridge temperatures were regularly checked and recorded to ensure medicines remained effective within the recommended temperature range. Cold chain protocols were strictly followed. This is the uninterrupted storage of vaccines and medication which are maintained within a given temperature range. We also saw that there were plans in place that if the practice nurse was unavailable then the fridge temperatures would be checked and recorded by the health care assistant. There was also a backup system in place to undertake this duty as administrative staff had been trained to do this. This was confirmed by staff.

Cleanliness and infection control

There were effective systems in place to reduce the risk and spread of infection. The consulting and treatment rooms were clean and well maintained with appropriate floor and surface coverings. There were dedicated hand washing facilities in each of the rooms. The appropriate hand washing procedure was displayed over the sinks as required and antibacterial hand wash and hand gel was available. We saw sharps containers that were labelled correctly and not overfilled. We also saw evidence of an infection control local audit that had gave the practice a score of 95.3%. Patients told us that the environment had always been hygienic and clean.

Staffing and recruitment

There was a practice recruitment policy in place that followed the principles and ethos of the equality act 2010. We looked at staff files which demonstrated that staff were provided with training and orientation on all the key aspects of their role as part of the induction process. During our inspection we looked at records relating to staff recruitment and induction. We saw records that confirmed that all staff had been through a recruitment process, references were confirmed and they had undergone identity checks prior to starting work at the practice. This indicated that appropriate checks were undertaken before staff began work and meant that patients were always looked after by suitable staff. We also saw evidence that the provider had obtained a Disclosure and Barring Service (DBS) check for staff.

Dealing with Emergencies

There was a proactive approach to anticipating potential safety risks, including changes in demand, disruption to staffing or facilities, or periodic incidents such as bad weather or illness. We reviewed the provider's emergency/ disaster handlings and recovery plan that confirmed this. This included contingencies in what to do in the event of loss of surgery, utilities, telephones, IT systems and medical records. It also had information on what to do if a doctor or other member of staff became incapacitated. It also detailed what to do in the event of fire. Although the service had not needed to implement this plan they did carry out fire practices in line with this.. We also spoke with staff who knew what to do in case of an emergency. Up-to-date emergency equipment and drugs were available for trained and competent staff working in the practice. We checked these and they were all in date. The practice nurse showed us the process for reordering out of date stock and the regular checklists for vaccines and medication held at the practice.

Equipment

We saw that staff had received training in the use of the defibrillator. There were maintenance contracts in place for fire and intruder alarms, CCTV, air conditioning, fridges and clinical waste disposal.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service was effective. Care and treatment was being delivered in line with current published best practice. Patients' needs were consistently met in a timely manner. There was a comprehensive schedule of internal audits. There were enough qualified, skilled and experienced staff to meet patient's needs to ensure that the health care needs of patients were consistently delivered to a good standard.

Our findings

Promoting best practice

We saw that care and treatment was delivered in line with recognised best practice standards. Staff carried out accurate, comprehensive assessments which covered all health needs. Care and treatment was planned to meet identified needs and is reviewed. There were treatment plans are in place for people with complex health needs. For example one patient we spoke with told us that they had a treatment plan in place for their condition that was monitored by the GP, practice nurse and also other health care professionals outside of the practice.

GPs and other clinical staff were able to perform appropriate skilled examinations with consideration for the patient. Staff had access to the necessary equipment and were skilled in its use. Decisions about treatment were based on good practice and evidence.

Management, monitoring and improving outcomes for people

The provider had an effective system to regularly assess and monitor the quality of service that people received. We spoke with people who used the service who all told us they were very pleased with the quality of the treatment and support they had received from the practice. They told us they had found all staff at the practice to be very helpful and supportive.

The practice participated in clinical audit and peer review which led to improvements in clinical care. 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**.** We saw evidence that the practice acted upon the results of clinical audits and undertook re audits to check if improvements that had been required were being sustained and this resulted in better outcomes for people.

Staffing

All staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. This included appropriate checks being carried out when recruiting new staff.

All new staff undertook a thorough induction on joining the practice. This included a period of shadowing another member of staff until they were competent to work individually. Staff we spoke with confirmed this.

Are services effective?

(for example, treatment is effective)

The learning needs of staff were identified and training put in place which had a positive impact on patient outcomes. There were opportunities for professional development. Staff had received training in a variety of subjects including basic life support, health and safety at work, fire safety, information governance, safeguarding, infection control, and equality and diversity,. There was a staff training plan which identified when staff were trained, training that was booked and when refresher training would be due. The staff we spoke with confirmed they attended this training and that any other training would be identified in their annual appraisal.

The practice had mechanisms in place to ensure appropriate levels of supervision and appraisal of all staff, and revalidation of doctors. We saw evidence of this. This meant that patients were cared for and treated by suitably qualified staff.

Working with other services

There were proactive engagement with other health and social care providers and other bodies to co-ordinate care and meet people's needs. Joint working arrangements which allowed services to work together were in place and are regularly reviewed. There were effective partnership arrangements.

There was effective communication, information sharing and decision-making about a person's care across all of the services involved both internal and external to the organisation. Particularly when a person had complex health needs. This meant that the provider ensured that the patient received the best possible treatment available for their condition.

Health, promotion and prevention

The practice proactively identified people, including carers who may need on-going support.

New patients were offered a consultation to ascertain details of their past medical and family histories, social factors including occupation and lifestyle, medications and measurements of risk factors. These could be smoking, alcohol intake, blood pressure, height, weight and body mass index (BMI). These consultations were also offered to newly registered children to support delivery of the Healthy Child Programme.

Information on a range of topics and health promotion literature was readily available to patients and were up to date. This included information about services to support them in doing this. For example smoking cessation schemes. There was also information displayed in the waiting area on infection control, information for children and pregnant women, safeguarding, sexual health, bipolar self-help group, men's health and mind.

People were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

Are services caring?

Summary of findings

The service was caring. All the patients we spoke to during our inspection were very complimentary about the service and said they were treated with dignity and respect. They also told us they were involved in decisions about their treatment and care and were always asked for consent.

Our findings

Respect, dignity, compassion and empathy

Patients and those close to them were treated with respect. Staff in all roles put significant effort into treating people with dignity. Patients who used the service felt supported and well-cared for. Staff responded compassionately to pain, discomfort and emotional distress in a timely and appropriate way. Although they have not had situations where they require to have an interpreter present, staff were able to describe what they would do if a person did not speak English as their first language.

The practice did not tolerate disrespectful, discriminatory or abusive behaviour or attitudes from staff towards patients and those close to them. Patients told us that they were treated with respect and were proud to be a member of the practice.

Staff were said to be kind and had a caring, compassionate attitude and built positive relationships with patients and those close to them. Staff spent time talking to people, or those close to them. People valued their relationships with staff and experienced effective interactions with them. There was a mutual respect. We observed staff interacting with patients and good rapport between them.

Confidentiality was respected at all times when delivering care, in staff discussions with people and those close to them and in any written records or communication. This included patients being able to talk in confidence with reception staff and consultation rooms that were lockable. An arrangement existed for private discussion between patients and non-clinical team members. There was a notice in the waiting area that detailed the arrangements if a patient required a private conversation.

The practice offered bereavement support to all its patients.

Involvement in decisions and consent

People's capacity to consent was assessed in line with the Mental Capacity Act 2005. People and those close to them, including carers were supported to make informed choices and decisions. Where a person lacked the capacity to consent, assessments were undertaken and outcomes were recorded. An appropriate system was in place for obtaining consent from children. This included obtaining explicit informed consent where necessary. For example in respect of any invasive or intimate procedures.

Are services caring?

The practice had a consent protocol in place that had been recently reviewed. This was supplemented by patient consent forms covering all population groups. All staff involved patients and those close to them as partners in their own care. Patients felt involved in planning their care, choosing and making decisions about their care and treatment and were supported to do so where necessary.

Family, friends and advocates were involved as appropriate and according to the person's wishes.

Patients were supported to understand the assessment process, any diagnosis given and their options for care and treatment. Staff told us they offered patients a chaperone if wanted and they had all been trained to do this.

Staff had effective communication skills. People were communicated with in a way that they can understand and was appropriate and respectful. This included providing information and advice about appointments, services provided by the practice and health promotion advice. We observed staff treating patients and visitors with respect, dignity, compassion and empathy.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The service was responsive to people's needs. There was an open culture within the organisation and a clear complaints policy. The provider participated actively in discussions with commissioners and patients about how to improve services for patients in the area ensuring that the provider was always helpful and sensitive towards patients' needs.

Our findings

Responding to and meeting people's needs

The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that meet people's needs.

There was a practice information leaflet available for patients. It included information about access to the service, out of hours provision, repeat prescriptions, practice staff, how to complain or make a suggestion and data protection. This leaflet was written in a way that patients could understand and was jargon free. There were also a number of useful external contacts detailed and the leaflet contained general health information.

Services were planned in a way that promoted person-centred and coordinated care, including for people with complex or multiple needs, good health and wellbeing, self-care and people's independence and also met the needs of people in vulnerable circumstances. We saw an example of a person with mental health needs being given an appointment to suit their circumstances.

If a patient had a learning disability or difficulty then annually an easy read survey was sent out to the individual or their carer for them to complete if they chose to.

The provider also encouraged personal continuity of care by doctors and other team members, for example appointments with a named doctor if that was what an individual wanted. They also supported people to have a choice over being seen by a male/female member of staff. This was confirmed in conversation with staff and patients.

The provider ensured there was a range of appropriate provision to meet needs, including capacity for appointments and services and ensured that the environment and facilities were appropriate and required levels of equipment were available promptly. For example we observed that there was sufficient seating in the waiting area. Where the practice could not meet the needs of the different types of people it served, it worked with other local practices, services or commissioners to ensure their needs were met.

Are services responsive to people's needs?

(for example, to feedback?)

People received support from the practice following discharge from hospital and the practice proactively followed up test results for patients with secondary care services. All the patients we spoke with confirmed this.

The practice had a "patient questionnaire" which was completed, reviewed and acted upon where necessary. The majority of survey forms were graded "very good" or "excellent". Some of the comments included; "Initial problems with electronic prescribing but all appears sorted now. An excellent service from a first class practice."

Access to the service

The appointments system was easy to use, supported choice and enabled people to access the right care at the right time. Patients were easily able to contact the practice to make an appointment. All the patients we spoke with confirmed this.

Opening hours met the needs of the practice population and were clearly stated. There were also late appointments and clinics available for those who were unable to make appointments at the surgery during regular working hours. Outside of this there was an out of hour's service available for patients. One patient commented, "I am always able to get an appointment when necessary."

Patients were able to be assessed by a GP in a timely way which meets their needs. This included urgent appointments if needed or telephone consultations and home visits for patients that would benefit from them

Concerns and complaints

Patients knew how to raise concerns or make a complaint. Patients, and those close to them, were encouraged to provide feedback about their care. We saw that the practice collated information about the service provided by means of a patient questionnaire. This was confirmed by patients we spoke with.

The practice had a complaints policy and took account of complaints and comments to improve the service. The complaints policy and ways to give feedback were easy to use. People were informed about the right to complain further and how to do so, including providing information about relevant external second stage complaints procedures. Whilst none of those spoken with had needed to complain, they all said they would be able to talk to the staff if they were unhappy about any aspect of their treatment.

The practice was open and transparent about how it dealt with complaints and concerns and information from whistle-blowers.

The practice did not have patient participation group (PPG) or patient reference group.

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 very well led. There was a strong and visible leadership team with a clear vision and purpose. Governance structures were in place and there was robust system in place for managing risks to demonstrate that the provider had an open and inclusive approach which enabled them to provide a good level of service to its population groups.

Our findings

Leadership and culture

Quality was integral to the practice's strategy and there was an awareness of potential risks to quality. Awburn House Medical Practice had a mission statement that was to provide high quality healthcare to all their patients. This was by a well-trained and motivated team underpinned by the ethos of a compassionate, caring, responsive and courteous approach. Staff were able to tell us about the values and ethos of the practice including compassion, dignity, respect and equality. Practice wide objectives were regularly reviewed by the GPs and practice manager to ensure they remained achievable and relevant. Staff told us they felt valued by the practice and that their work was recognised by the partners.

Governance arrangements

Governance arrangements were effective. Governance arrangements set out the principles by which the practice conducted its business for the benefit of the patients and the staff. Practice staff were clear about what decisions they were required to make, know what they were responsible for as well as being clear about the limits of their authority.

The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impacted on the quality of care. For example a member of staff had retired but prior to that the recruitment procedures had been initiated to ensure that staffing levels remained constant.

There were comprehensive policies and procedures in place. These included health and safety at work, Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), emergency incidents, fire safety and infection control. Staff we spoke with were aware of the policies and procedures available for them.

Regular practice meetings took place. These meetings discussed a variety of management and clinical issues. For example at one meeting accounts, dementia screening and Quality and Outcomes Framework (QOF) were focused on. Staff confirmed that the outcome of these meeting informed the clinical and administrative practices in the service and changes were made if necessary.

Are services well-led?

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

This means that good governance arrangements were in place that were risk based and flexible to meet the needs of all population groups.

Systems to monitor and improve quality and improvement

The practice had governance processes in place to monitor the quality of the service. We saw checks (audits) had been carried out in areas such as the cold chain audit, infection prevention and control and clinical audits. We also saw evidence of an external audit undertaken by the local Clinical Commissioning Group. The audit highlighted that the practice had done a lot of impressive work to improve systems and processes highlighted previously. This was supported by the recent clinical audits that showed significant improvement on previous submissions.

Patient experience and involvement

The practice and all staff recognised the importance of the views of patients and those close to them, including carers. A proactive approach was taken to seek a range of feedback. This was by means of patient questionnaires. There was no active patient participation/reference group however the patients we spoke with said they did not need one as they could provide feedback at any time and were always listened to.

Information on patient experience was reported and reviewed alongside other performance data. This meant that the provider listened to the patients who used the service and acted upon changes when appropriate and necessary.

Staff engagement and involvement

Staff feel supported, valued and motivated and told us they were treated fairly and compassionately.

All administrative staff attended regular meetings with the practice manager. These were named “target meetings” and all staff we spoke with told us they were valuable and that they were allowed to have their input into the way services were delivered. One staff member told us that if there was something important to be communicated then the practice would hold a meeting.

There was a strong team based working characterised by a cooperative, inter-disciplinary approach to delivering care in which decisions were made in the best interests of the patient. Staff had clearly defined tasks and roles. All staff we spoke with understood their role and how it supported patient treatment and care. One patient commented that all staff are caring over the phone and in the surgery.

Learning and improvement

There were management systems in place which enabled learning and improve performance. All staff management had clear objectives focused on improvement and consistent with the vision and values. We saw that all staff received an annual appraisal and regular supervision. This was qualified by staff. This meant that patients were looked after by suitably qualified and trained staff.

Identification and management of risk

When a risk was identified an assessment was undertaken. Staff we spoke with confirmed this. We saw evidence of risk assessments of general office, fire, staff, sharps and infections, maternity and new mothers, liquid nitrogen, oxygen and adrenaline. We also saw that these assessments were reviewed on a regular basis. This This demonstrated that the provider managed risk, was vigilant about risk, and helped to keep everyone safe that received health care in the practice.

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. We found that treatment and care was delivered in line with the patients' needs and circumstances, including their personal expectations, values and choices.

Our findings

The provider offered a range of services for this population group. This included appointments that met the needs of patients who used the service. For example home visits were provided for those people unable to get to the surgery. The service also provided a variety of information for this population group that included information for carers. If they GP considered a person may be suffering from mental ill health they would offer a cognitive assessment. They can also refer patients to the memory clinic for assessment and treatment

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. The practice team ensured that patients with long term conditions were regularly reviewed by practice staff and their care was coordinated with other healthcare professionals when needed.

Our findings

The service provided a variety of information for this population group. This included information on self-management of long term conditions. This was a programme that aimed to give a patient the skills and confidence to manage their conditions in daily life. This was undertaken in co-operation with a health professional. There were also clinics available to meet the needs of patients. These included clinics for asthma and Chronic obstructive pulmonary disease (COPD), and a warfarin clinic. The practice had a chronic disease register which allowed them to monitor and regular check those patients with long term conditions. If a patient was diagnosed with a long term condition then this was coded on their medical record and flagged up any ongoing support required.

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. A variety of services and clinics were in place to ensure that the diverse and specialist needs of this population group were being met.

Our findings

There was a specific GP who was the lead for matters concerning this population group. There were clinics available to meet the needs of the patients. These were mother and baby clinics and sexual health clinics. One patient we spoke with told us they were able to see a midwife at the practice.

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. The appointments system was regularly reviewed to try to maximise timely access to services for this population group.

Our findings

The service provided a variety of information for this population group. This included information on men's health, adult care and smoking cessation. The service also offered smear tests to patients when needed. They also offered a routine blood test to those over 40 years old. They also wrote to patients over the age of 40 to offer them a health check. Evening clinics were available for those people who could not get to the surgery during regular working hours.

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. During out inspection we did not encounter any barriers to access for this population group

Our findings

If a patient was identified as having a learning disability then an easy read healthcare pack was sent out to the individual or their carer to complete. It was their choice whether this was done.

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

We found that services provided for this population group were safe, effective, caring, responsive and well led. During out inspection we did not encounter any barriers to access for this population group. There were systems in place to enable timely and appropriate referrals to be made to mental health services for patients if needed.

Our findings

There was a specific GP who was the lead for matters concerning this population group. The service provided a variety of information for this population group. It included information about MIND, a mental health charity, and a bipolar self-help group. Staff informed us that if a patient had a specific mental health need then a detailed mental health care plan would be completed. This was done in co-operation with the patient or their carer.