Primary Medical Services
Population Group Guidance

This guidance is designed to support inspection teams to gather evidence for the population groups in order to answer the Key Lines of Enquiry for the key questions (safe, effective, caring, responsive and well-led). There are a very small number of additional prompts for the population groups which are included below. The rest of the guidance describes evidence relating to the six population which should be considered alongside the evidence gathered that applies to the whole practice population.

Older people		
Relevant KLOE and any additional prompts		**Evidence**
Safe S3		• Staff able to recognise signs of abuse in older people and know how to escalate or refer these concerns
Effective E1		• Register of older people who need extra support • Regular review of unplanned admissions and readmissions and action taken. • Provision of unplanned admissions enhanced service. For the 2% of patients who are at high risk of unplanned admissions. Includes: regular review of personalised care plan; appointment of a care coordinator (can be the GP) to oversee the care plan, making sure the patient (and/or their carer) is informed of changes and updated at regular intervals • Follow up consultations take place with older people following discharge from hospital and care plan is updated to reflect any additional needs. • Structured annual medication reviews for older people - levels of polypharmacy routinely reviewed and current medications are linked to a disease/problem. • Cognition testing including memory assessments have been offered, taken up or declined in records
Effective E3		• Staff recognise the particular needs of older people with multi-morbidities, frailties and complexities • Staff knowledge of treating older people including their physiological, mental and communication needs.
Effective E4	**Additional prompt:** how is care delivered in a way that minimise disruption and inconvenience to the older person and to support them to receive care in a coordinated way, particularly where they have complex needs?	• Involvement in multidisciplinary discussions. • Provision of enhanced service: Named GP work to with relevant associated health and care professionals to deliver a multidisciplinary care package that meets the needs of the older person

Effective E5	• Where older people have complex needs, special patient notes or summary care records are shared with local care services, including NHS 111, GP out-of-hours services and the local A&E department • EoLC information is shared with other local services
Effective E6	• Preplanning for EoLC where patient still has ability to consent • EoLC planning or declining of conversation about Eolic has taken place
Effective E7	• Health promotional advice and material supports older people to maintain their health and be as independent as possible • Vaccine uptake rate for older people including Flu, Pneumococcal, shingles
Caring C3	• Record of assessment of older people for anxiety and depression • Elderly carers given appropriate and timely support. • Support for isolated or house bound patients including signposting to support services or volunteer services such as local community groups/activates or charities such as Age UK, Contact the Elderly with help for mobility issues.
Responsive R1	• Home visits are available where needed • Longer appointments when needed
Responsive R3	• Same day telephone consultations where appropriate

People with long term conditions		
Relevant KLOE and additional prompts		**Evidence**
Safe S4	**Additional prompt:** How do staff identify and respond to changing risks to people who use services, including deteriorating health for people with long term conditions?	• Emergency processes and referrals for people with long term conditions that have a sudden deterioration in health
Effective E1		• Referrals for people diagnosed with a long term condition or for diagnosis of a long term condition in line with best practice • Regular review of unplanned admissions and readmissions with actions taken • Provision of unplanned admissions enhanced service. For the 2% of patients who are at high risk of unplanned admissions • Regular review of personalised care plan • Appointment of a care coordinator (can be the GP) to oversee the care plan, making sure the patient (and/or their carer) is informed of changes and updated at regular intervals • Structured annual medication reviews – levels of polypharmacy are routinely reviewed to

		make sure current medications are linked to a disease/problem. • Register of people with long term conditions • Use of relevant NICE guidelines for long term conditions
Effective E3		• Staff training knowledge of treating people with multiple long term conditions
Effective E4	**Additional prompt:** how is care delivered in a way that minimise disruption and inconvenience to the older person and to support them to receive care in a coordinated way, particularly where they have complex needs?	• Involvement in multidisciplinary discussions. Named GP work with relevant associated health and care professionals to deliver a multidisciplinary care package that meets the needs of 2% of patients with LTCs that have the most complex needs. • Follow up consultations take place with people with LTC/s following discharge from hospital and care plan is updated to reflect any additional needs.
Effective E5		• Summary care records and special patient notes are shared with local care providers • EoLC information is shared with local care services
Effective E7		• Identification of people at risk of developing LTCs and proactive action taken to monitor their health and help improve their lifestyle. • Health promotional advice, information and referral to support services take place including smoking cessation, obesity checks • People with LTCs provided with advice and/or referred to other services to support them to live healthier lives
Caring C3		• Recognition of links between long term conditions and mental ill health. Assessment for anxiety and depression
Responsive R1		• Longer appointments where necessary • Home visits where necessary
Responsive R3		• Same day telephone consultations where appropriate

Families, children and young people	
Relevant KLOE and additional prompts	**Evidence**
Safe S3	• Identification and follow up of children, young people and families living in disadvantaged circumstances (including looked after children, children of substance abusing parents and young carers) • System for identifying children and young people with a high number of A&E attendances • Attendance at children protection hearings and SCRS where appropriate. Reports are sent if they are unable to attend.

Safe S4	**Additional prompt:** How do staff identify and respond to changing risks to people who use services, including acutely ill children, young people and pregnant women?	• Emergency processes and referrals are in place for acutely ill children and young people • Emergency processes are in place for acute pregnancy complications
Effective E1		• Identification and review for newly pregnant women on long term medication • Antenatal referrals, post -natal mental health, issues around pregnancy and complex social factors
Effective E4	**Additional prompts:** How is care delivered in a coordinated way when different teams or services are involved, including joint working with midwives, health visitors and school nurses? How is care delivered in a coordinated way when different teams or services are involved, including involvement in developing a plan of care for children with complex needs who are transitioning into adult services?	• Joint working with midwives, health visitors and school nurses. • Practice involvement in developing a plan of care for children with complex care needs transitioning into adult services including Engagement with Team around child (TAC) • Support for premature babies and their family following discharge from hospital
Effective E6		• Staff knowledge of relevant guidance - Gillick competencies • Contraception for children and young people
Effective E7		• Children immunisation uptake, follow up for patients who do not attend • Health promotional advice, information and signposting to support organisations and services is available for children and young people, including for sexual health clinics and mental health services
Caring C1		• Confidentiality and privacy for children and young people
Caring C2		• Children and young people treated in an age appropriate way, recognised as individuals and preferences • Practice uses 'You're welcome' (DH quality criteria for young people friendly health services)
Responsive R1		• Appointments available outside of school hours for children and young people • Suitable premises for children and young people • Joint working with STI clinics

Working age people (including those recently retired and students)	
Relevant KLOE and additional prompts	**Evidence**
Effective E7	• Uptake rate for health checks (40-74 year olds) • Proportion in this group with blood pressure checks (QOF) • Uptake rate for cervical screening, including follow ups • Record of smoking status including referral to smoking cessation services if needed (QOF) • Health promotional advice is offered and material is easily accessible, including on website • Medical certificates/fit notes are audited
Responsive R1	• Understanding of student population and working age population and services reflect this. • Extended opening hours
Responsive R3	• Online booking system available and easy to use • Text message reminder for appointments and test results • Online or telephone consultations where appropriate • Support to enable people to return to work

People whose circumstances may make them vulnerable	
Relevant KLOE and additional prompts	**Evidence**
Safe S3	• Identification of people at risk of abuse and follow up actions taken • Systems for sharing information about people at risk of abuse with other organisations where appropriate
Effective E1	• Practice register for different groups of people living in vulnerable circumstances • Register of people with learning disabilities. • Effective annual health checks for people with learning disabilities and proactive follow up (enhanced service). Consideration of RCGP guidance Step by Step Guide for GP Practices: Annual Health Checks for People with a Learning Disability including annual thyroid function tests for patients with Down's syndrome. (Currently priority patients are adults over 18 years old with severe or moderate learning disabilities.) Routine blood tests are arranged at least 1 week in advance of health checks

Effective E4	• Links into Community Learning Disability team for training and checking the practice's LD register
Effective E6	• Staff understanding of the Mental Capacity Act Code of Practice
Effective E7	• Health promotional advice and information is given including smoking cessation, breast screening, cytology • Signposting to support organisations and third sector organisations • Signposting to the availability of sexual health assessments for those at high risk
Caring C1	• Staff interact with all people in a respectful and considerate manner. • There is a private area for speaking at the reception, receptionist offers the option for privacy • Same sex clinicians are offered where appropriate
Caring C2	• For people with learning disabilities, there is liaison with their families, carers or Community Learning Disability team
Responsive R1	• Partnership working to understand the needs of the most vulnerable in the practice population. Including working with the CCG, third sector organisations, local health authority public health department • Longer appointments for those that need them • Flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful
Responsive R2	• Register of people who may be living in vulnerable circumstances. • Follow up of people who 'did not attend' appointments • System for flagging vulnerability in individual records. • People are easily able to register with the practice, including those with "no fixed abode" care of the practice's address • People not registered at the practice are able to access appointments through drop in services available • There is a system to communicate with people of "no fixed abode" • Links to Community Team for publicising the value of health checks

People experiencing poor mental health (including people with dementia)		
Relevant KLOE and additional prompts		**Evidence**
Safe S4	**Additional prompt:** How do staff identify and respond to changing risks to people who use services, including people going through a mental health crisis?	• Staff able to identify and respond to a person experiencing a mental health crisis, including supporting them to access emergency care and treatment • Monitoring of repeat prescribing for people receiving medication for mental health needs (including where people do not request an expected repeat prescription)
Effective E1		• Consideration of physical health needs of people with poor mental health. Annual health check for people with serious mental health illness (QOF) • Consideration of the impact on mental health of long-term conditions or co-morbidities. • Prescriptions reviewed • Identification of people who may have poor mental health or dementia • Referral of people with poor mental health including dementia to enable them to access a variety of treatments (including listening and advice, IAPT and counselling) • Follow up after a patient attends A&E where there may be mental health needs (including attendances as a result of self-harm) • Prescribing data (including prescribing of antipsychotics) • People at risk of dementia and identified and offered an assessment to detect for possible signs of dementia. Where dementia is suspected, referral for diagnosis. In cases of diagnosis, provide advanced care planning (Dementia enhanced service)

Effective E3		• Staff skills and competencies to
		  ○ Assess and respond to risk for patients or mental illness (inc. suicide prevention)
		  ○ Recognise and manage referrals of more complex mental health needs to appropriate specialist services
		  ○ Identify and respond to people showing signs of dementia
		• Staff training in providing care for people with mental health needs

Effective E4		• Partnership working with local services to ensure people experiencing poor mental health are supported
Effective E5		• Summary care records and special patient notes shared with relevant local care providers
Effective E6		• Advance care planning for people with dementia, in line with the person's wishes (Dementia enhanced service)
Effective E7		• Health promotional advice and information is given and people are signposted to support organisations including peer support and help with self-management such as MIND, SANE, Mental Health Foundation • Increase health and well-being support offered to carers of patients diagnosed with

	dementia (Dementia enhanced service)
Responsive R1	• Mental health needs of the practice population including within hard to reach groups is monitored and informs service provision • Longer appointments for those that need them • Flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful