Ferrybridge Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Ferrybridge Medical Centre on 8 September 2015. Overall the practice is rated as outstanding.

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.

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice had identified a gap in the sexual health service in the area and they had commenced a weekly youth clinic for patients under the age of 18 years.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided in a number of formats to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs. The practice had pioneered GP and advanced nurse practitioner (ANP) appointments at Pontefract General Infirmary to improve access for patients at weekends and to reduce the burden on the local accident and emergency department.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place,

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was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of excellent team working across all roles.

We saw several areas of outstanding practice including:

- The practice had shared the outcomes of a clinical audit undertaken within the practice relating to guidance published by the National Institute for Health and Care Excellence (NICE). They had shared the outcomes internally, locally with the Clinical Commissioning Group and nationally in a published paper in the British Journal of General Practice in September 2015.
- The practice had identified a gap in the sexual health service in the area. An advanced nurse practitioner (ANP) had been recruited to improve access to advice and support, particularly for young people. The nurse had worked with the Terence Higgins Trust to commence a weekly youth clinic for patients under the age of 18 years.
- The practice offered separate advice lines for children and those with long term conditions during opening hours. These were staffed by the ANPs. This enabled patients to access clinical support and advice and where necessary and appropriate be prescribed medicines. Patients said they found this to be a very useful service.
- The practice worked with the local Clinical Commissioning Group (CCG) to improve access to services at weekends. They had pioneered GP and advanced nurse practitioner appointments at Pontefract General Infirmary (A common venue where patients go to the accident and emergency department). They had written the business case, managed the pilot and assumed information governance responsibility. GPs and ANPs from the practice had filled the rota for these clinics. This scheme had been launched in February 2015 and had been extended until end of September 2015.

However there were areas of practice where the provider should make improvements:

- Improvements should be made in the dispensary at the branch surgery in relation to security and receipt of waste medicines. Dispensary staff should be involved in root cause analysis where there are significant events or near misses in their area.
- The High Street building should have more immediate access to a defibrillator.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were robust systems in place to safeguard children and adults whose circumstances may make them vulnerable.

Improvements should be made in the dispensary at the branch surgery in relation to security and receipt of waste medicines. Dispensary staff should be involved in root cause analysis where there are significant events or near misses in their area. The High Street building should have more immediate access to a defibrillator.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. They had shared findings from clinical audits regionally via the CCG and nationally through publication in a professional journal. Data showed patient outcomes were at or above average for the locality. The practice used innovative and proactive methods to improve patient outcomes and it linked with other surgeries and organisations to share best practice. The practice had identified a gap in the sexual health service in the area and a nurse had worked with the Terence Higgins Trust to commence a weekly youth clinic for patients under the age of 18 years.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions

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about their care and treatment. Information for patients about the services available was easy to understand and accessible. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found positive examples to demonstrate how patient's choices and preferences were valued and acted on. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. For example, the practice had worked with the local Clinical Commissioning Group (CCG) to improve access to services at weekends. They had pioneered GP and advanced nurse practitioner (ANP) appointments at Pontefract General Infirmary (A common venue where patients go to the accident and emergency department). They had written the business case, managed the pilot and assumed information governance responsibility. GPs and advanced nurse practitioners (ANP) from the practice had help to fulfil the rota for these clinics. The GPs told us this had reduced attendance at accident and emergency.

The practice offered separate advice lines for children and those with long term conditions during opening hours. These were staffed by the ANPs. This enabled patients to access clinical support and advice and where necessary and appropriate be prescribed medicines. Patients said they found this a very useful service.

It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Patients told us it was easy to get an appointment with a named GP or a GP of choice, and urgent appointments were available on the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of excellent

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team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. Outcomes of practice based clinical audits were shared locally and nationally. The practice was involved in a number of innovative schemes to improve outcomes for patients within their practice and the locality. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG).

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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice provided weekly GP and advanced nurse practitioner visits to a local care home.

The practice operated an advice line for patients and access to week end appointments at the local hospital.

Flu vaccination rates were one of the highest in the area.

People with long term conditions

Outstanding

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice operated an advice line for patients and access to week end appointments at the local hospital.

Flu vaccination rates were one of the highest in the area. The majority of patients with three or more long term conditions had a care plan.

There were robust recall systems in place managed by dedicated clinical and non-clinical staff for each area. The practice held specific clinics for patients with more than one long term condition so they only had to attend once for their reviews. A walk-in blood test clinic was provided three times per week.

Clinical audits were used to improve the outcomes for patients with long term conditions. Outcomes of audits had been widely shared both locally and nationally.

Families, children and young people

Outstanding

The practice is rated as outstanding for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who

were at risk. The advanced nurse practitioner with the lead role for safeguarding worked closely with the health visitor and other agencies. Childhood immunisation rates for the vaccinations given were higher than local CCG averages. The practice had worked well with the local travelling community and had provided an immunisation programme for children living in these circumstances within their own environment. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

The practice had identified a gap in the sexual health service in the area and services had been developed to improve access to advice and support, particularly for young people.

There were a number of positive comments about the care and treatment of children in respect of access to urgent appointments and the caring attitude of reception and clinical staff. The practice had developed a telephone advice line for parents giving them quick and easy access to clinical support during practice opening hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

The appointment system was flexible and provided extended hours and walk-in blood test clinics. A telephone advice line was also provided which gave patients quick and easy access to clinical advice and support.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice had three nurse clinical leads and a dedicated administration person for learning disability patients. Annual health reviews were completed for these patients and care and treatment could be provided in the patient's own home where this was beneficial and assisted in engaging patients to have appropriate care. Ferrybridge surgeries were accredited as a "Safer Place" which is a scheme to provide a safe haven for

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vulnerable patients lost in the community. The practice had worked well with the local travelling community and had provided an immunisation programme for children living in these circumstances within their own environment. The practice provided in house services to provide care and treatment for patients with misuse of drug and alcohol related needs.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. There were robust systems in place to safeguard children and adults whose circumstances may make them vulnerable. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. Performance for mental health related indicators was 100% which was 5.8 percentage points above CCG average and 9.6 percentage points above England average.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A and E) where they may have been experiencing poor mental health.

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What people who use the service say

The national GP patient survey results published on 4 July 2015 for the most recent data showed the practice was performing well above local and national averages in a number of areas. There were 307 survey forms distributed for Ferrybridge Medical Centre and 107 forms were returned. This is a response rate of 34.9%. Results included;

- 86.4% found it easy to get through to this surgery by phone compared with a CCG average of 71.6% and a national average of 74.4%.
- 87.8% found the receptionists at this surgery helpful compared with a CCG average of 86.6% and a national average of 86.9%.
- 49% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 53.2% and a national average of 60.5%.
- 88.3% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 85% and a national average of 85.4%.
- 96.3% said the last appointment they got was convenient compared with a CCG average of 93.4% and a national average of 91.8%.
- 81.2% described their experience of making an appointment as good compared with a CCG average of 73.3% and a national average of 73.8%.
- 79.6% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 71.3% and a national average of 65.2%.
- 75.5% felt they didn't normally have to wait too long to be seen compared with a CCG average of 62.7% and a national average of 57.8%.

As part of our inspection we asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards all of which were positive about the standard of care and treatment received. We also spoke with 14 patients on the day of the inspection including a member of the patient participation group (PPG). Other than comments from one person the comments we received were very positive about their experience of the service. Patient's told us staff were very caring and professional. They told us the staff took their time to listen to them and explain treatments. They said they were treated with dignity and respect and they said the reception staff were helpful and polite. They also told us they found the practice to be clean and tidy. Patients were very positive about the appointment system and said they could always access a same day urgent appointment. They told us they received continuity in their care and could see a GP of their choice within an acceptable timeframe. There were a number of positive comments about the care and treatment of children in respect of access to urgent appointments and the caring attitude of reception and clinical staff..

Ferrybridge Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, pharmacist specialist advisor, a practice manager specialist advisor, nurse specialist advisor and an expert by experience.

Background to Ferrybridge Medical Centre

Ferrybridge Medical Centre is situated within a purpose built surgery in Knottingly, Wakefield known as Beauforth House. Beauforth House has a separate building, known as the High Street, where additional surgery space can be utilised for clinics as required. This building is situated a short distance across from Beauforth House car park. We visited both buildings during this inspection. There is also a branch surgery at The Surgery, Anne Sharpe Centre, St Edwards Close, Byram, WF11 9NT. We visited this branch surgery as part of this inspection.

The practice provides Personal Medical Services (PMS) for 9,911 patients across the three sites in the NHS Wakefield Clinical Commissioning Group (CCG) area.

There are five GP partners, and four salaried GPs, four advanced nurse practitioners, one specialist practitioner nurse, two practice nurses and three health care assistants who all work across both sites. There is a large administration team who also work across each site including a practice manager, reception manger and IT manager. The practice manager is responsible for all three sites.

The practice is open at the following times across the three sites:

- Beauforth House - Reception opening times are 8am to 6.30pm Monday to Friday. Surgeries are between 8.30am and 6.30pm Monday to Friday.
- High Street – Reception opening times are 8am to 6.30pm, Monday to Friday.This building holds surgeries and clinics between 8.30am and 6pm Monday to Friday as required and provides additional space to Beauforth House.
- Byram – Reception opening times are 8.15am to 11.30am and 2.30pm to 6.30pm Monday to Friday. Surgery opening times are from 8.30am to 11.30am and 2.30pm to 6.30pm Monday to Friday excluding Wednesdays. On Wednesdays, Byram closes at 11.30 am.

Extended Hours are provided 8.30am to 11.30am every Saturday at Beauforth House. Walk-in blood test clinics are available at the High Street building every Monday 1.30pm to 4.15pm, Tuesday 8am to 11.30am and Thursday 8am to 11.30am.

Longer appointments are available for those who need them and home visits and telephone consultations are available as required.

The practice provides a dispensing service to 2,700 of its patients from both Beauforth House and Byram surgeries.

Out of hours services are provided by Local Care Direct. Calls are diverted to this service when the practice is closed.

The practice also provided training in general practice for doctors and medical and nursing students.

Detailed findings

The practice is registered to provide the following regulated activities; maternity and midwifery services; surgical procedures, family planning, diagnostic and screening procedures and treatment of disease, disorder or injury.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 which is part of our regulatory functions. This inspection was planned to check whether the registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note 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 the time.

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations, such as the NHS Wakefield Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 8 September 2015. During our visit we spoke with a range of staff including six GPs, two advanced nurse practitioners, three practice nurses, health care assistant, practice manager, IT manager and six administration staff. We also spoke with 14 patients including a member of the PPG.

We observed communication and interactions between staff and patients, both face to face and on the telephone within the reception area. We reviewed 16 CQC patient comment cards where patients had shared their views and experiences of the practice. We also reviewed records relating to the management of the practice.

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. The practice carried out a root cause analysis of significant events and a quarterly report was completed and discussed at practice meetings.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared when an incident had occurred to make sure action was taken to improve safety in the practice. For example, there had been 15 incident's recorded as significant events over the last 12 months. One incident related to a vaccine. Actions and learning were clearly recorded and practice had been reviewed and changed to mitigate risk.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) electronic form to report patient safety incidents.

The practice had a good and robust system for dealing with medicine alerts. These were cascaded to both dispensaries and there was an audit trail to show that they had been dealt with appropriately.

Dispensers told us near misses or errors were reported centrally to the supervisor and logged on the intranet. However, we found there was no feedback loop for dispensary staff to share best practice or to have involvement in performing root cause analysis.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. One of the advanced nurse practitioners (ANP) was the lead member of staff for safeguarding. They worked closely with the health visitor and had good links with other teams such as the Police, domestic abuse team and multi-agency safeguarding hub. The health visitor attended monthly clinical meetings to discuss safeguarding concerns. The health visitor told us working together with the practice had improved the support for vulnerable children and families. The ANP also attended local Clinical Commissioning Group (CCG) meetings for safeguarding leads and disseminated information from these meetings to the practice team. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. Training relating to current safeguarding themes was also provided. For example, the safeguarding lead and the health visitor were scheduled to provide joint training in September 2015 in female genital mutilation and child sexual exploitation. There was a clear system for recording and sharing information and the IT system was used to identify vulnerable patients at risk of abuse.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones, if required. Nurses, healthcare assistant's and some reception staff acted as chaperones. They had received training and had a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had a health and safety manager, a health and safety policy was available and staff had received training in matters relating to health and safety. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working

properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.

- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The last audit had been completed in April 2015 with 89% compliance. The main areas of non-compliance identified were the lack of a designated dirty utility room for which options were being considered and also the lack of a hand basin in the cleaners room and where installation of a sink was planned. Other areas identified had been actioned. The infection control lead had provided training to the whole team on infection control and had addressed the issues from the audit with staff.
- The arrangements for managing medicines, including emergency drugs and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling and storing). For example, the controlled drugs cabinet provided safe and secure storage to current guidance standards and there were processes in place to keep keys secure. When we checked, the controlled drug inventory balanced with the records and these were accurate and complete. The systems to monitor the temperature of the fridges used for storing vaccines were robust and required the temperature to be logged on the computer twice daily. The computer system had an alarm in order to prompt staff to complete this task. Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use.
- The practice had a dispensary at Beauforth House and Byram surgery. The medication in both dispensaries was well organised with evidence of stock rotation. All dispensary staff had relevant NVQ level two qualifications. The dispensaries procedures and standard operating procedures were up to date and available on the intranet. The practice had a robust system for dealing with medication alerts. These were cascaded to both dispensaries and there was an audit trail to show that they had been dealt with appropriately. We saw some areas for improvement in the dispensaries. The dispensary at Byram was positioned in the corridor between the waiting room and surgeries and the dispenser had the task of also manning the reception desk. This meant the dispensary was unmanned for some of the time and could not be observed by the dispenser if dealing with a patient at the reception desk. We saw the dispensary had the door left open potentially providing unobserved access for patients. We highlighted this to the practice during the inspection and they assurred us us they would improve the security of this area. Patients could return waste medication to Byram where it was transported back to Beauforth House for destruction. These medicines were not logged on receipt at Byram to ensure a complete audit trail. Dispensers told us near misses or errors were reported centrally to the supervisor for investigation and logged on the intranet system. However, we found there was no feedback loop for dispensary staff to share best practice or perform any root cause analysis.
- Recruitment checks were carried out and the four files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff were all happy working at the practice and a number had worked there for many years. However, we had some comments that the administration staff team were short staffed and they had to increasingly work overtime to provide cover. They told us recruitment was ongoing but seemed to take too long.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted

Good

Are services safe?

staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. However we did note that one defibrillator was shared between Beauforth House and the High Street sites. The practice manager provided a risk assessment after the inspection and this identified that while access to the defibrillator met current guidelines they were going to purchase additional equipment. There was also a first aid kit and an accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet needs. For example, the practice had completed a clinical audit, following guidelines being published by NICE which recommended that every patient with the skin condition, Psoriasis, should have a cardiovascular risk assessment. The NICE guidance had identified that there was a significantly increased incidence of stroke, heart disease and diabetes in this group of patients. The practice identified the patients with this skin condition that had not already attended for a NHS health check and invited them to attend. A number of patients with risk factors requiring interventions to minimise the risks of stroke and heart attacks were identified and treatment was commenced. The outcomes of the audit were shared within the practice, locally with the CCG and nationally in a published paper in the British Journal of General Practice in September 2015.

Patients on the unplanned admissions register who were 75 years of age plus and the majority those with three or more long term conditions had a personalised care plan. Care plans reflected best practice and were reviewed at three, six and 12 monthly intervals. We were told that if the patient was not able to attend the practice then the nurses would visit the patient in their home or care home to ensure their involvement in developing the care plan. The practice was involved in a local pilot scheme relating to unplanned admissions avoidance whereby a GP and an advanced nurse practitioner (ANP) conducted weekly visits to a local care home. This enabled these patients to be involved in their care planning. There were also procedures in place for following up patients who had been admitted to hospital.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data showed the practice had attained 96.8% of the total number of points available, with 8.4% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/14 showed;

- Performance for diabetes related indicators was similar to the CCG and national average at 91.2% which was 0.2 percentage points below CCG average and 0.1 percentage points above England average
- The percentage of patients with hypertension having regular blood pressure tests was 82.4% which was 1.2 percentage points below CCG average and 0.7 percentage points below England average.
- Performance for mental health related indicators was 100% which was 5.8 percentage points above CCG average and 9.6 percentage points above England average.
- Performance for hypertension indicators was 86.5% which was 2.9 percentage points below CCG average and 1.9 percentage points below England average.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. For example:

- The practice was working with the CCG and was currently achieving six of the ten quality prescribing indicators. We saw they had used clinical audits to achieve these targets and they were on track to achieve all ten targets by the end of the year. The practice had also accessed prescription data to monitor prescribing habits of the clinicians. We saw action had been taken where prescribing was not in line with local/national policy.
- An audit on the care and treatment of patients with urinary tract infections had been completed. This had looked at differing practices among the clinicians in relation to care and treatment. From this study a new

protocol had been developed and implemented to ensure best practice. We were told this area would be reviewed in twelve months to look at how compliant the practice had been with the new protocol.

- The practice was involved with the Aspire National Study with Leeds University as practice figures for strokes were high indicating possible undiagnosed hypertension. They found detection rates for hypertension were good but outcomes where there were difficulties regulating blood pressure were less positive. The Aspire study provided an interactive programme from which the practice could get expert advice on care and treatment.
- The practice had also recently introduced atrial fibrillation testing using the Mydiagnostic tool to improve detection of atrial fibrillation and subsequent therapy in line with NICE guidelines.
- The nursing team were also involved in clinical audits, one nurse told us they conducted audits of smear tests for effectiveness and said they were involved in gathering information for other clinical audits held in the practice. They told us about an audit related to a pilot scheme which involved telephone reviews for patients with Asthma. The practice specialist nurse practitioner had presented the outcomes of this at a Respiratory network meeting. They said an annual recall system had been implemented which had improved patient attendance for asthma reviews. The independent nurse prescribers undertook an annual audit of their own prescribing practice and this audit was then peer reviewed at the CCG non-medical prescribing group.

The practice had good systems in place to monitor patients with long term conditions. For example, the practice had a documented procedure to ensure effective recalls of patients with long term conditions. This identified the member of staff responsible for each related task and included the procedure for contacting patients who did not attend. The practice held specific clinics for patients with more than one long term condition so they only had to attend once for their reviews.

The practice also had a good system for monitoring patients prescribed high risk disease-modifying anti-rheumatic drugs (DMARD's). For example, this was dealt with by one clinician who ensured all necessary blood tests were conducted. This prevented patients receiving repeat medication without review. Triggers were also in place to highlight anomalies in blood results in order to prompt a review.

The practice held monthly case reviews of patients registered at the practice that had died.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. The practice provided above national average, whole time equivalent, clinical staffing levels at 1.7 per 1,000 patients compared to national average of 1.6 per 1,000.

The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.

All staff received refresher training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

GPs confirmed there was opportunity for training and development and they said they were well supported. They told us they attended monthly training sessions within the practice and at the CCG. The practice also provided training in general practice for doctors and medical students.

There was a skilled nursing team at the practice led by an ANP. We found all nurses were trained in specific disease areas and were encouraged to attend updates at least annually. Training needs and prioritisation of training needs and desires were discussed at the weekly nurse meeting.

There was a clear and robust system of training and supervision for the health care assistant (HCA) team. All of the HCAs were included in the training programme for nurses as appropriate. They had their own training log and

were supported by a mentor. All HCAs received formal training on phlebotomy, had annual updates on flu and immunisation and were also encouraged to attend the annual HCA conference. All HCAs had attended study days on hypertension, NHS health checks and lifestyle modification and they had attended Wakefield CCG's bespoke training for HCAs on managing wound care. Two HCAs had also received further training on immunisation for flu, shingles and vitamin B12. The HCAs were supported by and had access to a registered nurse. They worked to their pateint specific directives which stipulated that a registered member of staff had to be on the premises if they are giving any immunisations/injections.

We found there was excellent workforce planning. There was a good understanding of the challenges facing the general practice nurse workforce and the lead nurse had been instrumental in bringing undergraduate nurse students for placements within the practice. The latest practice nurse recruit was a newly qualified nurse and we saw they had received a robust training programme. This had included attendance at a practice nurse course and training in cytology, asthma, immunisations, coronary heart disease and diabetes.

The nursing team mentor for student nurses and three other practice nurses had attended mentor updates in 2015 and all students had a mentor.

The practice was very active in the local CCG and the lead nurse was involved with external activities, for example, they were the chairperson of the non-medical prescribing group.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and its intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way, for example when people were referred to other services. A visitor from external agencies told us there was good communication with the practice.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and had received training in relevant areas. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. We saw a template for sexual health matters which had a section to address Fraser guidelines and a section for assessing Gillick competence (set of criteria which must be applied when medical practitioners are offering contraceptive services to under 16s without parental knowledge or permission) and a section for consent. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. The process for seeking consent was monitored through training and meetings to ensure this met the practice's responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking cessation and drug and alcohol misuse. Patients were then signposted to the relevant service. The practice also provided in house services for drug and alcohol misuse and dermatology.

The practice had three nurse clinical leads and a dedicated administration person for learning disability patients. Annual health reviews were completed for these patients. Care and treatment could be provided in the patient's own home where this was beneficial and assisted in engaging patients to have appropriate care. For example, one patient required a cervical smear but due to anxiety could not have this performed at the surgery. The nurses arranged for this to be completed in the person's own home.

Good

Are services effective?

(for example, treatment is effective)

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 80.86%, which was comparable the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were slightly higher than CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.8% to 99.2% and five year olds from 95.1% to 98%. Comparable CCG rates were 88.7% to 98% and 91.9% to 95.1%. Flu vaccination rates for the over 65s were 80.25% and at risk groups 62.17 %. These were above national averages of 73.24% and 52.29%. Nurses from the practice had provided a child-hood vaccination service to a local travelling community. Through this trust was gained with a family who subsequently began to attend the surgery.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. To support this, the practice provided walk-in phlebotomy clinics three days per week. Appropriate follow-ups on the outcomes of health assessments and checks were made where abnormalities or risk factors were identified.

The practice had identified a gap in the sexual health service in the area. An advanced nurse practitioner (ANP) was recruited to improve access to advice and support particularly for young people. The nurse had worked with the Terence Higgins Trust to bring in a weekly youth clinic for patients under the age of 18 years. The clinic ran once per week for two hours on a drop-in basis. The health advisor and sexual health nurse initially worked in this clinic but this was now also supported by the other practice nurses. The nurse told us this clinic was now well-known locally and well used. The clinic offered screening for sexually transmitted diseases such as chlamydia. They also offered rapid access HIV thumb prick tests and if positive, bloods were then taken immediately.

The practice had supported a member of staff to complete training to enable them to implement the use of social media as a tool to engage with patients. They had set up a Facebook page and Twitter account. They used these systems to give generic health information and to promote health awareness.

The practice had supported a health promotion day at a local supermarket to identify patients in the area who may have an undiagnosed condition no matter with which surgery they were registered. This had been arranged based on evidence of higher prevalence of hypertension and stroke in patients locally. Information had been shared with the patients' surgery with their consent.

The practice was also in the process of implementing the "All together better" practice health champions scheme. This involved the patients setting up interest groups and aimed to combat social isolation amongst the elderly. They had received a positive response from the patients with 52 expressing interest in becoming involved.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 16 patient CQC comment cards we received were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a member of the patient participation group (PPG) on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was similar to CCG and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 89.8% said the GP was good at listening to them compared to the CCG average of 88.8% and national average of 88.6%.
- 86.9% said the GP gave them enough time compared to the CCG average of 87.7% and national average of 86.8%.
- 91.4% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95.3%.
- 92.1% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 85.1%.
- 88.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and national average of 90.4%.
- 87.8% patients said they found the receptionists at the practice helpful compared to the CCG average of 86.6% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views. The nurses and GPs offered home visits for patients who required these to ensure they were involved in their care plans and received the care they required.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were above local and national averages. For example:

- 90.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86.3% and national average of 86.3%.
- 83.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81.3% and national average of 81.5%.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. The practice website had a translate page function and information leaflets were available in different languages and easy to read formats. For example, we saw leaflets in different languages relating to cytology and breast examination.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer and the practice held a register of all people/

Good

Are services caring?

patients who were carers. Written information was available for carers to ensure they understood the various avenues of support available to them such as the local carers association.

Staff told us that if families had suffered bereavement, they would be advised on bereavement counselling serves and the practice would send them a sympathy card.

Ferry bridge surgeries were accredited as a “Safer Place” which is a scheme to provide a safe haven for vulnerable people lost in the community.

Care and treatment could be provided in the patient’s own home where this was beneficial and assisted in engaging patients to receive appropriate care. For example, where one patient required treatment but due to anxiety could not attend the surgery, the nurses arranged for this to be completed in the persons own home.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to plan services and to improve outcomes for patients in the area. For example, the practice had pioneered GP and advanced nurse practitioner (ANP) appointments at Pontefract General Infirmary, Saturday and Sundays, 11am to 4pm for patients to improve access and reduce the burden on the local accident and emergency department. They had written the business case, managed the pilot and assumed information governance responsibility. GPs and ANPs from the practice had filled the rota for these clinics.

Services were planned and delivered to take into account the needs of different patient groups and to help provide flexibility, choice and continuity of care. For example:

- The practice offered extended hours on a Saturday morning from 8.30am to 11.30am at Beauforth House for routine pre booked appointments patients who could not attend during normal opening hours. Drop-in phlebotomy services were also available at the High Street building three times per week.
- The practice had maximised the skill mix within the nursing team which had made a positive impact on patient access to services.
- There were longer appointments and home visits available for people with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were disabled facilities, hearing loop and translation services available at all three sites. There was extensive use of braille throughout Beauforth House.
- The web site had a translate page function, the electronic patient check-in system was available in different languages, interpreter services were available and information leaflets were available in easy to read formats.
- The practice had worked with the local travelling community to provide childhood vaccinations within their own environment.

Access to the service

The practice was open at the following times across the three sites:

- Beauforth House - reception opening times were 8am to 6.30pm Monday to Friday. Surgeries were between 8.30am and 6.30pm Monday to Friday.
- High Street – reception opening times were 8am to 6.30pm. Surgeries and clinics were held between 8.30am and 6pm Monday to Friday.
- Byram – reception opening times were 8.15am -11.30am and 2.30pm -6.30pm Monday to Friday. Surgery opening times were from 8.30am to 11.30am and 2.30pm to 6.30pm Monday to Friday excluding Wednesdays. On Wednesdays, Byram closed at 11.30 am.

Extended hours were provided 8.30am to 11.30am every Saturday at Beauforth House. Walk-in blood test clinics were available at the High Street building every Monday 1.30pm to 4.15pm, Tuesday 8am to 11.30am and Thursday 8am to 11.30am.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

The practice offered two separate advice lines during opening hours, one for children and one for general queries. These were staffed by the ANPs and meant that patients could access clinical support and advice over the telephone and, where necessary and appropriate, be prescribed medicines. Patients said they found this a very useful service.

People we spoke to on the day told us they were able to get appointments when they needed them. For example, patients told us they could get appointments the same day and they could see a GP of their choice within a reasonable timescale. One patient told us how the practice worked with them to offer extended family appointments.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was much better than local and national averages For example:

- 82.6% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75.7%.
- 86.4% patients said they could get through easily to the surgery by phone compared to the CCG average of 71.6% and national average of 74.4%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 81.2% patients described their experience of making an appointment as good compared to the CCG average of 73.3% and national average of 73.8%.
- 79.6% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71.3% and national average of 65.2%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system and was available in the practice and on the website. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We found 19 complaints had been received in the last 12 months. We found these were satisfactorily handled and dealt with in a timely way.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. Learning was disseminated via meetings. For example, where a patient had experienced difficulties with online ordering and electronic transfer of prescriptions an investigation had been completed. Action had been taken in terms of addressing the error with the member of staff involved. The systems were monitored to ensure there were no further problems.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their aims and objectives were documented in its statement of purpose and included providing a high standard of health care to all patients, evolving health care services for patients in line with clinical evidence of their emerging needs and to make patients and carers an integral part of the decision making about health care. We found the aims and objectives were being achieved and were embedded within the culture of the practice. The practice had a robust strategy and supporting business plans which reflected the vision and values and were these were regularly monitored.

Governance arrangements

The practice had a strong overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was strong leadership in all areas of the practice and a clear staffing structure. Staff were aware of their own roles and responsibilities and worked well together.
- The practice carried out proactive succession planning.
- There was excellent team work and the practice worked well with others.
- Education and training was well supported and given a high priority within the practice.
- Practice specific policies were implemented and were available to all staff
- There was a comprehensive understanding of the performance of the practice
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to manage the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty. The GP, nursing and administration teams were well led as individual teams and they all worked closely together in a cohesive manner.

Staff told us that regular team meetings were held and there was an open culture within the practice. They said they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team away days were held. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice was in the process of initiating a detailed survey of patients in response to data from the national GP survey. This had indicated patients may not be fully satisfied with the continuity of care provided. The survey was to ask patients specific information relating to this area in order to improve the services provided.

There was a small but active PPG which met on a quarterly basis. One member of the PPG said that while they found the practice to be excellent they thought the involvement of the PPG and communication with the practice could be improved. They told us some action had been taken in relation to suggestions the PPG had made. For example, they had suggested that the practices withheld number be changed so patients could identify who was contacting them via the telephone and this had been actioned.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. Staff told us they would not

Are services well-led?

Outstanding ☆

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

hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example,

- The lead nurse, as part of her master's degree course, had set up a triage system in the practice. They said this worked well initially, but after review with patients this had evolved into an advice line service. There were two advice lines, one for general advice and one for parents to ask advice in relation to their children's health needs. These were staffed by the ANP and meant that patients could access clinical support and advice and, where necessary and appropriate, be prescribed medicines. They had undertaken several service reviews of the practice to ensure its effectiveness. The service was operated five days a week from 8am to 6.30pm.
- The practice had completed a clinical audit following guidelines being published by NICE which recommended that every patient with a specific skin condition should have a cardiovascular risk assessment. The outcomes of the audit were shared within the practice, locally with the CCG and nationally in a published paper in the British Journal of General Practice in September 2015.
- The practice had pioneered GP and advanced nurse practitioner (ANP) appointments at Pontefract General Infirmary (A common venue where patients go to the accident and emergency department) Saturday and Sundays 11am – 4pm. They had written the business case, managed the pilot and assumed information governance responsibility. GPs and ANPs from the practice had helped to fulfil the rota for these clinics. This scheme had been launched in February 2015 and had been extended until end of September 2015. The GPs told us this had reduced attendance at accident and emergency.
- The practice had identified a gap in the sexual health service in the area. One of the ANPs was recruited to try and improve access to advice and support particularly for young people. The nurse had worked with the Terence Higgins Trust three years ago to bring in a weekly youth clinic for patients under the age of 18 years. The clinic offered screening for sexually transmitted infections such as chlamydia and gonorrhoea. They also offered rapid access HIV thumb prick tests and if positive, bloods were then taken on the spot.
- The practice had supported a member of staff to complete training to enable them to implement the use social media as a tool to engage with patients. They had set up a Facebook page and Twitter account. They used these systems to give generic health information and to promote health awareness.
- The practice had supported a health promotion day at a local supermarket to identify patients in the area who may have an undiagnosed condition no matter with which surgery they were registered. This had been arranged based on evidence of higher prevalence of hypertension and stroke in patients locally.