The Church Lane 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

The Church Lane Practice is a large GP practice based in Merton, providing primary care services to over 16 000 patients. The practice has two sites, The Church Lane and The Patrick Doody site which is a satellite location and has the same patient list as the Church Lane site. During our inspection we visited the Church Lane Practice.

During our inspection we spoke with GPs, the practice manager, the business support manager, practice nurses, nurse practitioner, reception and administrative staff.We also spoke with patients and a mental health advocate group representative.

All of the patients we spoke with reported that they were satisfied with the service they had received. They reported receiving a good service at the practice and felt well cared for. Eight comments cards we received demonstrated that patients were pleased with the care given to them.

The practice was well managed and patients received care that was effective, and caring. We found some areas of improvement in the safety of the care provided and how the practice responded to the care of people experiencing poor mental health.

Older people had a named GP and emergency appointments were always offered to this population group. The practice operated a walk in triage system and babies and small children were prioritised for same day appointments. Extended opening hours were available at a satellite clinic and this enabled the working age people to attend the surgery at times that suited them.

Patients were able to book appointments and request for prescriptions online and this allowed flexibility for all population groups.

The practice worked well with people in vulnerable circumstances, for example the local Faith in Action group which provided accommodation to local homeless people.

People experiencing poor mental health were offered an annual health check and the practice worked in partnership with other providers. However an advocate felt that the appointments system for this population group could be improved to enable them to book appointments flexibly.

The practice is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening, and treatment of diseases and injury.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Patients received safe care. The practice reported and reviewed all incidents. All incidents had a learning outcome which was reflected upon and action taken to avoid future occurrence. We found that the practice had the right staffing levels with appropriate skills and experience. Patients were protected from the risk of abuse, because the practice offered training to staff and staff were aware of how to report safeguarding concerns. However the practice did not have sufficient infection control policies and processes in place to protect people. Emergency drugs were in date, but no formal records were kept of checks by staff to assure us the date of expiry was being monitored. We were told that the emergency equipment was also checked, but there were no records.

Are services effective?

The service provided effective care. Care and treatment was delivered in line with recognised best practice standards and guidelines, including guidance published by the National Institute for Health and Care Excellence (NICE). Arrangements for training and support for staff were in place including an induction programme for all staff. There was evidence of multi-disciplinary working to ensure that information was shared appropriately so that people received co-ordinated care. We found the practice proactively identified patients who required on-going support and offered a wide range of health promotion information to enable patients to make healthy choices.

Are services caring?

All the patients we spoke with during our inspection spoke highly of the services provided and described staff as very caring. We observed that all people were treated with dignity and respect and confidentiality was respected most of the time. Staff and patient discussions at the reception area were conducted discretely and all consultation rooms had lockable doors.

Are services responsive to people's needs?

The practice was responsive to people's needs. They operated a triage system for emergencies. However the appointments system did not always suit people experiencing poor mental health. The practice listened to patients views and made changes where necessary. The practice engaged with commissioners and other stakeholders to deliver integrated care and learned from their experience to improve the quality of care.

Summary of findings

Are services well-led?

The service was well led. The practice shared a clear vision and values. Responsibilities were clear and the leadership was transparent. Arrangements were in place to monitor and improve the quality of care provided.

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 provider had arrangements in place to respond to the needs of this population group. All patients we spoke with were positive about the practice. Emergency appointments and a named GP for patients over the age of 75 were some of the arrangements in place to meet their needs.

People with long-term conditions
The provider had arrangements in place to respond to the needs of this population group. Care was based on national guidance along with specific training for staff. The practice held meetings to discuss and update plans for people with chronic conditions with other care providers.

Mothers, babies, children and young people
The provider had arrangements in place to respond to the needs of this population group. The practice offered assessments to children and young people based on the "Healthy Child Programme", which ensured all care given was in line with national guidance.

Mothers could access the practice in a number of ways to suit them and their children. A variety of clinics for vaccinations and post natal checks were available and working mothers were able to book evening appointments at a local satellite location.

The working-age population and those recently retired
The provider had arrangements in place to respond to the needs of this population group. All patients we spoke with spoke highly of the services offered to them. Screening for conditions such as diabetes was available and patients could access evening appointments at the satellite clinic.

People in vulnerable circumstances who may have poor access to primary care
The provider had arrangements in place to respond to the needs of this population group. Patients who used temporary and undisclosed addresses could register at the practice and it worked in partnership with a voluntary organisation that provided support for homeless people.

Summary of findings

People experiencing poor mental health

The provider had some arrangements in place to respond to the needs of this population group. Services were well led by GPs who had a special interest in mental health. The practice worked in partnership with other health care providers to deliver care and patients were offered an annual health check.

Patients experienced some difficulty accessing the appointments booking system due to its early opening times (the side effects of the medication that some patients were on meant they found it difficult to wake up early in the morning). The practice had taken some action to address this issue.

Summary of findings

What people who use the service say

We spoke with 12 patients during our visit and received eight comment cards from patients who had visited the surgery two weeks before our visit. All patients we spoke with reported receiving good quality care. All eight comments cards we reviewed demonstrated that patients were happy with the care and treatment they received.

We looked at the patient participation group's survey results from January 2014. The survey received 1065 responses. The results showed that the number of patients describing the appointments system as being "very good" or "fairly good" had gone down slightly from the previous year.

Areas for improvement

Action the service MUST take to improve

Ensure that a system is in place to maintain appropriate standards of cleanliness and hygiene.

The Church Lane Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector who was accompanied by two specialist advisers, one a GP and the other a practice nurse/manager.

Background to The Church Lane Practice

The Church Lane Practice is a large GP practice based in Merton, providing primary care services to over 16 000 patients. The practice has two sites, The Church Lane and The Patrick Doody site, which is the provider's satellite location. During our inspection we visited the Church Lane Practice. The practice is open between 8am and 6.30pm, Monday to Friday. Evening appointments (6.30pm-8pm, Monday to Thursday) are offered at the satellite location. The practice has 12 GPs with some working part time hours, one business manager, a practice manager, four practice nurses, a nurse practitioner and a number of administrative staff.

The health of people in Merton is generally better than the England average, and deprivation is lower. While life expectancy is significantly better than the England average, there is wide variation within the borough from east, where life expectancy is lower, to west. Priorities in Merton include reducing the gap in life expectancy between the least and the most deprived parts of Merton, reducing mortality due to heart disease and cancer, addressing major risk factors such as smoking, diet, exercise and alcohol, and improving sexual health.

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 has not been inspected before. The practice was registered with CQC on 1 April 2013.

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.

Prior to our inspection we carried out an analysis of data from our Intelligent Monitoring system. This did not highlight any significant areas of risk across the five key question areas. As part of the inspection we contacted a number of key stakeholders, including NHS England,

Detailed findings

Merton Clinical Commissioning Group and Healthwatch Merton, and reviewed the information they gave us. We carried out an announced visit on 14/05/14. During our visit we spoke with 10 staff such as GPs, practice nurses, health care assistants and reception staff. We spoke with 12 patients who used the service and a representative from a local mental health group. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Are services safe?

Summary of findings

Patients received safe care. The practice reported and reviewed all incidents. All incidents had a learning outcome which was reflected upon and action taken to avoid future occurrence. We found that the practice had the right staffing levels with appropriate skills and experience. Patients were protected from the risk of abuse, because the practice offered training to staff and staff were aware of how to report safeguarding concerns. However the practice did not have sufficient infection control policies and processes in place to protect people. Emergency drugs were in date, but no formal records were kept of checks by staff to assure us the date of expiry was being monitored. We were told that the emergency equipment was also checked, but there were no records.

Our findings

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Safe patient care and Learning from incidents.

The practice had a range of mechanisms in place to ensure that patients received safe care, including monitoring of incidents and complaints. All incidents and patient complaints were investigated and used as learning opportunity for improvement.

Appropriate systems were in place for the reporting of incidents and staff were encouraged to report incidents within a no blame culture. All incidents were entered into a “significant event” log which was regularly reviewed by the lead GP and practice manager. All incidents had a learning outcome which was reflected upon and action taken to avoid future occurrence. We saw meeting minutes which documented the discussion and the learning outcomes.

There were arrangements in place to report incidents to other relevant organisations, such as the local Clinical Commissioning Group (CCG) and the Medicines and Healthcare Products Regulatory Agency (MHRA). There were no reported significant events or near misses reported at the practice in the three months preceding our inspection.

Safeguarding

We found that the provider had good practices in place to keep people safe and protected from abuse. Training records confirmed that all staff working at the practice had completed training on child protection. All GPs and nurses had completed Level 3 and Level 2 child protection training in line with national guidelines. Administrative staff had

Are services safe?

completed Level 1.The practice had a lead GP in safeguarding. They arranged training for staff, took the lead in safeguarding and also attended local safeguarding meetings for children.

Staff at the practice had not undertaken any formal training on safeguarding adults. However they were able to talk us through the steps they would follow to safeguard adults who used their service. Records showed the provider was in the process of ensuring that this training would be delivered to all staff.

Monitoring safety and responding to risk

The practice had systems in place to monitor safety and respond to risk. This included policies on dealing with disease outbreaks and staffing levels during busy periods such as the flu vaccination period. The premises were secure and locked overnight with appropriate alarm and security systems. We observed that records were kept secure in a room that was lockable and only authorised staff had access to it.

Medicines management

We found that medication was appropriately stored. Drugs fridges were fit for the purposes of storing medicines and vaccines. The temperatures were recorded and monitored appropriately. The fridge was wired into switch-less sockets to avoid them being switched off accidentally.

The practice had a repeat prescribing policy. When we spoke with the practice nurses and GPs it was evident that they understood and followed this policy. Medicines for repeat prescriptions were reviewed annually or more frequently to ensure they were still suitable for the patient, thus protecting them from risks associated with medicines. The practice had a secure system of keeping prescriptions safe and had auditing systems for prescriptions issued. This ensured the risk of misuse was minimised.

Cleanliness and infection control

There were insufficient policies and processes in place to protect people from the risk of infection. There was no infection prevention and control (IPC) policy specific to the practice. The practice had recently appointed an Infection Prevention and Control Lead nurse. When we spoke to the nominated person they did not have plans of how they would carry out necessary audits and checks. No infection control audits had been carried out and staff had not received infection prevention and control training. They were unclear who was responsible for ensuring relevant staff had received Hepatitis B immunisations.

Records showed the nurses cleaned equipment on a daily basis, but as no infection control audits or policies existed we could not be assured that the standard of cleaning was monitored.

A domestic company was contracted to undertake the general cleaning of the premises. During our inspection the practice was visibly clean. Patients told us that overall they were satisfied with the cleanliness of the practice, but some commented that the toilet facilities were not always clean. There were no formal mechanisms in place to check that the contracted cleaners had carried out the cleaning tasks sufficiently. There were appropriate facilities for hand-washing and for dealing with clinical waste.

Staffing and recruitment

The practice had 12 GPs and four practice nurses. Most of the staff worked part time but they ensured they had sufficient staff to meet the needs of the population it served. We observed that the practice had an induction procedure for new GPs, nursing and administration staff. On occasion the practice used locum staff who were familiar with the practice. An appropriate recruitment policy was in place. Records viewed demonstrated that all staff working at the practice had full Disclosure and Barring Service (DBS) clearance and appropriate references and qualifications that had been verified.

Dealing with Emergencies

The practice had emergency alarms and these were operated via each computer to ensure staff quickly responded to a call for help. Records confirmed these alarms had been tested and were in good working order. There were adequate systems in place to cover GP absences and for following up work generated by locums.

According to the practice's training log both clinical and non-clinical staff had attended basic life support training within last six months.

Equipment

There was emergency equipment in place, including oxygen and emergency drugs and a defibrillator. We were told these was checked regularly, but no records were kept of these checks.

Are services safe?

Anaphylaxis drug kits, which were for emergency use were kept in each treatment room. Whilst these were in date there was no record to demonstrate when they were checked to ensure their expiry dates were being monitored.

Are services effective?

(for example, treatment is effective)

Summary of findings

The service provided effective care. Care and treatment was delivered in line with recognised best practice standards and guidelines, including guidance published by the National Institute for Health and Care Excellence (NICE). Arrangements for training and support for staff were in place including an induction programme for all staff. There was evidence of multi-disciplinary working to ensure that information was shared appropriately so that people received co-ordinated care. We found the practice proactively identified patients who required on-going support and offered a wide range of health promotion information to enable patients to make healthy choices.

Our findings

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Promoting best practice

Each of the GPs and practice nurses were responsible for one or more clinical area. Each lead was responsible for keeping up to date with best practice guidance from NICE and other bodies and implementing changes where required. We looked at meeting minutes where such developments and changes were discussed and shared with all clinical staff.

Management, monitoring and improving outcomes for people

The practice had a lead GP who conducted clinical audits. Clinical audits were used as a quality improvement process that sought to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. For example, an audit had been carried out in November 2013 on people with diabetes to check whether their treatment followed NICE guidelines. The audit found that a 100% of people using insulin had been prescribed this medication in accordance with best practice.

Staffing

The practice had a standard induction programme for GPs, locums and non-clinical staff. The GP induction was two days and included approximately seven hours of supervised consultation time. The induction included a set of detailed learning objectives which required signing off by both GP and practice manager. The non–clinical staff induction was approximately six days with a large proportion of that time spent working alongside a senior member of support staff .There was no formal induction programme for other clinical staff, such as nurses. There had been no new staffing in the last year.

Are services effective?

(for example, treatment is effective)

According to the practice's training log all staff had completed child protection training to the appropriate level for their role and were in the process of completing training on information governance. However, no staff had received formal training on mental capacity and consent, safeguarding of vulnerable adults and infection control. The practice manager and lead GP for safeguarding confirmed they were in the process of arranging training and we saw records that confirmed this. The practice had also introduced e-learning resources for staff to familiarise themselves with the outstanding training. Clinical staff confirmed that they were supported in attending clinical practice updates training such as cervical smear taking and immunisations.

The practice used the NHS appraisal system which used external GP appraisers for partners and salaried doctors. Such appraisals were incorporated in the GMC revalidation process. All doctors had an annual review with the senior partner at the practice and they discussed the content of their external appraisal and fedback on any concerns or issues that may have been raised. We saw records which confirmed this had been carried out for the previous year.

All the nurses confirmed that they had taken part in observed consultations with an external supervisor, which they found useful in their clinical development. There were no formal notes of this provided and it had ended when the Primary Care Trusts (PCT) were disbanded. The practice manager and the lead nurse had developed a new appraisal system and this was being introduced in the following weeks. All other administrative staff had completed their appraisals between February and April of this year.

Working with other services

The practiced worked in collaboration with other providers to ensure patients received effective care.

We saw evidence of regular minuted meetings attended by district nurses, local community mental health teams and health visitors. Details of patients who had been seen by the out of hours services were received electronically to ensure continuity of care. Information that related to children at risk or on protection plans was shared amongst local authorities and the practice was active in attending such meetings or to responding to information requests. Patients were referred to secondary care services where required. GPs followed up on urgent referrals that fell in the two week rule within 24hours of making the referral to minimise delay in patients receiving care .All other referrals were completed online and referral confirmation received.

The lead GP working with children and families told us that they liaised with health visitors when they identified children and families that required support from an early stage. Women identified as being depressed were identified during the 6-8 week post-natal checks offered at the surgery which enabled early intervention.

There was also a system in place that ensured that details of all patients with long term conditions were handed over to the out of hours services care to ensure an accurate handover and consistency in care .

Health, promotion and prevention

We found the practice proactively identified patients who required on-going support and offered a wide range of health promotion information to enable patients to make healthy choices. We saw a variety of health promotion leaflets were available in the practice waiting rooms. All new patients were offered screening tests and checks were made for conditions such as diabetes, high blood pressure and obesity which meant that appropriate information and interventions could be discussed. The nurses at the practice ran a number of nurse-led clinics such as diabetic clinic and a travel clinic as well as a vaccination programme for all children.

Are services caring?

Summary of findings

All the patients we spoke with during our inspection spoke highly of the services provided and described staff as very caring. We observed that all people were treated with dignity and respect and confidentiality was respected most of the time. Staff and patient discussions at the reception area were conducted discretely and all consultation rooms had lockable doors.

Our findings

All the patients we spoke with during our inspection spoke highly of the services provided and described staff as very caring. We observed that all people were treated with dignity and respect and confidentiality was respected most of the time. Staff and patient discussions at the reception area were conducted discretely and all consultation rooms had lockable doors.

Respect, dignity, compassion and empathy

We observed staff to be caring. All staff were clear that the wishes of the patients were to be listened to, respected and responded to whenever possible. We noted that staff spoke to people in a discreet and friendly way. All consultations took place in rooms designed to ensure confidentiality and dignity was maintained. However we observed an incident were a practice nurse failed to close the door in a consulting room whilst attending to a patient.

There were clips being shown on a TV screen in the waiting room explaining to patients that they could ask for a chaperone during examinations if they needed one. All patients we spoke with told us that they felt their dignity was maintained at all times and they felt respected.

Involvement in decisions and consent

The provider operated a virtual Patient Participant Group (PPG) that communicated only by email. We saw survey results that had been carried out at the practice and the PPG had identified the areas to focus on, such as the evening extended clinics.

Patients told us that they felt involved in decisions relating to their care and information was readily available to support and inform them of care choices. Bereaved families were offered support with access to counselling services and these families were discussed at practice meetings, if required. All staff we spoke with were aware of patient consent to care. Patients told us that the staff always explained the care and treatment options available to them.

Staff told us that they rarely used interpretation services as most patients were English speaking but acknowledged that if needed or identified interpretation services were used.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to people's needs. They operated a triage system for emergencies. However the appointments system did not always suit people experiencing poor mental health. The practice listened to patients views and made changes where necessary. The practice engaged with commissioners and other stakeholders to deliver integrated care and learned from their experience to improve the quality of care.

Our findings

The practice was responsive to people's needs. They operated a triage system for emergencies. However the appointments system did not always suit people experiencing poor mental health. The practice listened to patients views and made changes where necessary. The practice engaged with commissioners and other stakeholders to deliver integrated care and learned from their experience to improve the quality of care.

Responding to and meeting people's needs

A duty doctor was available to triage telephone calls from patients. This resulted in some patients being advised to attend local Accident and Emergency services, some offered same day appointments and some calls being resolved over the telephone following verbal advice. The practice undertook home visits for those who were not able to physically visit the surgery. We were told by reception and clinical staff that interpretation services were available for patients if required. The practice told us that that by offering online appointments and the duty GP triage system they had responded to patients varying needs. They explained that patients could walk in at any time to request appointments and patients with mental health conditions were prioritised.

However, this may not have been adequate to ensure the practice responded to the varying needs of patients. This is because a representative from a local users and support group for patients raised concerns about the capacity of the practice in responding to the needs of people with mental health conditions. They were concerned about the appointments booking system which they felt was not user friendly for people with mental health conditions, as some could not always make an appointment at a time that suited them.

We observed that the practice was easily accessible to patients using walking aids and all patient consultation rooms were located on the ground floor.

Access to the service

There were a range of appointments available. For example, the practice operated a standard ten minute appointment bookable up to one month in advance and standard appointments that were released 72 hours in advance of the appointment day. There was also a double appointment for 20 minutes that was available for people

Are services responsive to people's needs?

(for example, to feedback?)

with complex or multiple problems. Same day appointments were available for patients whose problem meant they could not wait for routine appointments. Each day a duty doctor was available for patients who needed emergency consultations. The survey results we viewed showed that patients were happy with the appointments system including the availability of an online booking system and the evening sessions that were operated from a satellite practice. The practice also operated an online and walk in repeat prescription service. The nurses at the practice ran a number of nurse-led clinics such as diabetic clinic and a travel clinic.

Interpretation services were available for patients who did not use English as a first language. We spoke with a representative from a local home for homeless people, Faith In Action. They told us that they had previously telephoned the practice in emergencies requesting appointments. They told us that the practice was very caring and these patients had been treated promptly with respect and dignity.

Concerns and complaints

The practice had a complaints policy in place and this was available on the practice's website as well as being incorporated into the practice information leaflet which was given to patients. We saw records that demonstrated that the practice used most complaints and comments as a learning opportunity and if the complaint had a more general application it was shared with the whole team. The Patient Participation Group was also consulted to inform the practice of patient experiences and this information was used to improve the care provided.

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 shared a clear vision and values. Responsibilities were clear and the leadership was transparent. Arrangements were in place to monitor and improve the quality of care provided.

Our findings

The service was well led. The practice shared a clear vision and values. Responsibilities were clear and the leadership was transparent. Arrangements were in place to monitor and improve the quality of care provided.

Leadership and culture

There was a clear and shared vision of wanting to provide a high standard of general practice placing patient care at the centre and this was highlighted in the statement of purpose. The policies and protocols we viewed demonstrated this. Staff were aware of their roles and responsibilities and the leadership structure. Staff told us they were encouraged to report incidents and accidents and there was no fear of blame.

Governance arrangements

Staff and GPs we spoke with were all clear about their accountabilities and what their challenges were. The practice had a protocol in place and it detailed who was responsible for making decisions and deputising in absences. For example in the absence of the senior partner one of the experienced GPs would take responsibility of day to day duties.

Systems to monitor and improve quality and improvement

There were monitoring systems in place to improve the delivery of care and patient experience. For example, a recent audit had been undertaken on the practice's appointments system to determine if patients were reaching the appropriate health care professional in a timely manner. As a result the practice was in the process of developing a system that would help reception staff to direct patients to an appointment with the best health care professional that would meet their needs.

We observed that different audits such as asthma care, insulin dependent patients care and appointments system were undertaken and the findings were used to benchmark care.

The practice completed the annual Quality Outcomes Framework (QOF), a voluntary incentive scheme to encourage high quality care. Performance is measured

Are services well-led?

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

against certain indicators and targets to measure how well patients are cared for. At the time of our inspection, the practice had met its targets and achieved the maximum points required.

Patient experience and involvement

Patient feedback was on-going. We viewed records of comments cards that patients were encouraged to complete. Patients reported being happy with the practice appointment systems and the practice opening times. The practice operated a virtual Patient Participation Group (PPG) which was used to identify areas to focus on that would inform future changes such as the late evening appointment sessions that were being offered at the satellite location.

Staff engagement and involvement

Staff told us that they were encouraged to give feedback on the practice. The practice managers and senior partners demonstrated that they valued feedback from their staff. All staff attended a practice meeting held once a month at the practice and were minuted. Staff we spoke with told us that they felt involved in all developments related to the practice as they were discussed during staff meetings.

Learning and improvement

Our discussions with all members of staff demonstrated that staff shared the same objectives of delivering quality care. The practices used all incidents as learning opportunities .Incidents were discussed openly in staff forums and used as a learning opportunity for improvement. The practice attended local CCG meetings to monitor and improve care provided.

Identification and management of risk

The practice had identified and managed events that were likely to increase risk. For example, they had internal arrangements for locum staff to cover workload in the event of sickness.

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 the practice had arrangements in place to respond to the needs of this population group.

The provider had arrangements in place to respond to the needs of this population group. All patients we spoke with were positive about the practice. Emergency appointments and a named GP for patients over the age of 75 were some of the arrangements in place to meet their needs.

Our findings

The provider had arrangements in place to respond to the needs of this population group. All patients we spoke over 75 were positive about the practice. They felt well cared for and respected by staff. Care provided was responsive to people's needs in that patients were listened to and there was a named GP lead for patients over 75. The appointments system at the practice prioritised this population group by offering emergency appointments or a walk in service. A system was available that enabled repeat prescriptions to be requested either by telephone, online or in person.

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 the practice had arrangements in place to respond to the needs of this population group.

The provider had arrangements in place to respond to the needs of this population group. Care was based on national guidance along with specific training for staff. The practice held meetings to discuss and update plans for people with chronic conditions with other care providers

Our findings

The provider had arrangements in place to respond to the needs of this population group. We saw that the practice held meetings to discuss and update plans for people with chronic conditions with other care providers. Updates and clinical management guidance from NICE and other organisations were incorporated into care plans.

An audit carried out at the practice in January 2013 looked at patients who were prescribed insulin and whether it had been prescribed in accordance with NICE guidance. The practice found that all their patients using insulin were meeting the relevant standards.

There was a system in place that ensured that details of all patients with long term conditions were handed over to the out of hours services care to ensure an accurate handover and continuity of care.

Clinical staff undertook training and information sharing days to enhance their knowledge on managing specific conditions, including those that were long-term. The practice provided support to its patients and carers by holding meetings and signposting them to support networks. Home visits for people with long-term conditions were undertaken when needed.

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 the practice had arrangements in place to respond to the needs of this population group.

The provider had arrangements in place to respond to the needs of this population group. The practice offered assessments to children and young people based on the "Healthy Child Programme", which ensured all care given was in line with national guidance.

Mothers could access the practice in a number of ways to suit them and their children. A variety of clinics for vaccinations and post natal checks were available and working mothers were able to book evening appointments at a local satellite location.

Our findings

In line with national guidance, the practice offered assessments to children and young people based on the Healthy Child Programme. All mothers were offered screening such as cervical smears, as recommended nationally.

All mothers we spoke with said the staff were kind and caring and that they trusted them. They told us they were helped to understand the care they or their children needed.

Mothers could access the practice in a number of ways to suit them and their children. For example a variety of clinics for vaccinations and post natal checks were available and working mothers were able to book evening appointments at a local satellite location. The on call doctor was also always available as a walk-in service or via telephone. Most mothers we spoke with told us that this was useful for them with small children.

The practice had a paediatrician who worked with this group to provide specialist clinical knowledge.

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

The provider had arrangements in place to respond to the needs of this population group.The provider had arrangements in place to respond to the needs of this population group. All patients we spoke with spoke highly of the services offered to them. Screening for conditions such as diabetes was available and patients could access evening appointments at the satellite clinic.

Our findings

All patients spoke highly of the services offered to them. All patients confirmed that staff were caring. We found that the practice responded well to patient's changing needs through the use of information technology and offering evening appointments from the satellite clinic to those that were unable to attend day time appointments due to work commitments. This population group was offered screening for conditions such as diabetes, high blood pressure and cholesterol.

Repeat prescriptions and appointments could also be requested online which meant that patients could carry on with their day to day activities without disruption.

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 provider had arrangements in place to respond to the needs of this population group.The provider had arrangements in place to respond to the needs of this population group. Patients who used temporary and undisclosed addresses could register at the practice and it worked in partnership with a voluntary organisation that provided support for homeless people.

Our findings

Practice staff told us that they registered patients who had temporarily moved into the area, such as victims of domestic violence who would be using temporary and undisclosed addresses.

Interpretation services were available for patients who did not use English as a first language. We spoke with a representative from a local home for homeless people, Faith In Action. They told us that they had previously telephoned the practice in emergencies requesting appointments. They told us that the practice was very caring and these patients had been treated promptly with respect and dignity.

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 provider had arrangements in place to respond to the needs of this population group.

The provider had some arrangements in place to respond to the needs of this population group. Services were well led by GPs who had a special interest in mental health. The practice worked in partnership with other health care providers to deliver care and patients were offered an annual health check.

However an advocate for some patients reported difficulty accessing the appointments booking system due to its early opening times (the side effects of the medication that some patients were on meant they found it difficult to wake up early in the morning). The practice had taken some action to address this issue.

Our findings

Services were well led by GPs who had a special interest in mental health. Meetings were held once a month and patients care was discussed with other providers such as the community psychiatric team to ensure vital information was shared. Women were offered post natal checks and appropriate action was taken for those suffering from post–natal depression. All mental health patients were offered an annual health check.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010: Cleanliness and infection. People who use services and others were not protected against the risks associated with unsafe or inadequate maintenance of appropriate standards of cleanliness and hygiene. Regulation 12 (2) (c).