Abbey Medical Centre

Quality Report

42 Station Road
Kenilworth
Warwickshire
CV8 1JD
Tel: 01926 859955
Website: abbeymedicalcentre.co.uk

Date of inspection visit: 20 May 2014
Date of publication: 07/10/2014

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

Contents

Summary of findings

Overall summary

Abbey Medical Centre provides a range of primary medical services for just over 13,000 patients from a purpose built surgery in the centre of Kenilworth. There was building work being carried out during our inspection to extend the surgery and create space for an independent pharmacy.

The regulated activities we inspected were diagnostic and screening procedures, family planning, maternity and midwifery services, surgical procedures and treatment of disease, disorder or injury.

All the patients we spoke with were very complimentary about the service they received at the surgery. A representative of the patient participation group (PPG) described the ethos of the group as being the practice's 'critical friend'. The staff told us they felt valued, supported and motivated.

The partners at the practice adopted an informal approach to some leadership and governance issues. For instance, there were no regular team meetings and there was no formal process for staff to report significant adverse events. There was no evidence that this informal approach had caused the practice any problems because staff understood the working practices and cooperated well with each other. However, the practice may benefit from a more structured management approach.

We also looked at how services were provided for specific groups within the population. These were, vulnerable older people (over 75), people with long-term conditions, mothers, babies, children and young people, working age population and those recently retired (aged up to 74), people in vulnerable circumstances who may have poor access to primary care, and people experiencing a mental health problem. We found that the practice had adequate arrangements to look after the needs of the patients in these groups. The practice could consider having more proactive measures to identify and provide services for specific groups of patients.

The practice could consider ensuring more audit cycles are completed. The practice could also offer more flexible times for patients to attend clinics or appointments.

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 services at Abbey Medical Centre were safe. The practice had a good track record on safety. There was effective recording and analysis of significant events although there was no formal system to ensure that lessons learnt were always shared among relevant staff. There were robust safeguarding measures in place to help protect children and vulnerable adults. There were reliable systems in place to manage medicines in the practice effectively.

Are services effective?

The services at Abbey 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 audits of its activities but had not completed any clinical audit cycles. There was evidence of multi-disciplinary working and the practice was taking part in an initiative to reduce unplanned hospital admissions among its patients.

Are services caring?

The service at Abbey Medical Centre was caring. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who used the service in the weeks before our inspection and who completed a comment card were entirely 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?

There was an open culture within the organisation and a clear complaints policy. The service was responsive to people's needs although we did not see evidence of pro-active efforts to reach out to particular population groups. Patients told us that the appointment system at the practice worked well and that they could see the doctor of their choice with minimal delay. There was an open culture within the organisation and a clear complaints policy.

Are services well-led?

We found that the partners at Abbey Medical Centre had an informal leadership style and there were not always records of discussions or decisions. There was no formal long term strategy or business plan. There was a relatively recently formed patient participation group at the practice. Staff told us they felt supported and valued.

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 tailored to individual needs and circumstances. There were regular 'patient care reviews', involving patients and their carers where appropriate. Unplanned admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care.

People with long-term conditions
The practice supported patients and their carers to receive coordinated, multi-disciplinary care and retained oversight of this. The practice specifically reviewed unplanned hospital admissions for this group so that lessons could be learnt. The practice ran regular diabetic and asthma clinics.

Mothers, babies, children and young people
The practice worked with local health visitors to offer a full health surveillance programme for children under five. Checks were also made to ensure the maximum uptake of childhood immunisations. There were good links with local midwives who held clinics in the surgery twice a week.

The working-age population and those recently retired
Patients could also make appointments for telephone consultations. Appointments could be booked online. Patients were able to send fax requests for repeat prescriptions to save a journey to the surgery.

People in vulnerable circumstances who may have poor access to primary care
The practice had identified patients with learning disabilities. There was evidence of effective partnership working with the team for people with learning disabilities which also offered support for carers.

The practice told us that their population group did not contain significant groups of people in vulnerable circumstances and so it had not been necessary to make pro-active attempts to reach them.

Summary of findings

People experiencing poor mental health

The practice had a system for identifying and managing patients with mental illness. The was a wide range of support information for patients on the practice website. Doctors made appropriate referrals to specialist services when necessary. The practice had links with other services to ensure co-ordination of care.

Summary of findings

What people who use the service say

All the patients we spoke with were very complimentary about the service they received. Patients told us that reception staff were helpful and flexible, particularly with emergency appointments. Patients also told us that they were involved in decisions about their care and treatment, and that they were treated with dignity and respect.

We collected 12 comment cards from a box left in the surgery in the week before our visit. All the comments on the cards were very positive. In the most recent national GP patient survey, 88% of the practice's patients who responded said they would recommend Abbey Medical Centre to a friend. A member of the patient participation group at the practice told us that the group was still establishing itself as the surgery's 'critical friend'.

Areas for improvement

Action the service COULD take to improve

- The practice could introduce more formalised management systems and opportunities for information sharing and learning within the practice.
- The practice could consider ensuring more audit cycles are completed.
- The practice could offer more flexible times for patients to attend clinics or appointments.
- The practice could consider having more pro-active measures to identify and provide services for specific groups of its patients.

Good practice

Our inspection team highlighted the following areas of good practice:

- There was internal oversight of the performance of doctors at the practice which complemented the statutory revalidation process of GPs.

Abbey 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 general practitioner. The team included a second CQC inspector, a practice manager and an expert by experience. An expert by experience is a lay person with experience of using health services.

Background to Abbey Medical Centre

Abbey Medical Centre provides a range of primary medical services for just over 13,000 patients from a purpose built surgery in the centre of Kenilworth. There was building work being carried out during our inspection to extend the surgery to create space for an enlarged reception area and an independent pharmacy. At the time of our visit, the practice clinical team included nine doctors, four nurses and a health care assistant. The clinical staff were supported by a practice manager and an administrative and reception team. Abbey Medical Centre was an accredited teaching practice for recently qualified doctors wishing to become GPs, (registrars) but there were no registrars employed at the practice at the time of our inspection.

Why we carried out this inspection

We inspected this out-of-hours service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Before visiting, we reviewed a range of information we hold about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 20 May 2014. During our visit we spoke with a range of staff and spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We looked at comment cards left by patients who used the service in the week before our inspection. We reviewed national patient surveys and the practice's own patient survey.

Are services safe?

Summary of findings

The services at Abbey Medical Centre were safe. The practice had a good track record on safety. There was effective recording and analysis of significant events although there was no formal system to ensure that lessons learnt were always shared among relevant staff. There were robust safeguarding measures in place to help protect children and vulnerable adults. There were reliable systems in place to manage medicines in the practice effectively.

Our findings

Safe Patient Care

The practice had a good track record on safety. There were arrangements in place for reporting safety incidents but we were told that some incidents were raised verbally at meetings rather than recorded formally. There was no clear guidance as to when incidents should be recorded formally or discussed informally. Not all staff were aware of the significant event form on the practice intranet but they told us that they would raise any concerns with one of the doctors immediately. Staff told us they were confident that any concerns they had would be treated seriously and acted upon.

Learning from Incidents

There was a weekly clinical governance meeting where any significant events were discussed. There was no formal process for sharing learning from significant events with staff who did not attend the weekly clinical meeting. The notes of the clinical meetings were very brief and would be of little use to anyone who had not attended. We saw the note of a discussion about one significant event that simply reported that the event had been “signed off”. Staff told us there were no regular practice wide meetings or meetings for non-clinical staff at which learning from significant incidents could be effectively shared.

There was a named clinician with responsibility for receiving official alerts about medical devices and medicines. There was a procedure in place to ensure that this information was shared appropriately within the practice by email and at the weekly clinical meetings.

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. Effective safeguarding policies and procedures were in place and were fully understood and consistently implemented by staff. We saw that information about the local authority’s safeguarding process was readily available to staff. There was close cooperation with the local health visitors which helped to identify children at risk and keep them safe.

Are services safe?

Monitoring Safety & Responding to Risk

There were arrangements in place to ensure emergency cover for both administrative and clinical staff. None of the staff we spoke with could recall a time when they felt that staffing levels were inadequate. Patients also told us that there always seemed to be enough staff working at the practice.

The practice had carried out an audit of nurse appointments to help determine the number of nursing staff needed at different times of the day. The practice manager also told us that they regularly discussed staffing levels with the reception and administrative teams and adjusted rotas in response to any changing need. Staff told us that they would feel able to raise any concerns with the practice manger or a doctor and that they would be listened to.

We saw that the practice had a supply of medicines and equipment for use in an emergency. These were securely stored. We saw that regular checks had been carried out to ensure that the medicines and equipment were readily available and had not passed their expiry date.

Medicines Management

There were appropriate arrangements in place for the obtaining, recording, handling, using, storage, and disposal of medicines.

The practice had policies and practices in place to ensure the appropriate storage of temperature sensitive vaccines. The staff we spoke with were aware of the importance of storing and transporting vaccines at an appropriate temperature and were familiar with the practice's own guidelines. We saw records to show that checks were regularly made on the temperature of the fridge to ensure it remained within acceptable limits.

We looked at how controlled drugs were managed. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse. We found that the controlled drugs were stored, recorded and checked safely.

Cleanliness & Infection Control

The practice had a named nurse as the designated lead for infection control issues. The surgery building looked clean throughout. There was effective protection in place to prevent dust from the building works entering the surgery. There had been a full infection control audit at the surgery in January 2014. We saw an action plan that had resulted from the audit. The plan identified individual members of staff responsible for ensuring that the minor improvements required were made. We saw that the plan was up to date and all the required improvements had been implemented.

There was an adequate supply of personal protective equipment in the consultation and treatment rooms. There were hand gel dispensers around the building for patients to use to help prevent cross infection.

Staffing & Recruitment

Although the practice did not have a formal recruitment policy in place, a recruitment process was followed. Enhanced disclosure and barring service (DBS) checks were carried out on all nursing staff and health care assistants to ensure their suitability to work with vulnerable patients.

The practice checked that its doctors were correctly registered on the GP performers list. Doctors must have had a DBS (or old style criminal records bureau - CRB) check to be added to the GP performers list so the practice did not carry out its own additional checks. There were no DBS checks carried out on reception or administrative staff. Although such checks are not required on non-clinical staff they are available, but the practice did not have a rationale for not doing carrying out the checks.

We found evidence that written references were sought and obtained for some staff. We were told that telephone references were obtained for other staff but there were no records to support this.

Dealing with Emergencies

There was not a formal business continuity plan to help the practice cope with a major incident. However, we were told about contingency plans to deal with a major IT failure at the practice which could also be put into action if the whole building became unusable. Copies of key documents, emergency telephone numbers, a dicta-phone and prescription pads were kept in two secure boxes away from the surgery. One was at a doctor's house. The other was at another local GP surgery where it would be possible for Abbey Medical Practice to relocate temporarily if necessary.

We saw a written contingency plan to cover unexpected staff absences. The plan was clear about roles, responsibilities and levels of authority that individual staff would have in certain circumstances.

Are services effective?

(for example, treatment is effective)

Summary of findings

The services at Abbey 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 audits of its activities but had not completed any clinical audit cycles. There was evidence of multi-disciplinary working and the practice was taking part in an initiative to reduce unplanned hospital admissions among its patients.

Our findings

Promoting Best Practice

The practice participated in recognised clinical quality and effectiveness schemes such as the national Quality and Outcomes Framework (QOF) and local CCG led enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care in general practice.

The doctors at the practice met formally on a quarterly basis to discuss clinical issues. The agenda included any new guidelines from the National Institute for Health and Care Excellence (NICE). The doctors told us that they also met informally every lunchtime and were able to raise any cases they wished to discuss with their colleagues. They also told us that they held weekly meetings to discuss every patient referral made that week. This review process helped to ensure that doctors learnt from each other and that referrals were made appropriately.

Clinicians we spoke with were confident in describing the processes to ensure that written informed consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults and how to assess the competency of children and young people to make decisions about their own treatment.

Management, monitoring and improving outcomes for people

The practice was aware of data from the general practice outcome standards (GPOS) quality assurance scheme. This suggested that its performance was slightly worse than average in relation to the admission of diabetes patients to hospital and the prescribing of non-steroidal anti-inflammatory drugs (NSAID). Neither of these issues was of significant concern but the practice was able to show us how they had addressed both and had been able to bring their performance back in line with the national standards.

We saw evidence of a number of clinical audits carried out at the practice. The results of audits of minor operations, coil implants, and shoulder injuries had been discussed at

Are services effective?

(for example, treatment is effective)

a recent clinical meeting. The practice told us that they had not yet completed the cycle for any of these audits in order to demonstrate an improvement in performance stemming from any lessons learnt.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess performance.

We also saw the results of an audit of new and follow up consultations. The audit identified that a high proportion of follow up appointments could have been managed by telephone, but no action plan had been produced to help achieve this objective.

Staffing

The practice carried out its own appraisals of the performance of doctors working at the surgery on an annual basis. It did this to help doctors develop their skills and expertise alongside the more formal five year revalidation cycle that GPs undergo.

The nursing staff told us that they had weekly clinical supervision sessions and monthly team meetings. We saw the notes of the most recent nurse team meeting where the practice's Quality and Outcomes Framework (QOF) performance was discussed. Nurses also told us that they had annual appraisals that were good at identifying training needs. Nurses received six to eight days of mandatory training and were supported to complete additional continuous development in line with the requirements of their professional body.

We saw completed annual appraisals for several staff that included details of development needs and objectives for the coming year. Staff told us that the annual appraisal system had recently been improved in response to staff comments and they now found the process to be constructive and helpful.

There were regular 'educational meetings' held at the practice, mainly for clinical staff. We saw that recent topics discussed included Parkinson's disease and genetics.

We found that staff had undertaken training appropriate to their role. Some training was carried out online and some in small groups. The practice manager was developing a spread sheet to keep better track of when staff training was due to be updated or renewed.

Working with other services

There was evidence of effective multi-disciplinary team working at the practice. A multi-disciplinary palliative care meeting was held every two months to discuss patients receiving end of life care. The meeting was attended by doctors and nurses from the practice along with community nurses and Macmillan nurses where appropriate. The practice used a traffic light system to help prioritise care. Relevant information about patients receiving end of life care at home was shared effectively with the out of hours service to ensure good continuity of care.

We also saw that doctors met with clinical colleagues regularly to discuss patients with long term medical conditions.

We were told that information about patients seen by the out of hours service was reviewed daily by the on call doctor at the practice. If follow up was necessary by a specific doctor to achieve continuity of care then this was actioned.

Health Promotion & Prevention

We saw that new patients were invited into the surgery when they first registered to ascertain details of their past medical and family histories. They were also asked about social factors including occupation and lifestyle, medications and measurements of risk factors.

Health promotion literature was readily available to patients and was up to date. This included information about services to support them in smoking cessation schemes for instance. People were encouraged to take an interest in their health and to take action to improve and maintain it. Doctors told us that they considered it an important part of their role to advise patients on the effects of their life style choices on their health and well-being.

The practice proactively identified patients who were also carers and offered them additional support. Staff and clinicians were automatically alerted to patients who were also registered as carers. This ensured that doctors were aware of the wider context of the person's health needs. Carers could also be referred to external carer support organisations that could provide additional practical and emotional support.

The practice had a self-service machine to take patients' blood pressure and calculate their body mass index. No appointment was necessary to use the machine and all

Are services effective?

(for example, treatment is effective)

patients were encouraged to use it. We were told by staff that a print out of the results for each patient was reviewed by a nurse who could refer the patient to a doctor if necessary.

Are services caring?

Summary of findings

The service at Abbey Medical Centre was caring. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who used the service in the weeks before our inspection and who completed a comment card were entirely positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

Our findings

Respect, Dignity, Compassion & Empathy

All the patients we spoke with during our inspection were complimentary about the service they received at Abbey Medical Practice. Patients particularly commented on the doctors' good communication skills, the care and time they were given during consultations and the considerations made for their privacy. We particularly asked patients about privacy and confidentiality as building work in the surgery meant that there was a cramped temporary waiting room with a freestanding reception desk close to patient seating. None of the patients we spoke with felt that their privacy or confidentiality had been compromised. The practice had attempted to minimise the risk of confidentiality being breached by displaying signs asking patients to stand well back from the person at the desk in front of them and by offering a private room for more confidential discussions.

We saw details of the system in place for a doctor to telephone a patient's relative a little while after the patient died. This enabled the doctor to assess the health and wellbeing of the bereaved person. The doctor always offered to visit the relative to offer support and answer any questions they might have. The practice was also able to refer patients to external bereavement counselling services if required.

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

Involvement in decisions and consent

Patients told us they felt that they had been involved in decisions about their own treatment and that the doctor gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

Doctors told us that when they obtained verbal consent from patients for a particular treatment, this was recorded in the patient's notes. We saw the forms used to gain written consent from patients undergoing minor procedures requiring local anaesthetic at the surgery. The forms covered the potential side effects and the alternatives to the treatment proposed.

We saw the practice's consent policy and its guide to the Mental Capacity Act 2005 (MCA) which provided staff with

Are services caring?

information about obtaining consent on behalf of patients who lacked the capacity to make their own decisions. Clinicians were aware of patients who needed support from nominated carers and ensured that carers' views were listened to as appropriate.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

There was an open culture within the organisation and a clear complaints policy. The service was responsive to people's needs although we did not see evidence of pro-active efforts to reach out to particular population groups. Patients told us that the appointment system at the practice worked well and that they could see the doctor of their choice with minimal delay. There was an open culture within the organisation and a clear complaints policy.

Our findings

Responding to and meeting people's needs

The practice had not undertaken any particular work to pro-actively identify and provide services for specific groups of its patients. We were told that the local population was relatively affluent and there were no real issues with deprivation. Staff told us that they treated all patients as individuals and did not judge anyone according to their personal circumstances or beliefs.

The practice was based in a purpose built surgery. There was access for people with mobility problems. There was an accessible toilet, and baby changing facilities. The building was being extended to create a larger more comfortable reception area. There were plans in place to ensure the new reception desk was accessible to patients with a disability. We saw a 'disability protocol and checklist' which had only been partially completed. There was no action plan to address the improvements identified as required in the checklist.

We were told that the surgery liaised with the local Age Concern charity to help promote its annual flu vaccination programme.

The practice's website included links to a range of basic information about the NHS in a number of different languages.

Access to the service

Appointments at the surgery could be made by telephone, online or in person. In a recent survey at the practice, only 5% of patients said they used the online booking service. Patients could book appointments with a doctor of their choice up to one month in advance. Most of the practice's appointments were released at 8.30am each morning for same day consultations. The practice had recently introduced a new telephone system for handling calls. A recent survey of patients showed that some patients were unhappy with the time it took for their call to be answered once they got through. Some were unhappy that they continually got an engaged tone. Others said they were happy with the system.

Patients could also order repeat prescriptions online. This service was used by 25% of patients who responded to the practice's survey.

Are services responsive to people's needs?

(for example, to feedback?)

The surgery was open five days a week during standard hours. There were no extended opening hours to assist people who worked during the day.

The practice's website was designed so that patients could change the style, size and colour of the font used, as well as the background colour. This was particularly useful to patients with a visual impairment.

Concerns & Complaints

There was a complaints process publicised in the waiting room, on the practice web site and in the practice leaflet.

The practice web site included details of an advocacy group that could support patients wishing to complain. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

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.

Are services well-led?

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

Summary of findings

We found that the partners at Abbey Medical Centre had an informal leadership style and there were not always records of discussions or decisions. There was no formal long term strategy or business plan. There was a relatively recently formed patient participation group at the practice. Staff told us they felt supported and valued.

Our findings

Leadership & Culture

There was no written strategy or long term plan for the practice in place. We were told that the partners in the practice often discussed longer term plans informally but they did not feel it necessary to record these discussions. There were no practice wide objectives in place to drive the quality of care up. The partners told us that they preferred an informal approach to leadership.

We asked about the planning for the extension to the surgery building. We were told that the partners had discussed and agreed the extension but that there was never a formal proposal for them to consider.

There were plans to build 1,000 new homes within the practice's catchment area over the next two to five years. We were told that there had been informal discussions about the plans with the only other general practice in the town but no definite proposals had emerged for coping with the increased patient numbers.

Partners were visible within the practice and staff told us that they were approachable and receptive to their ideas. Staff described an open and transparent culture in which they felt supported, motivated and valued. Practice meetings were held when required.

Governance Arrangements

The practice adopted an informal approach to some governance issues. Although there were nominated GP leads for most areas, there was little evidence of formal terms of reference, objectives, action plans or meeting notes for governance activities. There was no formal register of corporate risks at the practice but we saw evidence that some risks had been identified and action taken to minimise their potential impact. For example, there was a contingency plan in place to deal with unexpected staff absences.

Systems to monitor and improve quality & improvement

The practice had carried out a number of audits that had produced good quality clinical and management information, but there were no processes in place to ensure that this information was used effectively to improve performance.

Are services well-led?

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

Patient Experience & Involvement

There was a patient participation group (PPG) at the practice. A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The group's membership had dwindled in 2013 so a new steering group was established to recruit new members and increase its effectiveness. A member of the PPG steering group told us that the PPG's ethos was to act as the practice's 'critical friend'. We saw evidence that the group had been consulted about the most recent patient survey questions. We also saw that the group had been given the opportunity to comment on the building works currently underway at the surgery.

The most recent patient survey concentrated on communication with the surgery. Patients were pleased that the surgery's old 0844 telephone number had been replaced with a local number as this saved money for most people. The practice used the survey to ask patients various questions about how communication might be further improved.

Staff engagement & Involvement

We spoke with nine members of staff during our inspection. Staff told us they enjoyed working at the practice and felt supported by the partners and the practice manager. We were told they attended a range of regular training. The staff told us that there were no regular team meetings, such as department meetings or whole practice meetings. This limited the opportunities for learning to be formally shared among staff.

Identification & Management of Risk

There was no formal register of corporate risks at the practice but we saw evidence that some risks had been identified and action taken to minimise their potential impact. For instance there was a contingency plan to deal with unexpected staff absences.

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

Care was tailored to individual needs and circumstances. There were regular 'patient care reviews', involving patients and their carers where appropriate. Unplanned admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for their care.

Our findings

The practice actively targeted older people to attend surgery for 'flu vaccinations. Patients who attended for 'flu vaccinations or a health check were always offered additional relevant health information. Housebound patients were visited by the nurse for routine 'flu vaccinations

All patients over the age of 75 were being provided with a named GP to help achieve continuity of care and reduce risk to patients.

The practice undertook work to review older patients who had frequent unplanned hospital admissions and readmissions. This was to identify any unmet health needs or need for education regarding management of their condition to prevent subsequent admissions.

People with long term conditions

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

Summary of findings

The practice supported patient and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. The practice specifically reviewed unplanned hospital admissions for this group so that lessons could be learnt. The practice ran regular diabetic and asthma clinics.

Our findings

The practice proactively managed patients with long term conditions by routinely offering patients a

review to assess, monitor and offer advice on how to manage their condition. The staff told us the practice kept a register of patients with chronic long term conditions and employed a nurse with additional training in chronic disease management. We were told that patients with conditions such as chronic obstructive pulmonary disease (COPD), dementia and coronary heart disease were invited for an annual review of their mental and physical health needs and their carers were encouraged to attend.

We saw evidence that all patients with unplanned hospital admissions and readmissions were regularly reviewed to identify any gaps in treatment or education regarding self-management.

We found there were links with different members of the multi-disciplinary team which enabled co-ordination of care to patients in this group.

Mothers, babies, children and young people

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

Summary of findings

The practice worked with local health visitors to offer a full health surveillance programme for children under five. Checks were also made to ensure the maximum uptake of childhood immunisations. There were good links with local midwives who held clinics in the surgery twice a week.

Our findings

The practice offered services for mothers, children and young people in a safe environment providing staff who were trained in safeguarding procedures. Childhood vaccinations and medical examinations were offered to pre-school children and there was signposting to local health visiting services. Parents were able to access a doctor quickly for urgent childhood illness. The practice provided contraceptive treatments and family planning advice. Local midwives held a clinic in the surgery twice a week which meant that expectant mothers could receive care and treatment locally.

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

Patients could also make appointments for telephone consultations. Appointments could be booked online. Patients were able to send fax requests for repeat prescriptions to save a journey to the surgery.

Our findings

Patients who needed to speak to a doctor but did not need to visit the surgery were able to book a telephone appointment. This was particularly useful for people who found it difficult to visit the surgery during the working day. The practice regularly monitored the availability of appointments and consulted patients about their experience of obtaining convenient appointments.

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

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

Summary of findings

The practice had identified patients with learning disabilities. There was evidence of effective partnership working with the team for people with learning disabilities which also offered support for carers. The practice told us that their population group did not contain significant groups of people in vulnerable circumstances and so it had not been necessary to make pro-active attempts to reach them.

Our findings

The practice had good links with the team for people with learning disabilities and made referrals appropriately for those patients who needed support.

There were no pro-active approaches to reaching out to other vulnerable groups but staff told us they were confident that patients could feel able to access the practice's services without fear of stigma or prejudice

People experiencing poor mental health

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

Summary of findings

The practice had a system for identifying and managing patients with mental illness. The was a wide range of support information for patients on the practice website. Doctors made appropriate referrals to specialist services when necessary. The practice had links with other services to ensure co-ordination of care.

Our findings

The staff told us that they identified patients with mental health problems and ensured that these patients were offered a routine annual health check. The practice had established links with the community mental health team and we saw evidence that they provided information to patients about the Improving Access to Psychological Therapies (IAPT) service where appropriate. This enabled patients with mental health problems to access other services for additional specialist support. There was further information and links to other support organisations on the practice website.