

# Bridge Street Medical Centre

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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# Summary of findings

## Overall summary

Bridge Street Medical Practice offers a wide range of primary medical services from its city centre location at 2 All Saints Passage, Cambridge.

Prior to our inspection we consulted with the local clinical commissioning group (CCG) and the NHS local area team about the practice. Neither of these organisations had any significant concerns.

We carried out an announced inspection on 27 August 2014. During the inspection we spoke with patients and carers that used the practice and met with members of the Patient Participation Group. The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. We also reviewed comments cards that had been provided by CQC on which patients could record their views.

We found that the practice provided a safe, effective, caring, responsive and well led service. Patients we spoke with told us that they were treated with respect and their dignity was maintained.

We looked at patient care across the following population groups: older people; those with long term medical conditions; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. We found that the practice had in place a wide range of systems and services to ensure that appropriate care was available to patients in these groups.

Readers should be aware that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

# Summary of findings

## The five questions we ask and what we found

We always ask the following five questions of services.

### **Are services safe?**

Bridge Street Medical Centre was safe. The practice had a good track record on safety. There was effective recording and analysis of significant events to ensure that lessons learnt were always shared among relevant staff. The practice had a range of safeguarding measures in place to help protect children and vulnerable adults. There were effective systems in place to manage medicines.

### **Are services effective?**

The services provided at Bridge Street Medical Centre were effective. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines. The practice had carried out a number of reviews of its activities and had fully completed clinical audit cycles. There was clear evidence of multi-disciplinary working and meeting the needs of a patient list that contains a high proportion of younger patients.

### **Are services caring?**

The service at Bridge Street Medical Centre was caring. Patients we spoke with during our inspection were complimentary about the service and said they were treated with respect and their dignity was maintained. Patients who had completed a comment card before our inspection were positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

### **Are services responsive to people's needs?**

The practice was responsive to patients' needs. Patients told us that the appointment system at the practice did not always work well as they would wish and that there could be some delay in getting a routine appointment. There was an open culture within the organisation and complaints were dealt with effectively and in line with the practice's policy. The practice responded to the high percentage of younger patients by offering walk in clinics during university term times.

### **Are services well-led?**

The service was well led and managed by knowledgeable and committed staff. There was evidence of strong leadership with a clear vision and purpose, although it was not clear how staff were made aware of the practice's stated mission and values. Appropriate governance structures and systems were in place to manage risks.

# 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

Care was appropriately provided to meet individual patients' healthcare needs. There were regular 'patient care reviews' involving patients and their carers where appropriate. In line with the new enhanced service for avoiding unplanned hospital admissions, every patient over 75 had a named GP. Due to the patient demographic a lower than average percentage of patients than the national average fell into this population group.

### People with long-term conditions

The practice supported patients and carers to receive coordinated, multi-disciplinary care. Patients with long term conditions such as diabetes, asthma and chronic pulmonary obstructive disease were invited to attend at the surgery to have their care and treatment reviewed annually or more frequently if necessary.

### Mothers, babies, children and young people

A community midwife held a weekly clinic at the surgery to undertake prenatal checks for expectant mothers. The practice provides childhood immunisations and eight week postnatal checks.

The practice offers a walk in clinic for patients aged between 17 and 25 on a daily basis during university term times and fostered a good working relationship with nurses who were based in the surrounding university colleges.

### The working-age population and those recently retired

The practice offered pre-bookable GP, nurse and healthcare assistant appointments up to six weeks in advance. Extended opening times two days a week were provided to improve access for patients who were at work during the day.

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

The practice had identified patients with learning disabilities and treated them appropriately. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities. The practice worked closely with a refuge to meet the needs vulnerable residents.

# Summary of findings

## People experiencing poor mental health

Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered those patients on the mental health register. The practice worked with the university colleges to try to assist patients suffering from stress and anxiety related to their examinations.

# Summary of findings

## What people who use the service say

We spoke with seven patients during our inspection. They varied in age and represented older people, mothers with children, patients with long term conditions, a patient with mobility issues and working age patients. They described the staff as caring and helpful. They said the practice was clean and safe.

Patients also told us they felt fully involved in decisions about their care and treatment, and that the effects of prescribed medicines were explained to them.

Patients told us that getting an appointment to see a GP or nurse was sometimes difficult and could take up to two weeks to see a GP of choice.

We reviewed Care Quality Commission comment cards from a box left in the surgery in the days before our visit. The comments on the cards were very positive, although the difficulty in getting an appointment was mentioned.

## Areas for improvement

# Bridge Street 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 and the team included an additional CQC inspector, a GP practice manager and an Expert by Experience.

An Expert by Experience is a person who has experience of using this type of service and helps to capture the views and experiences of patients and carers.

### Background to Bridge Street Medical Centre

Bridge Street Medical Centre is located in Cambridge city centre and sits in close proximity to the university colleges. It delivers primary medical care to approximately 9,200 patients. 40% of the patients are aged between 17 and 25.

It is located within the area covered by Cambridgeshire and Peterborough Clinical Commissioning Group.

The practice is staffed by five partners and two practice nurses, two healthcare assistants. They are supported by a practice manager, administration and reception staff.

The surgery was open until 6pm each weekday with extended opening hours on one morning and evening a week.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Camdoc.

The practice is located in a large converted town house and clinical rooms are spread over four floors. A passenger lift was available for patients.

### Why we carried out this inspection

We inspected this practice 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 poor mental health.

## Detailed findings

Before inspecting, we reviewed a range of information we had received from the practice and asked other organisations to share their information about the practice. This including the local clinical commissioning group (CCG) and the NHS England local area team.

We carried out an announced inspection on 27 August 2014.

During our inspection we spoke with a range of staff, including GPs, nurses, administration and reception staff and the practice manger.

We also spoke with patients who used the service.

We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place.

# Are services safe?

## Our findings

### Safe patient care

The practice was able to demonstrate that it had a good track record on safety. We saw records to show that performance had been consistent over time and where concerns had arisen they had been addressed in a timely way. The manager showed us that there were effective arrangements in line with national and statutory guidance for reporting safety incidents. We saw that the practice kept separate records of clinical and non-clinical incidents and the manager took all incidents into account when assessing the overall safety record.

There were clear accountabilities for incident reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how the practice manager recorded incidents and ensured that they were investigated.

### Learning from incidents

The practice had a system in place for reporting, recording and monitoring significant events. The record of significant events was made available to us. We saw that such events had been carefully and fully investigated, with thorough collection of evidence and root cause analysis. However it was not clear how the action plans resulting from the analysis and any learning from the investigation had been cascaded down to staff throughout the practice to help reduce the risk of any re-occurrence. The practice manager was aware of this shortcoming and had already taken steps to ensure such knowledge was disseminated throughout the staff structure.

All staff we spoke with were aware of the system for raising issues or concerns and were encouraged to do so.

### Safeguarding

The provider had policies and systems in place to ensure that patients were safeguarded against the risk of abuse. There was a named GP lead for safeguarding and we saw that all staff had received training appropriate to their role. Staff knew their responsibilities regarding information sharing, how to access key policies and information and how to report their concerns.

We viewed the practice chaperone policy and observed that notices informing patients of their right to have a chaperone present was displayed in each clinical room. although we did notice that no such notice was displayed in the reception and waiting areas.

Enhanced disclosure and barring service (DBS) checks were carried out on all nursing staff and health care assistants to help ensure their suitability to work with vulnerable patients.

### Monitoring safety and responding to risk

We saw that the practice had the appropriate systems in place for ensuring adequate clinical cover to respond to medical emergencies and referrals. For example we saw how GP's had provided additional consultations to cover a colleagues absence from work for an extended period of time. We also saw how GPs and other clinical staff were flexible in meeting known peaks in demand for services. The practice ran a 'duty doctor' system that facilitated walk-in patients to be seen, but also gave the capacity to allow children who were presenting as ill to be seen straight away.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and staff knew of their location.

### Medicines management

We checked the medicines stored in the treatment rooms and fridge and found them to be stored appropriately.

The expiry dates were recorded so that staff knew when they were due to expire and needed to be replaced. Controlled drugs were not stored at this practice.

The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered such things as how repeat prescriptions were managed and how patients had their medicines reviewed. The majority of prescriptions were issued electronically but GPs also occasionally used paper prescription pads that we saw were stored securely when not in use.

### Cleanliness and infection control

The practice was visibly clean. Patients we spoke with said they were satisfied with standards of hygiene at the practice. Cleaning was carried out by an external contractor and the manager told us they regularly checked upon the efficacy of the cleaning. Actions arising from a cleaning audit had been dealt with.

# Are services safe?

There was a member of staff who was the designated infection prevention and control lead and who had received appropriate training to fulfil that role. The infection control policy had been reviewed and set out the scope and responsibilities of staff in helping to minimise the risk of healthcare associated infections. Staff understood the importance of ensuring that the policies were always followed.

A Legionella audit and assessment had been completed by an external provider to help minimise the risk of infection from water borne bacteria and the recommendations in the report had been implemented.

We saw how the used instruments and other clinical waste were stored securely and safely disposed of.

The practice checked the Hepatitis B status of all staff and inoculation details were recorded in their individual staff files.

## **Staffing and recruitment**

The practice based its staffing requirements on its experience of how the practice had operated over the years and the care and treatment requirements of its patients. Consideration had been given to the treatments and care that patients required. Two practice nurse were employed along with two health care assistants who had received training to support the clinical staff with such things as asthma reviews.

Staffing levels were monitored and reviewed. We were told by the practice manager, and staff confirmed that administrative and receptionist staff were aware of each other's roles and so were able to stand in for each other in times of absence or busy periods

## **Dealing with Emergencies**

The practice had a written business continuity plan in place. The document detailed the responsibilities of the partners and the practice manager in the event of the plan needing to be implemented. We saw that the plan was reviewed and updated regularly. The plan covered eventualities such as the loss of computer system/essential data, incapacity of doctors or staff and loss of essential utilities. The plan was clear and told staff what to do in an emergency. Staff were aware of the plan and where to locate it. Staff we spoke with were clear about what action they should take in the event of an emergency.

## **Equipment**

There were policies in place for the safe use and maintenance of equipment. Medical equipment had been tested and re-calibrated where necessary. Portable electrical appliance testing had been regularly carried out on electrical equipment throughout the surgery. Fire extinguishers had been checked and fire alarm testing had been carried out.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Promoting best practice

The practice was able to demonstrate that patient care and treatment was delivered inline with best practice and recognised national standards. The practice routinely collated information regarding patients treatment and health outcomes. It used the Quality and Outcomes Framework (QOF) to assess performance. We saw evidence that where applicable the practice followed guidance issued by The National Institute for Health and Care Excellence (NICE).

The practice was a high achiever for key clinical outcomes such as cervical smears, childhood immunisations and QOF clinical outcomes.

We saw effective use of clinical templates to deliver consistent care for patients who were at the end of their lives.

### Management, monitoring and improving outcomes for people

We saw that clinical audits had been carried out, for example a completed audit on the repeat prescribing of topical steroids, ensuring that the use of medicines was appropriate and met the healthcare needs of patients.

The practice was able to demonstrate learning as a result of clinical peer review in areas such as cancer diagnosis, dermatology and orthopaedics.

### Staffing

The practice had a recruitment policy in place and we saw evidence that an appropriate process was followed when recruiting new staff. The practice ensured employees had the relevant skills, qualifications and experience to fulfil the role.

The practice checked that its doctors were correctly registered on the GP performers list. Regular checks were undertaken to ensure that GPs and clinical staff were registered with their appropriate professional body.

Staff told us that they received appraisals and that the process was supportive and positive. They also told us that training was readily available. We viewed the training that had been undertaken by staff and found it to be up to date and relevant to their role.

### Working with other services

The practice provided evidence of appropriate pro-active care, integrated with other professionals. There were monthly multi-disciplinary team meetings for end of life care with district and specialist nurses. Patient records could be accessed electronically by the out-of-hours service to ensure continuity of care.

Incoming correspondence relating to patient care and test results were reviewed by GPs who took the appropriate action. Recognised referral systems such as 'Choose and Book' with referral letters written by the GPs, were used to refer patients to other health care providers where that was necessary.

### Health, promotion and prevention

Health promotion literature was readily available to patients and was up to date. This included information about services to support them for example smoking cessation schemes, alcohol advice, meningitis, memory loss and student health. People were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice had taken a pro-active approach to promoting sexual health in young people. Chlamydia testing kits were freely available in the toilet and free condoms were available at reception.

A range of other health promotion and prevention services were available to patients including influenza vaccinations and cervical smears.

# Are services caring?

## Our findings

### **Respect, dignity, compassion and empathy**

We observed patients being treated with respect and dignity throughout our time at the practice.

Patients were given the time they needed to ensure they understood the care and treatment they required. Patients we spoke with confirmed that they never felt rushed and that their confidentiality was respected although they said that maintaining privacy at the reception area was an issue. We observed that patients could be overheard when speaking to the receptionist although we did note that the receptionist deliberately lowered their voice when addressing patients.

Following the death of a patient the practice was able to signpost the bereaved to a counselling service.

### **Involvement in decisions and consent**

Patients were involved in the decisions and gave consent regarding their care and treatment. For example we saw how patients who were regarded as vulnerable due to their age or frailty had consented to be included on an urgent care dashboard and their information shared with the out-of-hours service, physiotherapy and home care services.

Patients we spoke with all said that they felt fully involved and that the treatment choices and options were clearly explained.

The practice had access to telephone and in-person translation services for patients whose first language was not English and who may have difficulty in understanding the treatment options available to them.

Staff were conversant with the provisions of the Mental Capacity Act 2005 and the need to obtain informed consent before delivering care and treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. 40% of the practice list were patients aged between 17 and 25, many of whom were students. The practice had taken steps to ensure their healthcare needs were appropriately met through initiatives aimed specifically at this age group. The practice worked closely with healthcare professionals located in the university colleges to meet their needs. We saw how the practice was engaging with a particular college to allow the nurse there to work under the practice's existing nursing protocols. There was also work in progress to try and reduce the number of GP consultations taken up with minor illness and ailments that could be dealt with by the college nurses.

### Access to the service

The practice was located in a passageway in the centre of Cambridge and the access footpath was uneven and could be difficult for patients in wheelchairs to negotiate. This was beyond the control or influence of the practice. The surgery was located in a converted house and was laid out over several floors with the clinical treatment and consultation rooms being spread over four floors. A passenger lift was available for those patients who experienced difficulty using stairs.

The practice offered a choice of appointments including same day appointments, home visits for patients who were unable to attend the surgery and visits to care homes for those patients in residential care.

Information to patients about access to appointments was clearly displayed on the practice website and in the practice leaflet.

Patients we spoke with and comments cards we reviewed reflected the difficulty that some patients had experienced in getting an appointment on the day and at the time of their choice. We looked at the appointment booking system and saw that the next available routine pre-booked appointment for seeing a GP five days away. Patients in need of urgent and clinically necessary care were seen earlier through the duty doctor system or through patients using the same day clinic that was bookable on-line from 8pm the previous evening.

We saw that healthcare professionals had a designated telephone number which enabled them to access the practice which bypassed the practice telephone queuing system.

### Concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Seven complaints had been recorded in the past 12 months. We saw the practice's log and annual review of complaints it received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting. For example we saw how one complaint had resulted in an apology and had highlighted a training need that had been implemented.

The complaints process was accessible to patients. One patient we spoke with told us they had in the past had reason to make a complaint and that it was dealt with effectively and expeditiously.

# Are services well-led?

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

## Our findings

### Leadership and culture

We found the practice to be well led by an enthusiastic and knowledgeable practice manager. We were aware that they had taken up their post within the previous year. GP partners told us this had been a positive step and they felt the manager was making excellent progress and making much needed improvements. Staff we spoke with told us that the manager was approachable and was driven to improve the quality of care for patients.

Although there was no written strategy or long term plan for the practice in place, the manager told us that they often discussed longer term plans at the partners meetings. Staff we spoke with unanimously said that improving patient care was at the forefront of everything they did.

All the staff we spoke with said they felt valued and respected by the GPs and practice manager. There were regular practice meetings for clinical and non clinical meetings although the practice nurses had only recently been invited to the clinical meetings.

We were told by staff that the practice had arranged a team building exercise which all staff had taken part in. A member of staff told us that they felt like a 'whole team' and that all of the staff felt they were contributing to the team effort.

### Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for key areas such as medicines management, complaints and incident management, and safeguarding. Staff knew who held these lead roles. The responsibilities were shared between the doctors, nurses and the practice manager.

### Systems to monitor and improve quality and improvement

The practice had a system to assess and monitor the quality of service that patients received. We saw the provider carried out a number of audits designed to assess the quality of its services. Some of this monitoring was

carried out as part of the Quality and Outcomes Framework (QOF). This is an annual programme designed to identify good practice. The practice was able to demonstrate that it was achieving high QOF scores.

### Patient experience and involvement

Bridge Street Practice used the General Practice Assessment Questionnaire (GPAQ) to collect the views of patients attending the surgery in 2012/13 and 2013/2014. We viewed the results and found them to be positive. The results of the survey were available to view on the practice website.

We met with two members of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care. The practice manager was aware that the PPG for Bridge Street was not wholly representative of the practice population and there were few active participants. The practice manager was exploring ways of recruiting new members, especially from younger age groups to be more reflective of the patient demographic. However the group was consulted on a variety of issues affecting the running of the practice. We saw the most recent patient survey carried out by the group and the action points that the practice had taken from the survey. They included better training for reception staff, reviewing the practice website to provide more information for patients with chronic conditions and action to address the reasons for patients not keeping booked appointments.

We spoke with seven patients during the course of our inspection. They told us that the practice was clean, safe and that they felt they were properly involved in decisions and options regarding their care.

### Staff engagement and involvement

We saw that regular meetings were held for all staff at the practice that enabled staff, both clinical and administrative to express their views about the way the practice was run and how it was performing in meeting patients' needs. We viewed the minutes of the meetings and saw they had addressed a wide range of subject matters relating to patient care, welfare and safety.

# Are services well-led?

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

## **Learning and improvement**

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

## **Identification and management of risk**

We saw evidence that risks had been identified and action taken to minimise their potential impact. For instance we

looked at the business continuity plan for the practice. This helped ensure that the staff could respond in an appropriate manner in the event that circumstances adversely affected the delivery of care and treatment. We saw that a wide range of assessments had been completed to help identify and minimise the risk to patients, staff and others.

# Older people

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

## Our findings

The practice had entered all patients over 75 years of age on the caseload for Multi-Disciplinary Team (MDT) working. The MDT met monthly to discuss the needs of those patients. A GP and the MDT coordinator reviewed the MDT dashboard to look at current hospital admissions and discharges to ensure care plans were appropriate and implemented.

As part of the New Enhanced service for avoiding unplanned hospital admissions all patients over the age of

75 had been informed of their named GP. This was aimed at achieving continuity of care and reduce risk to patients. Patients in this group had been informed by letter who their named doctor was.

Very few, a total of 19, of the patients registered with Bridge Street Medical Practice were in nursing and residential care homes. Those few that were visited as required by their GP.

Home consultations were carried out by GPs for those older patients who are unable to attend the surgery.

# People with long term conditions

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

## Our findings

The practice had a GP who acted as the named lead in diabetes. We saw evidence that this GP worked closely with other GPs in the practice to manage those patients with the condition. The practice used QOF data and their own patient records to manage the recall of patients for review. Patients we spoke with confirmed they were invited to make an appointment in order to undertake a review of their condition and medication.

The practice was able to tell us the numbers of patients who were on the asthma and chronic pulmonary obstructive disease (COPD) registers. A GP was the named lead in these areas and supported the other GP in managing the conditions. In addition nurse led clinics were held for patients with upper respiratory tract conditions. A Healthcare Assistant had been trained to carry out asthma reviews and worked closely with the lead GP.

# Mothers, babies, children and young people

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

## Our findings

The practice worked with the other healthcare professionals, for example the Community Midwife to cater for patient needs. The midwife held a weekly clinic at the practice to carry out prenatal checks on expectant mothers. Blood for tests requested by the midwife were taken by practice staff. The practice nurses administered prenatal whooping cough vaccinations.

The practice had opted to undertake baby checks, normally carried out at six week, to be done at eight weeks of age. This allowed for the first immunisations to be

completed at one visit to minimise inconvenience to mothers. The GPs viewed this as safe and appropriate though there is a clear understanding that mothers were free to seek advice at any time if they had any concerns.

Due to the location of the practice has a high proportion of young people registered at patients. At the time of our visit 40% of patients were aged between 17 and 25. To meet the demands of this patient group the practice offered a nurse led young persons drop in clinic every weekday during term times from 11am to 12 noon.

The practice took a pro-active approach to improving the health and well being of young people and provided free condoms and chlamydia testing.

## Working age people (and those recently retired)

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

### Our findings

At the time of our visit we found that 90% of patients registered at Bridge Street were aged between 17 and 74 years. To cater for these patients the practice offered a range of clinics and appointments. These included; a same day clinic that ran for an hour daily and was bookable on

line from 8pm the evening before; pre-bookable GP, nurse and healthcare assistant appointments; extended access clinics which comprised a late evening and early morning clinic; home visits to those unable to attend the surgery and duty doctor clinics which predominantly provided telephone triage for urgent issues and enabled same day appointments to be made if necessary.

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

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

## Our findings

The practice was responsible for seeing patients from the local women's refuge. These are patients in very vulnerable circumstances, some of whom have children. The GPs and nurses supported this group of vulnerable mothers and children appropriately, including childhood immunisations, prenatal and postnatal checks.

Homeless people in need of routine healthcare were not seen at Bridge Street Medical Practice but were directed to the nearby access centre.

The practice accepted temporary patients in need and immediately necessary treatment.

Patients with learning disabilities and recorded on the register were recalled for their annual health reviews.

# People experiencing poor mental health

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

## Our findings

The practice had 90 patients on the mental health register. Patients were recalled for their reviews using data from the QOF system. Diagnostic tests were carried out within the practice as required.

The practice had extensive knowledge in treating patients experiencing anxiety, depression and stress related

disorders in the student population, in particular around the time of examinations. The practice worked alongside the university counselling service to deliver best outcomes for patients. One GP at the practice sat on the University Counselling Advisory Panel.

Information on how to contact counselling was clearly displayed in the surgery and patients could access the service directly without the need for a GP referral.