Newtown Health 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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Overall summary

Newtown Health Centre serves the local general community and provides a service to a densely populated and culturally diverse area of Birmingham.

Newtown Health Centre was safe. There were appropriate safeguarding procedures and an open and transparent culture among staff. Medicines were managed safely, the practice was clean and hygienic and there were arrangements in place to respond to emergencies.

The practice was effective and had procedures in place that ensured care and treatment was delivered in line with appropriate standards. The practice measured its effectiveness through clinical audit except that in most case the clinical audits had not been reviewed. Staff were trained to work effectively and there were good links with other providers in the area.

The practice was caring, where patients were treated with dignity, respect and compassion. Patients spoke very positively of their experiences and of the care and compassion offered by the staff. Patients were involved in their treatment planning.

The practice was responsive to people's needs and met the needs of specific patient groups within its local population such as those with long term conditions, older people, younger people and families. The practice had an accessible appointments system and was also accessible to people with limited mobility or to people whose first language was not English.

The practice was well led. There was strong and visible leadership except that there was no clear practice development strategy or vision that was shared with staff. There were effective governance procedures in place and a system of using information from patients and from records to monitor the effectiveness of the practice. There was an active patient participation group in place.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, 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?

Newtown Health Centre was safe.

The practice had an open and transparent culture about keeping people safe and supported by clear procedures for escalating incidents and learning lessons from them. There were reliable safety systems in place including an effective safeguarding policy which had been used appropriately on a number of occasions.

There were safe recruitment procedures in place that ensured patients were cared for by staff who were fit to do so. Staff were trained to deal with medical emergencies and were also confident in identifying patients who had acute clinical needs and required a priority consultation.

There were safe procedures in place to manage medicines, including prescriptions. The practice environment and equipment were clean and staff followed hygienic procedures to minimise the risk of infection.

Are services effective?

The practice was effective.

Patients' needs were effectively assessed and their care and treatment was provided in accordance with established standards, legislation and best practice.

The practice was proactive in using patient data to benchmark their standards of care with local and national comparisons. This included peer review within the local practice area and clinical audits. Where clinical audits identified the need to make changes, the practice took action to do so. However, we found that most of the audits had not been fully completed and so the effectiveness of any changes made as a result of initial data gathering could not be ascertained. The practice should take steps to ensure that audit cycles were fully completed.

There were arrangements in place for assuring the competence of staff and the effectiveness of equipment and facilities. Clinical staff were properly re-validated according to their professional standards.

Summary of findings

The practice worked effectively with other services including the out of hours service, the local pharmacy and the multi-disciplinary team for patients receiving end of life care.

The practice was proactive in identifying ways of promoting good health within its population group. This included a sexual health service for young people. It also included the provision of advice and information in written form and on the practice website about health and lifestyle.

Are services caring?

The practice was caring. Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice and this was confirmed by our observations.

We received 45 comment cards from patients in advance of our visit 98% of which reported mostly or wholly positive experiences. The proportion of patients who reported positive experiences in the national patient survey was significantly higher than the national average.

Patients' confidentiality was respected and patients had access to a chaperone if required.

The relatives of people who died were supported once they were bereaved by way of a follow-up call by one of the nurses to determine whether they needed any additional emotional or practical support.

We found that patients were involved in decisions about their treatment with patients reporting that they felt listened to by the doctors and nurses. Patients also said they were provided with enough information by the clinical team.

Patients' capacity to consent was properly assessed where appropriate. Assistance was provided to patients with limited capacity to help them understand their care and treatment. Patients whose first language was not English were provided with an interpreter to help them to understand the care and treatment they needed.

Are services responsive to people's needs?

The practice was responsive to people's needs.

We found that the practice was proactive in trying to understand the needs of its patient population and tailor its services to meet their

Summary of findings

needs. The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific needs. The practice had well established clinics for asthma and chronic lung disorders and promoted independence and self-care for this group of patients.

The practice's Patient Participation Group (PPG) had been instrumental in helping the practice to make progressive improvements to the telephone system. PPGs are made up of groups of patients from particular practices who volunteer to be part of a consultative forum that provides feedback in order improve quality and standards.

The practice offered two thirds of its appointments as pre-bookable with the remainder being released at 8.30am and at 3.30pm to help to manage demand throughout the day. Patients told us that they were satisfied with the appointment system and the practice opening hours.

The practice took steps to ensure patient's cultural expectations were met when transferring to different services. This was particularly relevant due to the diverse nature of the patient population. The advanced nurse practitioner told us that they maintained their presence with the community and had established links with local Asian women groups. At this group talks were given on health topics which included sexual health, family planning, menopause and lifestyle in relation to health and wellbeing. We consider this to be an example of outstanding practice.

Nurses and Doctors undertook home visits for patients who were unable to get to the practice, for older people and for patients who required a visit following discharge from hospital.

The practice had an effective system in place for handling complaints and concerns.

Are services well-led?

The practice was well-led.

The practice had an open and transparent leadership style. The whole team adopted a philosophy of care that put patients and their wishes first. The practice recognised and rewarded good practice and staff told us that they felt valued and supported by the management team and all staff were enabled to maintain their professional knowledge by attending training events.

Summary of findings

There were effective governance arrangements in place and staff were aware of their own roles and responsibilities. There was also a documented organisational structure, which showed clear lines of leadership. Key decisions about the practice were taken at the weekly practice management meetings that involved the management team as well as the senior partner. These decisions, including any learning from significant events, were disseminated to staff at all-staff practice meetings.

The practice shared and analysed information arising from clinical audits carried out among the local practices by way of peer review. The practice had made use of a predictive tool known as 'risk stratification' to identify particular patients that might be at high risk or hospitalisation.

The practice had an effective Patient Participation Group (PPG) although the information about its existence was limited. Some patients reported that they were not aware of the group. Similarly, the practice was receptive to feedback from patients although it was not always the case that patients were clear about how to leave feedback.

Positive feedback from patients for staff was celebrated and shared.

There was a culture of improvement albeit that this was not underpinned by a documented practice development strategy or vision. There was evidence, however, that the practice was a 'learning organisation' where all staff were party to a culture of learning and improving.

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

Patients aged 75 and over had their own allocated GP but had the choice of seeing whichever GP they preferred. Flu vaccines for older people who had problems getting to the practice were administered in the community by visiting clinicians. Nurses and doctors undertook home visits for older people and for patients who required a visit following discharge from hospital.

The practice appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including older people.

People with long-term conditions

The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients.

Patients who had developed type 2 diabetes could undergo a process known as an 'insulin start', a programme of treatment to help such patients learn how to manage their diabetes through the use of insulin. This was supervised by a diabetic specialist nurse at the practice.

The practice identified patients who might be vulnerable or have specific complex or long term needs and ensured they were offered consultations or reviews where needed. Patients with long term conditions had tailor-made care plans in place. Particular clinics operated for patients with diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions.

Mothers, babies, children and young people

The practice had put an action plan into place that provided them with opportunities to diagnose ongoing diabetes in women who had been at risk of diabetes in pregnancy.

Summary of findings

Staff were effective in identifying potential child abuse and the computerised alert system alert system identified individual patient's risk to enable clinicians to consider issues for consultations with children who were known to be at risk of harm.

The practice was proactive in identifying ways of promoting good health within its younger population group. Examples included offering a confidential service to young people by providing full sexual health screening, the provision of condoms upon request and the availability of private facilities for self-testing for chlamydia.

The advanced nurse practitioner had established links with local Asian women groups within the community. At these groups talks were given on health topics which included family planning and lifestyle related to health and wellbeing. We consider this to be an example of outstanding practice.

The practice ran a programme of childhood immunisations and hosted baby clinics provided by the health visiting team. This was supported by the availability, in leaflet form and online, of a range of information about child health and development.

The working-age population and those recently retired

The practice offered advance appointments up to six weeks in advance designed to assist patients who might not be able to access appointments due to their work times.

The practice had referred patients to a local slimming club in order to help them with weight control and diet.

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

The reception desk was constructed with a cut-out section at low level that enabled patients in wheelchairs to talk with reception staff at an appropriate height.

Patients whose first language was not English were supported to understand their needs by involving interpreters in the discussion of their care and treatment. The practice also took steps to ensure patient's cultural expectations were met when transferring to different services.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

Summary of findings

The practice provided health care for an unidentified number of sex workers in the area, including a sexual health service although this was on an as-needed basis as opposed to being part of a co-ordinated programme.	
People experiencing poor mental health The practice facilitated access to an independent advocacy service for patients who lacked capacity to consent. One of the nursing staff was designated as lead for mental ill-health and had a direct link with the local mental health services. Patients with mental ill-health were invited for an annual review of their health, including their physical health, and their medicines.	

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection. They all reported that they were treated with kindness, respect and dignity by all the staff at the practice.

We also reviewed 45 comment cards that had been collected from patients in advance of our visit. Only one of the comment cards indicated a negative view with the remainder, 98%, reporting mostly or wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We spoke with representatives of the practice's patient participation group (PPG) and reviewed data from the national patient survey and further survey questions commissioned by the PPG. The survey, which had been carried out in the previous year, showed that between 91% and 94% of patients commented positively about various aspects of their experience ranging from whether the staff and clinicians were polite and considerate, to whether they were given enough time for their consultation. This was significantly higher than the national average which showed that between 77% and 83% of patients reported the same positive experiences.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure a process is in place to measure the effects of any changes made as a result of significant events analyses or clinical audits, thus completing the audit cycle.

Steps should be taken to ensure patients are aware of and can contribute to the patient participation group.

The practice should consider how its overall strategy and vision is conveyed to patients and staff to enable broad support of the development of the practice.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice maintained a presence with the community and had established links with local Asian women groups. At these groups talks were given on health topics which included sexual health, family planning, menopause and lifestyle related to health and wellbeing.

Newtown Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, supported by another CQC inspector, a GP specialist adviser, a practice manager specialist adviser and an expert by experience. An expert by experience is someone with experience of using services that helps us to make judgements.

Background to Newtown Health Centre

Newtown Health Centre, known locally as 'Raydocs' is a large community general practice service around 12,000 patients in a densely populated area to the West of Birmingham city centre. The patient population is highly diverse with a rich cultural, faith and ethnic mix.

The health centre is one of two locations run by the same provider with the other being the nearby, and separately registered, Aston Pride Community Health Centre. For our inspection we only visited the main practice at Newtown 171 Melbourne Avenue.

There are seven GPs, three are partners and the remaining four are salaried GPs. There are also seven nurses including one advance nurse practitioner as well as three healthcare assistants.

When the practice is closed, patients receive an out-of-hours service from another out-of-hours provider.

Why we carried out this inspection

We inspected this GP 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

We conduct our inspections of primary medical services, such as Newtown Health Centre, by examining a range of information and by visiting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the service.

We carried out an announced visit on 04 August 2014. During our visit we spoke with the members of the management team, the principal partner and a salaried GP, the advanced nurse practitioner, two further nurses and receptionists and administrative staff. We also spoke with 10 patients using the service on the day of our visit. We observed a number of different interactions between staff and patients and looked at the practice's policies and other general documents. We also reviewed CQC comment cards completed by patients using the service prior to that day where they shared their views and experiences.

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?

Detailed findings

- 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 poor mental health

Are services safe?

Our findings

Safe Track Record

We found that Newtown Health Centre had an open and transparent culture amongst its staff about keeping people safe. This was supported by clear procedures for escalating incidents and allegations of abuse through the practice management team. Staff we spoke with demonstrated a broad understanding of the processes for reporting such incidents and knew the extent of their accountability.

We saw that the practice took account of a number of different sources of information to help them to understand whether or not they were operating safely. For example, we looked at complaints records, comments received, records of incidents and notes of staff and management meetings. These records showed that incidents, feedback and concerns were discussed at practice management meetings. Outcomes and any learning arising from the incidents were communicated to staff through staff practice meetings.

The practice made use of information arising from clinical audits to ensure patients experienced safe care and treatment. For example, one of the GPs had carried out a clinical audit about their approach to monitoring and treating women with a history of diabetes in pregnancy, known as gestational diabetes mellitus (GDM). A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented to assess their effectiveness. The GDM audit highlighted deficiencies with the management of this group of patients when compared with quality standards issued by the National Institute for Care and Health Excellence (NICE). The practice put an action plan into place that resulted in 100% of women who were affected by GDM being followed up with further blood tests after their pregnancy. This provided the practice with opportunities to diagnose ongoing diabetes and to give appropriate diet and lifestyle advice that previously might have been missed.

Learning and improvement from safety incidents

We found evidence showing that the practice had a system in place for reporting, recording and monitoring significant events; a process known as significant event analysis (SEA). We saw a number of examples of SEA where the practice had learned lessons and taken action to improve their safe practice as a result. Such examples included incidents relating to the correct coding of patient computer data and the prescribing of repeat medication. These incidents had been correctly recorded as significant events and analysed. Action had then been taken to improve and to communicate lessons learned to staff. However, unlike the clinical audit of the monitoring of women with gestational diabetes mentioned above, none of the SEAs we looked at had had a review of the agreed actions to see if they had been effective in ensuring safe practice.

Reliable safety systems and processes including safeguarding

The practice had reliable systems to keep people safe and protected from abuse. There was a designated safeguarding lead for the practice who took a proactive role in making sure that procedures were up to date and that staff knew how to identify and respond to potential abuse. We spoke with nursing staff and reception staff and we looked at records that indicated they had received training appropriate to their role in protecting children and vulnerable adults. The designated safeguarding lead and the other clinicians had received safeguarding training to level 3 of the recognised inter-agency training framework which is the level appropriate for medical staff.

Staff we spoke with were able to recognise different kinds of abuse and described the process they would follow if they had any concerns about particular patients. We saw that the practice staff were effective in identifying potential abuse because 12 referrals had been made to the local authority under safeguarding procedures since April 2013. Furthermore, information about relevant safeguarding contacts was displayed in the waiting areas alongside printed leaflets about child and vulnerable adult abuse that were available for all patients.

We also found that the practice management team had assured themselves that all staff were of good character and suitable for employment in a healthcare environment by means of a thorough recruitment process. For example, each clinical staff member had undergone enhanced criminal records checks whilst all non-clinical staff had been subject of standard criminal records checks.

Monitoring safety and responding to risk

One of the practice management team told us that a culture of empowerment existed where staff at all levels could share concerns about risks to individual patients with

a clinician, even if they were unsure about what they had identified. For instance, as part of their first aid training staff were trained in recognising patients who might have acute clinical needs requiring a clinician's input as a priority. This was borne out in our discussions with staff members who told us they felt confident to identify and report anything that they were worried about. All incidents of concern were discussed at the practice management meetings every Tuesday to monitor the effectiveness of any action taken at the time.

We saw that the practice had procedures in place to deal with potential medical emergencies. An automated external defibrillator (AED) was available in the reception area, emergency oxygen and medicines were readily available in a side room and were checked weekly to make sure they were within date and safe to use. All staff were trained in basic life support techniques and in the use of the AED.

Medicines management

We found that there were clear procedures for the management of medicines that minimised the potential for error. We saw that the cold chain was maintained for the storage of temperature sensitive vaccines and insulin from the time they were received at the practice to the time they were administered. For example, flu vaccines for older people that were administered in the community by visiting clinicians were transported to patients by means of a cold-box and by pre-arranged appointment to ensure that the vaccines remained at the same temperature.

We saw that all medicines were stored appropriately and were checked weekly by the designated lead nurse who was in charge of medicines. We saw signed and dated entries in a log book which showed that there were also arrangements to check the medicines when the nurse was on leave.

The practice managed all patients' repeat prescriptions on the computer system which allowed an effective audit trail to be kept. The system also enabled staff to be alerted when a patient's medicines were due to be reviewed or if a patient had not requested a repeat prescription by the due date. Blank paper prescription forms were locked away securely and were not used unless there was an emergency, such as a power cut. This eliminated the risk of paper prescriptions being used inappropriately.

Cleanliness and infection control

There were effective arrangements in place to ensure that patients and staff were protected from the risks of acquiring health care associated infections and that the relevant Department of Health (DH) guidance and codes of practice on infection control were followed. We looked at the practice infection control policy and spoke with staff about their awareness of it. We found that staff worked hygienically and followed established guidelines for their working practices such as hand-washing and the disposal of clinical waste and 'sharps' that had been used.

The practice was proactive in managing the risks from healthcare associated infections. We spoke with the designated lead nurse for infection control who told us that they provided regular refresher training to staff on various aspects of infection control. We noted that an update session on hand-washing was planned for the month following our inspection.

The lead nurse was also responsible for carrying out an infection control audit using the DH audit tool designed for this purpose and we saw that an audit had been carried out in April 2014. This had resulted in a number of actions being raised for most of the clinicians in respect of the rooms they were responsible for in order to maintain compliance with the DH guidelines. A second audit had been carried out two weeks afterwards and we saw that all actions had been completed.

The practice employed NHS Property Services to clean and maintain the premises according to a cleaning schedule. The standard of cleaning was monitored by one of the practice management team. We saw that cleaning arrangements met with the requirements of the DH guidance and the communal areas and treatment rooms were visibly clean on the day of our inspection.

Staffing and recruitment

We saw that the practice planned its staffing requirement around the services it provided so that there were enough competent staff on duty with the appropriate skill mix at all times to support safe care and treatment. Staff rotas were set in advance and the staffing requirement was managed as a specific agenda item on the weekly management meetings between the senior partner and the management team. In this way, planned absences such as staff leave and unexpected absence due to sickness were managed and cover arranged as appropriate.

Are services safe?

Dealing with Emergencies

The practice anticipated risks to the service arising from major incidents and had a robust business continuity pan to manage any interruption to the service as a result. This enabled the practice to relocate the service at the partnership's second practice site located within five minutes' walk. The plan showed that the use of a hosted telephony system enabled the practice to divert incoming calls and that patients could be redirected with minimum disruption. All of the management team held off-site copies of the plan so it could be located whenever it was required.

The practice planned ahead to deal with seasonal or changeable demand with minimum disruption. For example, seasonal flu vaccination clinics were planned to take place outside normal surgery hours on Wednesday evenings and Saturday mornings so that normal service was not compromised.

Equipment

We found that patients were protected from the risks arising from the use of unsafe equipment because there were arrangements for maintaining such equipment according to a programme managed by the NHS Property Services. We saw test and calibration records of the vaccination fridge and other electrical equipment, such as the blood-pressure machine, that showed they had been checked regularly and were working correctly.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

We found evidence that the practice used recognised guidance and best practice standards in the assessment of patients' needs and the planning and delivery of their care and treatment. For example, we saw that the practice appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. The MDT is part of the arrangements required by the quality standards for end of life care described by the National Institute for Health and Care Excellence (NICE). We saw that every patient receiving palliative care was reviewed every quarter by the MDT to ensure that their specific needs were met.

The GPs we spoke with displayed a thorough knowledge of the law and the processes that underpin the way that consent for medical examinations and procedures is sought and recorded in different situations. Such situations included, for example, the assessment of some patients' capacity to consent under the Mental Capacity Act 2005 and the criteria for supporting people to make decisions that were in their best interests. They also included an assessment of the particular criteria for establishing whether young patients under 16 years of age understood information about their treatment and were competent to make decisions about it.

Patients we spoke with also told us that information about their treatment was clear and well communicated to them by the clinicians and that they had opportunities to ask questions to help their understanding before making decisions.

Management, monitoring and improving outcomes for people

We found evidence that demonstrated that the practice was proactive in using patient data to benchmark their standards of care with local and national comparisons. The senior partner at the practice was the chair of one of the five locality commissioning groups in the area covered by the Clinical Commissioning Group (CCG). This provided an opportunity for the practice to share and analyse information arising from clinical audits carried out among the local practices by way of peer review. For example, the practice had agreed to take part in a clinical audit on the rate of laxative prescribing after the analysis of data from the CCG had identified this as a local priority. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented to assess their effectiveness. This audit was in the process of being carried out at the time of our inspection.

We saw that the practice had also carried out a number of internal clinical audits and had produced action plans arising from them. These audits included the prescribing of ACE inhibitors (a medicine used predominantly to regulate blood pressure and cardiac function) in women of child bearing age, the treatment of migraines of women using the contraceptive pill and the provision of prostate specific antigen (PSA) tests for men at higher risk of prostatic disease. However, whilst these audits indicated a proactive approach towards improving outcomes for patients, there was no means of determining the effectiveness of the action plans arising from the analysis of the data. Apart from the audit carried out on the assessment of women with a history of gestational diabetes, none of the audits we looked at had a scheduled review date and so the clinical audit cycle had not been completed.

Effective Staffing, equipment and facilities

We looked at records and spoke with staff and found that staff were appropriately trained and supported to carry out their roles effectively. This was the case for both clinical and non-clinical staff. For example, one member of the healthcare team told us about their two week induction programme. The programme involved shadowing an experienced colleague, carrying out their role in accordance with procedures and having their competence checked and signed off before being deemed suitable to work alone.

We saw that objective driven annual appraisals were carried out for each staff member by relevant senior colleagues or members of the management team as well as with six-monthly interim reviews. Staff we spoke with told us that they felt supported by the appraisal process and that they were provided with opportunities to identify their developmental or training needs. Much of the training took place during specific days allocated for this purpose known as protected learning time (PLT). PLT events were quarterly and were held at an external venue where staff received training in specific topics, for example, infection control, from internal or external speakers.

Are services effective?

(for example, treatment is effective)

Clinical staff were revalidated according to their professional requirements which included appraisal and opportunities to undertake continuing professional development. There were also opportunities for clinicians to update their professional knowledge from recent developments, audits and significant events at monthly clinician's meetings.

We also saw that there was a process for managing poor or variable performance. The emphasis of this process was on development and seeking improvement but it also had a range of other sanctions where these might be required.

We found that, although the practice was located in an older building, the internal layout of the premises was clean, bright and functional and had been adapted for the benefit of patients. For example, the reception desk was constructed with a cut-out section at low level that enabled patients in wheelchairs to talk with reception staff at an appropriate height and we saw this being used during the morning session. In addition, the accessible toilets were on the ground floor, were clearly marked and had a wide uncluttered approach area from the waiting room to allow wheelchairs to move freely in and out.

The practice also used appropriate equipment to help them to meet patients' needs. For example, a lung capacity testing machine, known as a spirometer, was in use for the clinics for asthma and chronic lung conditions to help in assessing patients more effectively.

Working with other services

We found that the practice engaged regularly and effectively with other health care providers in the area such as the district nursing service, the community matron, the emergency department of the local hospital and the out-of-hours GP service. All records of contact that patients had with other providers were received by fax and scanned into the records system for clinical review. The records of all such contacts and post from other providers were distributed to the doctors who were on duty that day for review and action as appropriate. This ensured that the practice retained clinical oversight of their patients' encounters with other health services and could coordinate any further or follow-up action indicated by them.

These joint arrangements extended to the adjacent pharmacy that took part in the minor ailments scheme and fed back patient information to the practice, which was also added to patient records.

The evolving needs of every patient receiving palliative care were discussed at quarterly MDT meetings. As patients neared the very end of life, their care plans and any documents that related to their decisions about resuscitation were sent to the out-of-hours provider to ensure that specific wishes about their death could be met.

We noted that there was a large range of information leaflets in the waiting areas. These leaflets contained comprehensive, up to date information and contact details for local health and care services, such as mental health services and the local authority safeguarding team. To support this, the practice website also had a dedicated page linked to NHS Choices to help patients find local health care services such as hospitals, dentists, chemists and independent healthcare providers. For example, the practice provided information about, and coordinated referrals to, local drug and alcohol services and also to services that were aimed at those who were caring for others.

Health, promotion and prevention

The practice was proactive in identifying ways of promoting good health within its population group. For example, the practice had identified that there were some cultural barriers to young people locally being able to gain access to information or procedures relating to their sexual health. We saw that the practice offered a confidential, service to young people by providing full sexual health screening. This was supported by the provision of condoms upon request and by the availability of private facilities for self-testing for chlamydia.

We found that the practice promoted good health by providing NHS health checks, extensive health education information and referrals to other organisations that supported healthy living. We saw that the practice had access to a health trainer service that encouraged patients to make good lifestyle choices. There were leaflets and posters providing advice to patients about improving their lifestyle and their health, such as smoking cessation, nutrition and exercise. Patients could also be referred by their GPs to a chronic disease education service to help them to understand how to manage long term conditions.

Are services effective?

(for example, treatment is effective)

In addition to the information held in the reception area, the practice website also had links to established web-based resources and media. Such links included extensive information about long term conditions and their management and also about the promotion of health specifically for families, men, women and older people.

Patients we spoke with told us that they were aware of the information on display and found it helpful. Some patients also told us that they had been directed to particular services by their GP. For example, we learned that the practice had referred patients to a local slimming club in order to help them with weight control and diet.

The practice ran a programme of childhood immunisations and hosted baby clinics provided by the health visiting team. This was supported by a range of information about child health and development in leaflet form and an even greater range of child health education information on the practice website relating to pregnancy, children aged 0-5 years and children aged 6-15 years.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were treated with kindness, respect and dignity by all the staff at the practice. We spoke with 10 patients on the day of our inspection who all reported that they were treated with kindness and respect.

We also reviewed 45 comment cards that had been collected from patients in advance of our visit. Only one of the comment cards indicated a negative view with the remainder, 98%, reporting mostly or wholly positive experiences of patients. Some of the cards referred to doctors and staff by name, singling out individual examples of kindness, care and compassion.

We spoke with representatives of the practice's patient participation group (PPG) and reviewed data from the national patient survey and further survey questions commissioned by the PPG. The survey, which had been carried out in the previous year, showed that between 91% and 94% of patients commented positively about various aspects of their experience ranging from whether the staff and clinicians were polite and considerate, to whether they were given enough time for their consultation. This was significantly higher than the national average which showed that between 77% and 83% of patients reported the same positive experiences.

This data was reflected in our observations on the day of our inspection. We observed a number of interactions between staff and patients where people were consistently treated with respect, compassion and dignity, both in person and on the telephone.

We noted that patients' confidentiality was respected. In several short periods during the morning of our inspection we saw that a line of patients had begun to build up so that the reception staff were kept busy with visitors to the desk. We noted that patients remained behind a sign that asked them to wait until called forward. This ensured that patients could not be overheard talking with reception staff.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required a chaperone. A chaperone is a person who might be present during a consultation when an intimate examination is taking place to ensure that patients' rights to privacy are protected. Female patients we spoke with confirmed that they had either been offered a chaperone or that a chaperone had been present during an examination by a male doctor.

We noted that patients' relatives were also supported once they were bereaved by way of a follow-up call by one of the nurses to determine whether they needed any additional emotional or practical support. In addition, the computer system incorporated an alert system to notify reception staff whenever a recently bereaved person came into the practice so that they could make discreet enquiries about the patient's welfare.

Involvement in decisions and consent

We found that patients were involved in decisions about their treatment. The survey carried out by the PPG showed that 94% of patients felt the GP was good at listening to them and 91% in relation to the nurses. As before, this was significantly above the national average of 83% and 81% respectively. Patients we spoke with on the day of inspection confirmed that they had the opportunity to ask questions and felt their views were listened to.

Furthermore, patients told us that their diagnoses were well explained by their GP and that this was often supported with written information to enable them to make informed decisions. This was particularly the case with patients who had developed type 2 diabetes who were undergoing a process known as an 'insulin start'. This is a process that involved educational information being given to patients about their condition and the treatment using insulin so that they learn how to manage it over a period of time. Our discussion with patients confirmed that the information provided about diabetes was helpful.

We learned that the GPs had received particular training in assessing patients' capacity to consent and that they were confident in their ability to make decisions in patients' best interests where this was required. The practice facilitated access to an independent advocacy service for patients who lacked capacity to consent. This was in order to help them to understand their treatment where this was indicated although we did not discuss any specific examples where this had been the case.

Although the practice was located in a diverse population area, we saw that everyone who visited the practice on the day of our inspection spoke and understood English.

Are services caring?

However we saw that there were arrangements in place to call a local interpreting and translation service to patients when needed. The staff also had access to a range of printed fact sheets in different languages and the practice website had a facility that translated its informative content.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

We found that the practice was proactive in trying to understand the needs of its patient population and tailored its services to meet their needs. The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific needs This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review, patients receiving palliative care or those who were recently bereaved. A further example was women whose cervical screening tests were due or overdue. This was particularly relevant since the data from the Clinical Commissioning Group (CCG) suggested that cervical screening rates for the city were of concern.

The alert system also identified individual patient's risk to enable clinicians to consider issues for their consultations with patients, such as children who were known to be at risk of harm.

The practice is located in an area which is considered to be deprived with large sections of the community experiencing poor quality housing. As a result there is an expected prevalence of long term respiratory conditions. The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of a range of printed information about healthy living and a dedicated smoking cessation clinic.

We saw that the practice was working with the CCG on a number of initiatives to help reduce admissions to Accident and Emergency (A&E). These initiatives included access to same day appointments and clinical consultations on the telephone although the effectiveness of this had yet to be measured at the time of our inspection.

As part of our inspection we consulted with members of the practice's Patient Participation Group (PPG). PPGs are made up of groups of patients from particular practices who volunteer to be part of a consultative forum that provides feedback in order improve quality and standards.

The Newtown Health Centre PPG operated on a large, open meeting basis with between 20 – 40 patients regularly in attendance. Meetings were quarterly and were always attended by one of the senior partners and one or more nurses or a member of the practice management team.

We learned that the PPG had contributed ideas and feedback that had been well received by the practice and the members we spoke with felt that the PPG was a vital element in the practice's quality system. For example, the practice had recently consulted the PPG on the implementation of a telephone triage system. The PPG meeting had agreed that the triage system might be beneficial and so the practice had planned to implement the system at a future start date following the date of our inspection.

Access to the service

The practice did not routinely offer appointments outside of their core opening hours although we learned that patients could book some appointments up to six weeks in advance. Each GP had 19 morning appointments and 16 in the afternoon, with 12 – 15 for each session with the practice nurses and advanced nurse practitioners. Two thirds of the appointments were pre-bookable with the remainder being released at 8.30am and at 3.30pm to help to manage demand throughout the day. Patients told us that if they wanted to see a particular doctor they could generally do so if they were prepared to wait a few days but that they would always be seen on the day in the case of an emergency or urgent need.

The practice had not yet begun to offer a telephone triage service although they planned to do so in the near future. Appointments could not be booked online but we were told that this would be part of the plan for the coming year. We note, though, that this was a stated intention as opposed to a formal written plan as no such strategy was yet in existence.

The national patient survey results showed that patient satisfaction with the practice's opening hours was among the top 25% in the country whilst patients' satisfaction with their experience of making an appointment was at 73%, among the middle range. On the day of our inspection, all 10 of the patients we spoke with said that they were happy with the appointment booking system and that they appreciated being able to make an emergency appointment on the day.

Are services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

Two of the nursing staff we spoke with told us that patients were supported to understand their needs by involving interpreters in the discussion of their care and treatment. Interpreters were requested from a local interpreting service in advance of the patient's appointment. Both staff members reported that they did not generally experience problems accessing the services of an interpreter. However, on the rare occasions when an interpreter was not available, such as for an emergency consultation, a telephone language service was used.

We saw that the practice took steps to ensure patient's cultural expectations were met when transferring to different services. For example, Muslim women were always seen by a female doctor or nurse at the practice if this was their choice. However if the patient was referred to a community clinic or hospital for minor surgery the referral was accompanied by an explicit written request for a female clinician to carry out the procedure.

The practice's patient population was younger than the national average with a high proportion of school children from different cultures and backgrounds. It was acknowledged by the practice that this often presented difficulties with promoting awareness of sexual health and contraception. To address this the advanced nurse practitioner with a GP at the practice used to support sessions in local schools run by a local sexual health advisory agency. These sessions were now run by an agency.

In addition we saw that clinics intended to increase the uptake of cervical screening had been held on Saturdays and in the evenings during the week with all female staff in attendance. However, this had not appreciably increased the uptake of the screening procedure and so those clinics had been halted.

We noted that nurses and doctors undertook home visits for patients who were unable to get to the practice, for older people and for patients who required a visit following discharge from hospital. The practice maintained a good relationship with the community nursing team and collaborated with them to ensure that visits to patients were coordinated where both services were involved.

Concerns and complaints

The practice had a system in place for handling complaints and concerns according to a policy that was in line with recognised guidance and contractual obligations for GPs in England. There was information on the practice website, in leaflet form in the reception area and in a notice on the notice board. All of the patients we spoke with said they had never had cause to complain. However, none of the patients could describe how they would make a complaint other than to say they would raise the issue with reception staff.

We saw that both formal and informal complaints were logged and details of advocacy services were provided to complainants should they wish to consult independently or seek support whilst the complaint was being investigated. The final response to complaints included information about how to contact the Health Service Ombudsman if they were unhappy with the outcome.

Complaints were recorded on a spreadsheet which summarised key questions about the nature of the complaint and who was involved. We saw examples that showed that lessons were learned from complaints and that these were disseminated at practice meetings.

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

It was evident from our interviews with the management team, the GPs and the staff that the practice had an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. For example, as we have previously noted, a culture of empowerment existed where staff at all levels could share concerns about risks to individual patients with a clinician even if they were unsure about what they had identified.

We saw that the practice recognised and rewarded good practice and staff told us that they felt valued and supported by the management team. This was reflected in the arrangements for training staff and an appraisal system that was supportive, meaningful and driven by individual objectives. We noted, for instance, that there were performance related contracts for salaried GPs. This required them to play an active role in developing and leading the practice by carrying out clinical audits and taking lead responsibility for particular areas of the practice such as diabetes or respiratory conditions.

The practice was a GP training practice and we noted that there was an emphasis on learning throughout the staff team. For example, new staff were mentored through an induction programme that focused on them reaching a level of competence. Further, all staff were enabled to maintain their professional knowledge by attending protected training events where they could focus on their learning and development uninterrupted by regular duties.

Although there was a shared understanding of good patient care, we found that there was no clear vision or strategy to develop the practice that was shared by all the staff. There was also no succession plan for the medical staff. The practice had an annual business plan but this was largely financial in nature and there was also a five year development plan that had been laid down more than five years previously. However, this had not been actively used to develop the practice and was out of date and largely ineffective at the time of our inspection. As a result, there was no opportunity to develop organisational learning or to tailor future services based on how well such a strategy might be working. For example, there was no clear intention about what was going to happen next to improve the uptake of cervical screening after the abandonment of the extra screening sessions on Saturdays and Wednesday evenings.

The senior partner acknowledged that this was an area that needed to be addressed. They told us that their intention was to run an all-staff consultation event away from the practice for a day in the near future that would involve all of the staff team in helping to set the practice's strategic direction; however this had yet to be arranged at the time of our inspection.

Governance arrangements

We found that there were effective governance arrangements in place and that staff were aware of their own roles and responsibilities. For example, we saw that some staff members had designated lead roles for different aspects of the practice's business. This included roles such as safeguarding lead, infection control lead and Patient Participation Group (PPG) lead. PPGs are made up of groups of patients from particular practices who volunteer to be part of a consultative forum that provides feedback in order improve quality and standards. We saw that the senior partner was a 'Caldicott Guardian', the designated person for protecting the confidentiality of patient information and enabling appropriate information sharing.

There was also a documented organisational structure. The practice had a management team, each of whom had particular responsibility for key aspects of the practices business such as finances and human resources, practice performance and reception. Key decisions about the practice were taken at the weekly practice management meetings that involved the management team as well as the senior partner. For example, a standing agenda item at each weekly meeting dealt with any anticipated risk from the staffing establishment for the next and subsequent weeks and arrangement they needed to make to ensure sufficient skilled staff were working. These decisions, including any learning from significant events, were disseminated to staff at all-staff practice meetings. Staff we spoke with told us that they felt the communication from the management team was very good and that they felt they were kept up to date with everything they needed to be.

Are services well-led?

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

Systems to monitor and improve quality and improvement (leadership)

As previously mentioned in this report, the senior partner at the practice was the chair of one of the five locality commissioning groups in the area covered by the Clinical Commissioning Group (CCG). This provided an opportunity for the practice to share and analyse information arising from clinical audits carried out among the local practices by way of peer review. For example, the practice had agreed to take part in a clinical audit on the rate of laxative prescribing after the analysis of data from the CCG had identified this as a local priority. This audit was in the process of being carried out at the time of our inspection.

We also found that the practice had made use of a predictive tool known as 'risk stratification' to identify particular patients that might be at high risk or hospitalisation. This had resulted in specific care plans being drawn up for the 2% of the patient population that were seen as being at highest risk of hospitalisation.

Patient experience and involvement

As previously reported, the PPG operated on a large, open meeting basis with between 20 – 40 patients regularly in attendance. Quarterly meetings were always attended by one of the senior partners and one or more nurses or a member of the practice management team. The PPG was chaired by patients as opposed to practice staff which ensured that it retained a degree of independence.

We spoke with two representatives of the PPG and with the staff member who was designated as coordinator for the group. All three told us they felt the PPG was valued by the practice and that Ideas and feedback that the PPG had contributed had been influential in the way the practice was run. Although the PPG had an influential role and was made up of a broad age, gender and cultural cross section of the patient population, the information about its existence was limited. There was a section about the PPG on the website but only a small section of the notice board in reception. Three of the patients we spoke with on the day were unaware of the existence or the function of the PPG.

We found that good, written feedback received from patients about particular staff members was celebrated. We saw examples showing that the staff member concerned received a personal copy of written feedback with a further copy placed on their file for noting at their next appraisal. The original written feedback was placed on the staff notice board. Staff we spoke with told us this was a supportive and motivating measure that they clearly appreciated.

Practice seeks and acts on feedback from users, public and staff

We found that the practice was receptive to feedback from patients although it was not always the case that patients were clear about how to leave feedback. For example, the reception area of the practice had a wall-mounted suggestions box. However, this was in a connecting section of the reception between two waiting areas and was grey in colour and quite small. It was our assessment that this was not as visible as we might have expected it to be for a practice that was as concerned about patient's views as Newtown Health Centre. Patients we spoke with said they were unaware of how they might leave feedback.

This was in contrast to the involvement of the PPG. We noted that the practice had recently consulted the PPG on the implementation of a telephone triage system and that the PPG's continued influence had led to progressive improvements to the telephone system.

The practice management team told us that they were aware of the newly created 'Friends and Family' test, a simple method of gathering information about patient satisfaction with a service based on whether or not they would recommend it to their friends or family. However, the practice management team told us that they had not yet implemented the programme as they were waiting for further guidance to be issued by NHS England.

Identification and management of risk

The practice had clear and robust systems in place for identifying and managing risks to patients. This included the use of a risk assessment tool known as 'risk stratification' for identifying patients at heightened risk of re-hospitalisation, and the use of data from the records system to ensure patients with long term conditions were properly reviewed.

In addition to this, as we have already reported, the practice had systems in place to identify and manage the risks to patients associated with the level of staffing and their skill, the use of equipment and facilities and the cleanliness of the environment.

Are services well-led?

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

Management lead through learning and improvement

We found that there was culture of improvement albeit that this was not underpinned by a documented practice development strategy or vision. We noted that the practice carried out clinical audits and significant event analyses (SEA) with a view to identifying opportunities to improve. Action plans were put into place where audits and SEAs identified any shortfalls, such as the analysis of a significant event relating to the prescribing of repeat medication and the gestational diabetes mellitus (GDM) audit. Whilst there was plentiful evidence of reacting to shortfalls and action planning, most of the audits or action plans had not been subjected to a review or re-audit to measure their effectiveness as we have previously noted.

The effectiveness and value of staff appraisals; the opportunities for staff development; the empowerment of staff and the designation of lead roles; the system of performance based rewards for the medical team and the approach to seeking feedback from the PPG were all evidence that the practice was a 'learning organisation'. Such an organisation strives to develop and improve throughout its leadership and organisational structure and this was the overall impression of Newtown Health Centre that we were left with.

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

All patients aged 75 and over had their own allocated GP who was accountable for their care in accordance with current Department of Health guidance. Patients with allocated GPs were not bound to see their allocated GPs each time but could choose which doctor they saw.

We saw that flu vaccines for older people who had problems getting to the practice were administered in the community by visiting clinicians and were transported to patients by means of a cold-box.

We noted that nurses and doctors undertook home visits for patients who were unable to get to the practice, for older people and for patients who required a visit following discharge from hospital. The practice maintained a good relationship with the community nursing team and collaborated with them to ensure that visits to patients were coordinated where both services were involved.

The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including older people.

We found that the practice had made use of a predictive tool known as 'risk stratification' to identify particular patients that might be at high risk or hospitalisation. This had resulted in specific care plans being drawn up for the 2% of the patient population, predominantly patients from this population group that were seen as being at highest risk of hospitalisation.

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 is located in an area which is considered to be deprived with large sections of the community experiencing poor quality housing. As a result there is an expected prevalence of long term respiratory conditions. The practice had well established clinics for asthma and chronic lung disorders and used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients through the provision of a range of printed information about healthy living and a dedicated smoking cessation clinic.

Patients who had developed type 2 diabetes could undergo a process known as an 'insulin start' supervised by a diabetic specialist nurse at the practice. This was a process that involved information being given to patients about their condition and the treatment using insulin so that they learned how to manage it over a period of time.

The practice made use of an alert system on the computerised patient database to help them to identify patients who might be vulnerable or have specific complex or long term needs and to ensure that they were offered consultations or reviews where needed.

Patients with long term conditions were recalled and monitored regularly and they had tailor-made care plans in place. Particular clinics operated for patients with diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions.

The practice provided information about, and coordinated referrals to, local drug and alcohol services.

The practice website included extensive information about long term conditions and their management. Patients could also be referred by their GPs to a chronic disease education service to help them to understand how to manage their long term conditions.

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 had run a clinical audit about their approach to monitoring and treating women with a history of diabetes in pregnancy, known as gestational diabetes mellitus (GDM). The GDM audit highlighted deficiencies with the management of this group of patients. As a result the practice put an action plan into place that provided them with opportunities to diagnose ongoing diabetes and to give appropriate diet and lifestyle advice that previously might have been missed.

Staff received safeguarding training in support of their policy and the local procedures. We saw that the practice staff were effective in identifying potential child abuse because 12 referrals had been made to the local authority under safeguarding procedures since April 2013. Furthermore, the computerised alert system identified individual patient's risk to enable clinicians to consider issues for their consultations, such as children who were known to be at risk of harm.

The practice was proactive in identifying ways of promoting good health within its younger population group. For example, the practice had identified that there were some barriers to young people locally being able to gain access to information or procedures relating to their sexual health.

We saw that the practice offered a confidential, albeit opportunistic service to young people by providing full sexual health screening. This was supported by the provision of condoms upon request and by the availability of private facilities for self-testing for chlamydia.

The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including families and women.

We saw that there was a chaperone policy in operation and a notice was displayed in reception that invited patients to ask if they required a chaperone when an intimate examination was taking place.

The practice ran a programme of childhood immunisations and hosted baby clinics provided by the health visiting team. This was supported by a range of information about child health and development in leaflet form and an even greater range of child health education information on the practice website relating to pregnancy, children aged 0-5 years and children aged 6-15 years.

GPs and the clinical staff understood the particular considerations for establishing whether young patients under 16 years of age understood information about their treatment and were competent to make decisions about it.

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

The practice website included a number of links containing extensive information about the promotion of health for a number of different population groups including families, men and women.

The practice did not routinely offer appointments outside of their core opening hours although we learned that patients could book some appointments up to six weeks in advance. This was designed to assist patients who might not be able to access appointments due to their work times.

We also learned that the practice had referred patients to a local slimming club

referred patients to a local slimming club through a lifestyle management service in order to help them with weight control and diet.

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 reception desk was constructed with a cut-out section at low level that enabled patients in wheelchairs to talk with reception staff at an appropriate height. In addition, the accessible toilets were on the ground floor, were clearly marked and had a wide uncluttered approach area from the waiting room to allow wheelchairs to move freely in and out.

Patients whose first language was not English were supported to understand their needs by involving interpreters in the discussion of their care and treatment. Interpreters were requested from a local interpreting service in advance of the patient's appointment. On the rare occasions when an interpreter was not available, such as for an emergency consultation, a telephone language service was used.

We saw that the practice took steps to ensure patient's cultural expectations were met when transferring to different services. For example, Muslim women were always seen by a female doctor or nurse at the practice if this was their choice. However if the patient was referred to a community clinic or hospital for minor surgery the referral was accompanied by an explicit written request for a female clinician to carry out the procedure.

The practice had run clinics intended to increase the uptake of cervical screening on Saturdays and in the evenings during the week with all female staff in attendance. However, this had not appreciably increased the uptake of the screening procedure and so those clinics had been halted.

Patients with learning disabilities were offered a health check every year, during which their long term care plans were discussed with the patient and their carer if appropriate.

The practice provided health care for an unidentified number of sex workers in the area, including a sexual health service although this was opportunistic as opposed to being part of a programme.

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 facilitated access to an independent advocacy service for patients who lacked capacity to consent. This was in order to help them to understand their treatment where this was indicated although we did not discuss any specific examples where this had been the case.

One of the nursing staff was designated as lead for, and had considerable expertise in mental ill-health. The nurse had a direct link with the local mental health services and personally managed all referrals to those services.

Patients with mental ill-health were invited for an annual review of their health, including their physical health, and their medicines.