

The 6 CQC population groups: WHY does caring for each of the population groups matter?

'It is our job not to impart power on the people we provide care to, but to help them find their power to lead their lives the way they want to. This is true for every population group we provide care to.' Dr Liz Dawson

Note: This list has been generated through a combination of what our services already offer combined with a desk top review of a series of 'outstanding' CQC reports

| Population Group | Older People |
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| CQC Definition | <p>This group includes all people in your practice population who are aged 75 and over.</p> <p>It includes those who have good health and those who may have one or more physical or mental long-term conditions.</p> <p>It includes people who are living at home as well as those who are in a care home or a nursing home, where your practice provides general medical services to these people.</p> <p>For this population group, an inspection will focus on the role of the GP practice in developing a proactive and personalised programme of care and support, which is tailored to the needs and views of older people registered with the practice.</p> |
| Our ELFT Primary Care 'WHY' | <p>For older people life can be challenging, frustrating and lonely. Advancing age can bring problems with ill-health, caring responsibilities, social isolation, fear and frustration. Whilst our bodies age our minds often stay young and the physical limitations of older age can cause sadness, fear and frustration. Requiring the help of others can make it difficult to maintain dignity.</p> <p>The care we provider to older adults can help people to feel connected and less lonely, reduce fear and anxiety and help people to stay in control of their health and decisions about their lives.</p> <p>Providing the best care to older people should enable people to have the power and autonomy to make choices about their care and to live with dignity and in comfort.</p> |
| What an outstanding offer to older people includes | <ul style="list-style-type: none"> • Health Fayres • End of life MDTs for preferred place of death • Access to a holistic wider workforce • face to face comprehensive health check / MOT annually. • Work with Groundswell regarding an event eg a tea party for them • 6 monthly welfare check by social prescriber/admin eg need new glasses/ any concerns • carers service • Hot meals service • Flu Clinics • Outreach • any transport that is needed for their hospital appointment in association with Groundswell • Monthly MDT • Monthly MDT with care homes • Social Prescribers (Wellbeing Calls) • Calls to those shielding • Named GP for all patients of this age group • CMC (For EOL) • The practice ran community-based groups including health coaching and access to exercise, cooking etc • The practice ran initiatives to reduce social isolation • Medication Reviews • Weekly Care Home Ward Rounds with a named GP • Annual Checks • Continuity of care • All patients had a named GP who supported them in whatever setting they lived. • The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • A clinician visited weekly all seven care homes in the local area to provide training and advice to staff. This had led to an 80% reduction in home visit requests from care homes and a reduction of 30% in all home visits |

| Population Group | People with long term conditions |
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| CQC Definition | <p>People with long-term conditions are those with an ongoing health problem that cannot be cured. Long-term conditions can be managed with medication and other therapies.</p> <p>Examples of long-term conditions are diabetes, cardiovascular disease, musculoskeletal conditions, chronic obstructive pulmonary disease (COPD), long-term neurological disorders (such as epilepsy), HIV or cancers (this list is not exhaustive).</p> <p>This population group does not include people with long-term conditions who are aged 75 and over as they are included in the older people population group.</p> <p>It does not include children or young people under the age of 18 with long-term conditions, as they are included in the families, children and young people population group.</p> |
| Our ELFT Primary Care 'WHY' | <p>Ill-health at any point in a person's life can be frightening and frustrating. It is our role, when working with people living with a long-term condition, that we work in partnership and help people to make their own choices about their health care.</p> <p>To ease people's frustration and fear it is our job to provide information in a way that makes sense for individuals, to provide choices in treatment options that suit the individual we are caring for.</p> <p>Our role is to help people maintain good health and this needs to be done in partnership at every step.</p> |
| What an outstanding offer to People with long term conditions includes | <ul style="list-style-type: none"> • Health Fayres • Engagement with established volunteer groups • Access to a holistic wider workforce • Proactive chronic disease management • Risk stratification • Care planning and carer identification • Improving links with local services • Clinical pharmacist • LTC reviews are held at the practice. • Call and recalls are done regularly. • Aim to get everything done for the patient in 1 visit or as less as possible visits • Offer free space (time to talk) where patients can attend with anything they want to speak about • Usual regular reviews • Regular programme of events in our new space upstairs eg. • Healthy eating on a budget • Stress busters • Exercises • Benefits Advice • Group consultations • Dialog+ for areas such as medically unexplained symptoms • We plan to involve the local community and Groundswell and AARS staff on this • Named GP for patient with 3 or more LTC. • Chronic Disease Management. • MSK Physiotherapist. • Individuals Care Plans. • PCN Physiotherapist on site • PCN Paramedic will be available for clinicians to use when need. • A Social prescriber is also on site • We have a diabetic and an Asthma nurse • Proactive chronic disease management • Risk stratification • Care planning and carer identification • Improving links with local services • Clinical pharmacist • Referrals made to initiatives such as Desmond |

- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

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| Population Group | Families, children and young people |
| CQC Definition | <p>This group includes expectant and new parents, babies, children and young people.</p> <p>For parents, this includes expectant and new parents only, and includes prenatal and antenatal care and advice, where provided by the GP practice.</p> <p>We will consider the specific services that a practice provides, including whether it is registered with CQC to provide the regulated activity of maternity services, as this will influence the level of services a practice can provide to mothers.</p> <p>For children and young people, we will use the legal definition of a child, which includes young people up to their 18th birthday.</p> |
| Our ELFT Primary Care 'WHY' | <p>The demands families face can be hugely challenging. The impact good early years care can have on children and their families is massive and far reaching.</p> <p>Conversely the impact of educational challenges, housing difficulties, poverty, parental ill-health and lack of support cannot be under-estimated. In caring for children, families and young people we have an opportunity to have a life-long impact.</p> <p>With the demands on families we need to ensure we are able to provide convenient, joined up and holistic care.</p> |
| What an outstanding offer to Families, children and young people includes | <ul style="list-style-type: none"> • Health Fayres • Engagement with established volunteer groups • Multi agency partnership working across health, housing and care • Access to a holistic wider workforce • A youth club • CYP PPG / Forum • Involve young people in our service either in volunteering roles or helping to shape events such as a garden party or health fairs, or art / photography / jigsaw clubs • Health Fayres • Access to a holistic wider workforce • Family planning appointments • Antenatal and postnatal care • New baby registrations, 6w checks, immunizations • Support and management to families who have overweight children • Safeguarding lead; review of CP issues in clinical and general meetings • Adult safeguarding reviewed at MDT's. • Cervical Screening / YouScreen • Citizens Advice • Midwife on site, Imms and Boosters clinics are being set up, advice and guidance information in a patients native language • Specialized Baby Clinics. • Contraception Clinic for long acting contraception such as coils, implants etc. • SMOPS. • Monthly Safeguarding Meetings. • After School Session for MI during the winter. • Inclusion services working with them to ensure seamless registration for them and their newborn delivered into mainstream practice prior to delivery- involve Groundswell ahead of time • Six weekly meeting with Public Health Midwives, Health Care visitors to address Safeguarding issues, registering patients with a mainstream practice once baby is delivered • The practice had a system in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this. • All parents or guardians calling with concerns about a child were offered a same day appointment when necessary • DNA audits |

- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- Young people could access services for sexual health and contraception

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| Population Group | Working-age people (including those recently retired and students) |
| CQC Definition | <p>This includes all people in your practice population who are of working age and those recently retired (up to the age of 75).</p> <p>Working age includes adults up to the age of 75, whether or not they are in employment.</p> <p>For example, it includes students aged 18 and over.</p> <p>Inspections will include a focus on how people in this group are able to access appointments and services at the practice.</p> |
| Our ELFT Primary Care 'WHY' | <p>For people of working age convenient health care is a priority. For this group of people staying healthy, being able to engage in screening programs and having quick and easy access to healthcare advice when needed are often priorities.</p> <p>To ensure people have access to the care they need we will often need to think differently about access to care, this may involve the use of technology and clinics at different times.</p> <p>We need to work with our patients so that we are able to be responsive to their different needs. For working age people who are not currently in work, life can be financially challenging and this can lead to stress and anxiety. We should be playing our part to help people navigate the services that are available to help them.</p> |
| <p>What an outstanding offer to Working-age people (including those recently retired and students) includes</p> | <ul style="list-style-type: none"> • Health Fayres • Engagement with established volunteer groups • A Women's Group to use a room one weekend a month which could coincide with a smear/sexual health clinic • Menopause Clinics • Multi agency partnership working across health, housing and care • Access to telephone, F2F and video calls • Footfall and streaming • Accrux for surveys and making contact • Extended hours apts • Access to a holistic wider workforce • Ground consultations run by personalized care team • The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. • Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. • Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery • Practice has book on the day appointment system. Also patients can book appointments two to four weeks in advance to plan their work around. • Phlebotomy service is available at the practice. • Offer extended hours • Telephone/video consultations • Can book and manage prescriptions & appointments on-line • SMS/Email communication • Late Night Clinic. • Video Consultations • Contact your GP or Nurse via our website functions. • Self-referrals for a number of different services. • Communication via social media and sms for the latest updates |

| Population Group | People whose circumstances may make them vulnerable |
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| CQC Definition | <p>This population group may include a number of different groups of people.</p> <p>It includes those who live in particular circumstances that may make it harder for them to access primary care, or mean they are more at risk of receiving poor care. Some of these people may also be living in circumstances that make them vulnerable.</p> <p>We recognise that not everyone in this population group will consider themselves as being vulnerable.</p> <p>We will determine which groups to focus on by looking at your practice's population and your own assessment of the groups of patients that are most vulnerable, find it particularly difficult to access primary care, or are at risk of receiving poor care.</p> <p>However, we expect to always include people with a learning disability, people who are homeless</p> <p>We may also include gypsies, travellers, vulnerable migrants, and sex workers.</p> <p>This is not an exhaustive list and you should determine which groups of people are most relevant in your practice population.</p> <p>When we look at a group, inspectors will focus on access to general practice services generally, rather than the physical access to a practice for an appointment.</p> <p>This includes registration with a practice, and the ability to book appointments and receive services</p> |
| Our ELFT Primary Care 'WHY' | <p>For patients who are vulnerable navigating the health system can be particularly challenging, frightening and disempowering.</p> <p>Our role in providing care for this group of people is to help individuals be able to make their own choices about their health care in a dignified way.</p> <p>We need to care with empathy and an open mind and be able to have the time and space to listen to an individuals lived experience.</p> <p>Part of our role with this group of people is connecting services to achieve the best outcome for people and navigating the system with the person we are caring for to get the best outcomes possible for each individual.</p> |
| What an outstanding offer to People whose circumstances may make them vulnerable includes | <ul style="list-style-type: none"> • Health Fayres • Taxi Service • Outreach Services • Engagement with established volunteer groups • Safeguarding MDTs • Hot food service • Meal boxes during the pandemic • Calls to those shielding • The practice held a register of patients living in vulnerable circumstances including those with a <ul style="list-style-type: none"> • learning disability. • People in vulnerable circumstances were easily able to register with the practice. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability • Carers register and carers offer • End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. • The practice held a register of patients living in vulnerable circumstances and those with a learning disability. • The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule. • Specialised Clinics for Learning Disabilities. • Primary Care Link Worker. • Social Prescribers. • Home visit's |

- Monthly Safeguarding Meetings.
- Outreach Clinics
- Clinical Pharmacists
- Social Prescribers
- Drug & Alcohol Clinics
- Citizens Advice
- Same Day Appointments
- Home Visits
- Monthly MDT Reviews
- Discuss high risk cases at in-house meetings
- Interpreters
- Contract with Groundswell who can support patients to attend appointments/ help with transport etc
- Part of the safer surgery initiative
- Engagement events eg Christmas Fair, Summer BBQ
- Virtual Ward rounds
- Working with Amurt to provide hot meals once a week
- Looking to work with Change Please to do joint work on the bus to access even more who have not yet been reached
- Reviewing our registration policy to ensure best access for the population
- Appointment system always has open access on the day every day
- Patients are allowed to bring their dogs with them, providing they are under control and other patients in waiting area do not object
- Different types of consult available daily telephone, video, face to face, e- consult.
- Practice registered homeless people, There is no catchment area which means most of the homeless people around get benefitted by this service.
- Practice registers patients under various situations, those who are homeless.
- Offer annual health check-up to Learning Disabilities patients.
- Outreach team joint working, providing better access to healthcare for patients
- Work with housing first and step-down bed providers
- Links in all three boroughs with pathways charity
- The practice provided care to the asylum-seeking population
- The practice ran a weekly citizens advice bureau clinic for its patients that was provided by professional welfare benefit advisers.
- The practice provided services for residents of a local bail hostel for recently released ex-offenders. The practice had to cope with a rapid turnover of patients from the hostel, many of whose residents had pre-existing or developing health conditions.
- Homeless patients are registered as care of practice address.
- Close working relations with Single Homeless Projects / Street Link / St Mungos / London Probation Service / CGL
- Engagement with traveler communities

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| Population Group | People experiencing poor mental health |
| CQC Definition | <p>This includes the spectrum of poor mental health, ranging from depression, including postnatal depression, to severe and enduring mental illnesses, such as schizophrenia.</p> <p>It also includes people with dementia.</p> |
| Our ELFT Primary Care 'WHY' | <p>Struggling with your mental health can be terrifying and can leave people powerless to find the help they need.</p> <p>For people experiencing poor mental health our focus needs to be working with each individual, setting recovery goals in partnership and helping people to find their power to make choices about their health care.</p> <p>We also need to be able to focus on providing care to the families whose loved ones are experiencing poor mental health.</p> |
| What an outstanding offer to People experiencing poor mental health includes | <ul style="list-style-type: none"> • Health Fayres • Engagement with established volunteer groups • Priority appointments were allocated when necessary to those experiencing poor mental health • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly • The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. • There was a system for following up patients who failed to attend for administration of long-term medication. • When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. • Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. • All staff had received dementia training in the last 12 months • Staff skill mix reflects this- Psychologist, CNDS Mental Health • Very quick access to high level mental health services such as CNS , • Psychiatrist • Virtual ward rounds • Events eg hopefully new psychologist can do some mindfulness/relaxation etc in groups with the patients • Link them in with Groundswell who provide welfare checks • Engagement with social prescriber re activities eg gardening club- all patients to be offered this if they present with/have a history of mental health diagnosis • We have a mental health nurse who pays visits • MH practitioner who sees patients • Practice used to have face to face appointments with Extended Primary Care liaison service and a Psychiatrist on premises • Monthly MDT's • Psychiatric Liaison Nurse (PLN) • Social Prescriber • Health and wellbeing coach on site • Care Planning • CMC (For EOL Monthly MDT's • Psychiatric Liaison Nurse (PLN) • Social Prescriber • Care Planning • CMC (For EOL • Pro-active followed up by clinicians, Hospital DNA's are followed up, including mental health disabilities and paediatric patients • Referrals to charities such as MIND |

Understanding what matters most to our patients – engaging them in the offer (hints and tips)

- Run a PREM survey to ask patients around the 6 population groups asking what they would like from the service
- Engaging via mechanisms such as social media
- Advertising the offer on the practice's website, through the leaflet etc
- Running information sessions with the PPG and others
- Going out into the communities where the population are and actively seeking their views
- Using interpreters to accompany you to visits such as the work in the Asylum seeker hotel in old street
- Using complaints and compliments themes and trends to develop the offer
- Signposting pts for further information about condition
- Group consultations
- Developing working group on shaping the future services with patients
- 1:1 Drop-in sessions with the practice manager and others