FMC Health Solutions Limited

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at FMC Health Solutions Limited on 15 September 2015. Overall the practice is rated as good.

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

Summary of findings

- The practice had a substance misuse and abuse worker to support alcohol reduction and could demonstrate this had a positive impact for patients using this service. Overall patient satisfaction was the best in the CCG
- Clinician staff to patient ratio was amongst the highest in the CCG
  - Patient satisfaction ratings: Access, Quality, Patient Experience, amongst the highest in the CCG.
  - Friends and Family Test scored 97% approval (July 2015)
  - The practice obtained a top ten Flu vaccination rate in the CCG
  - 65% of patients with three or more Long Term Conditions (LTCs) had a care plan
  - The practice is accredited as 'Safer Place' a safe haven for vulnerable patients lost in the community
  - Internet development included on-line video tutorials for patients on managing long term conditions and new medication compliance

We saw several areas of outstanding practice including:

- 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. During the period of the pilot the GP service saw 760 patients. These patients would otherwise have been managed by the A&E clinicians, so it reduced A&E's workload.
- The practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the GP out of hours service and very positive patient survey results.
- The practice had reached out to the local community by approaching schools and had attended them to promote better health. If any underlying health issues were identified the patients (if they belonged to the practice) were offered an appointment at the practice and patients from other practices were advised to attend their own GP.
- The practice was involved with two national studies and a quality improvement programme to better manage patients with Diabetes with detailed action plans which target higher risk patients. One of the GPs recently had this work published by RCGP and the results were disseminated nationally.

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 report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

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 also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing significantly better than neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes, better use of resources and it linked with other local providers to share best practice.

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 almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical

Summary of findings

Commissioning Group (CCG) to secure service improvements where these had been identified. The practices efforts in screening, identification and diagnosis within Park View, resulted in prevalence being higher than the CCG average. As a result more patients who were affected by diabetes were being treated.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments 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 and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. 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 using new technology, and it had a very active patient participation group (PPG) which influenced practice development.

The practice was being constantly alert to ways in which it might make improvements for patients seeking to use whatever opportunities arose to provide better services, that are more accessible and responsive for their patients and the local community.

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 and had a range of enhanced services, for example, dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Patients with a high need for medical care; at risk of hospital admission or isolated were reviewed by the practice to provide additional support in their own home. This included referral to multidisciplinary teams and voluntary sector services.

People with long term conditions

Good

The practice is rated as good 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.

Flu vaccination rates were one of the highest in the 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.

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.

The practice showed us that 65% of patients with three or more Long Term Conditions (LTCs) had a care plan.

The practice were currently developing the next phase of the website in which they will include on- line tutorials for patients with long - term conditions and other resources, which will have a positive impact on patients.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

The practice is rated as good 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, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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. We saw good examples of joint working with midwives, health visitors and school nurses.

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.

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 reflects the needs for this age group.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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. 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.

Summary of findings

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). Over 65% of people experiencing poor mental health had received an annual physical health check. 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.

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&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The practice has improved the dementia prevalence significantly in the last 12 months as a result of additional work and screening within the patient population. The dementia prevalence rates are close to the CCG and National averages (0.4% difference), according to QOF 2014/15.

Patients who had learning disabilities, dementia or autism and were registered with the 'Wakefield Safer Places' scheme and were able to come to the practice if they were out in the community and were lost or disorientated. All the surgeries were registered as Safer Places and displayed the Safer Places logo. Staff knew to check that the patient has a card on which there will be several people or organisations that can be contacted and to ensure the person is protected. The Safer Place scheme is a voluntary scheme to assist vulnerable people with learning difficulties, autism and dementia to feel safer when travelling independently in the community. The practice is registered by Wakefield Council.

Summary of findings

What people who use the service say

The national GP patient survey results published on 2 July 2015 showed the practice was performing above local and national averages. Of 427 survey questionnaires sent out to patients there were 128 responses, representing a response rate of 30% or 4.7% of the patient list.

- 96% find it easy to get through to this surgery by phone compared with a CCG average of 72% and a national average of 73%.
- 98% find the receptionists at this surgery helpful compared with a CCG average of 87% and a national average of 87%.
- 62% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 53% and a national average of 60%.
- 94% 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%.
- 94% say the last appointment they got was convenient compared with a CCG average of 85% and a national average of 85%.
- 91% describe their experience of making an appointment as good compared with a CCG average of 73% and a national average of 73%.
- 90% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 71% and a national average of 65%.
- 91% feel they don't normally have to wait too long to be seen compared with a CCG average of 63% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards which were all positive about the standard of care received. Comments included how patients found visiting the practice a pleasure and the staff were always courteous and helpful.

Outstanding practice

- 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. During the period of the pilot the GP service saw 760 patients. These patients would otherwise have been managed by the A&E clinicians, so it reduced A&E's workload.
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FMC Health Solutions Limited

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and three specialist advisors (a GP, a practice manager and a practice nurse). Our inspection team also included an Expert by Experience who is a person who uses services themself and wants to help CQC to find out more about people's experience of the care they receive.

Background to FMC Health Solutions Limited

FMC Health Solutions Limited is registered with CQC to provide primary care services, which includes access to GPs, family planning, surgical procedures, treatment of disease, disorder or injury and diagnostic and screening procedures. It provides GP services for patients living in the Normanton area of Wakefield.

There is a team of GPs at the practice, some male and some female who all together are equivalent to two full time GPs. The practice also has a management team, practice nurses, healthcare assistants and administrative staff.

The practice is open 8:30am to 6:00pm on Monday to Friday with a closing time of 12 noon on Wednesday. Patients can book appointments in person, via the phone and online. Appointments can be booked five weeks in advance for both the doctor and nurse clinics. Out of hours services are provided by Local Care Direct. Calls are diverted to this service when the practice is closed.

The practice has an Alternative Provider Medical Services (APMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

The practice is part of NHS Wakefield Clinical Commissioning Group (CCG). It is responsible for providing primary care services to 2,728 patients. The practice generally comprised of an equal number of women and men.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme.

We carried out an announced comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as 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 in accordance with 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 CQC at that time.

How we carried out this inspection

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

Detailed findings

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

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

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

Before our inspection we carried out an analysis of the data from our intelligent monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the policies, procedures and other information the practice provided before the inspection. The information reviewed did not highlight any significant areas of risk across the five key question areas.

We reviewed all areas of the practice including the administrative areas. We sought views from patients through eight face-to-face interviews. We spoke with GPs, the practice manager, a nurse practitioner, the IT manager and receptionists.

We observed how staff treated patients when they visited or phoned the practice. We reviewed how the GP made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

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. All complaints received by the practice were entered onto the system and automatically treated as a significant event. The practice carried out an analysis of the significant events.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, Heart Failure management, the practice recognised (as a result of a quality and improvement audit) that after diagnosis patients with heart failure may not have their treatment optimised. Patients were coded for heart failure. Therapy had improved for all 14 patients on the register.

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.

As all the GPs and nurses have different specialities whom bring new NICE guidance to the various team meetings e.g. substance misuse specialist, dermatology specialist, cardiology specialist. These new NICE guidelines are disseminated to all staff once a week. As a result of this information sharing and education effective patient plans were then put in place.

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. There was a lead member of staff for safeguarding. 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. The safeguarding lead and the health visitor were scheduled to provide joint training in September 2015 in female genital mutilation and child sexual exploitation. This training was planned to be delivered to both locations owned by the practice (Ferrybridge & FMC Health Solutions).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. All staff who acted as chaperones were trained for the role and had received 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. There was a health and safety policy available with a poster in the reception office. 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 and infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The 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 audit dated 17 August 2015 showed an above 90% score.

- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Regular medication audits were carried out with the support of the local CCG (Clinical Commissioning Group) pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. A GP at the practice was the prescribing lead. They received all emails from the Medicines Optimisation team and disseminated this to all the GPs. The prescribing lead also attended quarterly CCG GP prescribing lead meetings, and had CCG support from the prescribing technician who provided bespoke support to other practices. We discussed a recent medication alert, the GP conducted searches on the IT system, as a result a letter was sent for telephone consultation. As a result of the consultations a repeat audit was completed and the outcome of this audit was that just one patient was now on the drug domperidone. The CCG prescribing data which was reviewed showed better than average results for antibiotic usage.
- Recruitment checks were carried out and the three files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. These included proof of identification, references from previous employers, qualifications, registration documentation 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 from the Ferrybridge practice helped out when staff shortages occurred.

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 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. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all 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. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

An audit on diabetic testing kits highlighted inappropriate use. As a GP and nurse specialism was in diabetes care. The practice have now put everyone on the same testing kits and now all GPs are conforming to this in their prescribing habits. We saw the audit report to confirm this.

Also, the practice had completed a clinical audit, following guidelines published by NICE which recommended that every patient with a specific skin condition 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 then identified the patients with this skin condition that had not already attended 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.

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. Current results were 99% of the total number of points available, with 11% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- Performance (prevalence) for diabetes related indicators was better than the CCG and national average, 6% prevalence with a CCG Average 5% prevalence. QOF 2013/14 latest data for performance against diabetes indicators, 95% which was 5% above CCG average
- 5% above NHS England average. The practices efforts in screening, identification and diagnosis within Park View, does mean that the prevalence is higher than the CCG average. As a result more patients who are affected by diabetes were being treated.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the CCG and national average, QOF 2013/14 78%, 3% below CCG average and 1% below the national average.
- Performance for mental health related and hypertension indicators was similar to the CCG and national average QOF 2013/14. Hypertension 87%, 2% below CCG average and 1% below NHS England average.

The practice has improved the dementia prevalence significantly in the last 12 months as a result of additional work and screening within the patient population. The dementia prevalence rates areclose to the CCG and National averages (0.4% difference), according to QOF 2014/15.

One of the reasons why the practice has a lower dementia prevalence and incidence is because the age distribution forpatients over 75 at Park View surgery is lower than the Wakefield CCG and National average. (Source: HSCIC - Public Health England 2014).

Another indicator for this is that they only have four patients out of 2700 in care homes and a low number, nine, on the QOF dementia register (Source: Primary Care Web Tool - March 2015).

However, the practice continues to make efforts to accurately assess and identify those considered to be at risk of dementiain order to counteract the statistical effect ofthe lower patient population. Also as the practice has a below than average over 75 age profile this system ensures the appropriate patients receive the care they need.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to

Good

Are services effective?

(for example, treatment is effective)

improve care and treatment and people's outcomes. There had been five clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored.

The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve services. Recent audits included a smear audit, audit around out of hours admissions which demonstrated admissions avoidance and a minor illness audit.

Also

- Park View has engaged with Wakefield CCG in Medicines optimisation programme to ensure safe and effective prescribing of medicines to patients. 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 we were told that all ten targets would be achieved by the end of the year.
- An audit on the care and treatment of patients with urinary tract infections had been completed. This had looked at differing methods among the clinicians in relation to care and treatment. From this study a new protocol had been developed and implemented to ensure best practice. A review to look at how compliant the practice had been with the new protocol would take place in the near future.
- 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 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 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 involved in clinical audits. For example 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. An annual recall system had been implemented which had improved patient attendance for asthma reviews.

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 polyclinics so that patients with more than one long term condition 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 who 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 1.26 per 1,000 patients compared to national average of 0.9 per 1,000 (Source GP Workforce Tool).

- The practice had an effective induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- Unsuccessful candidates were always given constructive feedback as part of a through selection process.
- 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 on-going 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.

Good

Are services effective?

(for example, treatment is effective)

- Staff received 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 advanced nurse practitioner (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 development ideas were discussed at the weekly nurse meeting.
- There was a focused 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 patient specific directives which stipulated that a registered member of staff had to be on the premises if they are giving any immunisations and/or injections.
- We found there was effective workforce planning. There was a good understanding that general practice nurse workforce was challenging and the lead nurse had been instrumental in bringing undergraduate nurse students for placements within the practice. The latest practice nurse recruited was a newly qualified nurse and we saw they had received a comprehensive 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 their 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.

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 on-going 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.

A senior partner is chair of the CCG board so an effective local relationship is maintained. Another GP is also a CCG board member and ANP was formerly involved with the CCG. The practice was very proactive with the CCG and actively involved in pilots. Examples included the Vanguard scheme for care homes, flexible walk in blood clinics (Flexible walk in blood clinics are primarily for patients, with long-term conditions who require regular and frequent blood tests. The blood clinicsare available and require no appointment so patients can simply turn up between times at their convenience.The waiting time is also kept to the minimum), Aspire diabetes national study, quality improvement programme to better manage patients with diabetes and 'Mydiagnostik'.

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

Good

Are services effective?

(for example, treatment is effective)

legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. 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 records audits to ensure it met the practices 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 and alcohol cessation. Patients were then signposted to the relevant service. A drugs and alcohol worker was available on the premises and smoking cessation advice was available from a local support group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 82% (2013/14) and 82% for 2014/15 which was comparable to the CCG average of 83% and the national average of 82%. (2013/14). The local Cytology Service operates the cervical screening programme. It sends out three reminders to patients who do not attend an appointment. The practice was then alerted to patients who had not attended a screening appointment and discussed this with the patient. 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 comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 93% to 100% and five year olds are 97%.
- Flu vaccination rates for the over 65s were 77%, and at risk groups 57%. These were also above the CCG NHS Wakefield 73% for over 65s and NHS Wakefield 50% for at risk groups. 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. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

The practice co-ordinated a shared care drugs service which was run by a local provider Turning Point , the practices drugs worker attended the surgery once per week for substance misuse. A GP was qualified in substance misuse and ran sessions every week as part of a local drugs misuse service. Alcohol substance patients were signposted to this GPs surgery, also referred onwards to substance misuse services as required.

Opportunistic health screening was offered to over forties and used the practice to offer health promotion. For all new patients an audit alcohol screening tool was completed to allow intervention with regards to alcohol consumption.

With regards to young people the practice became a C-Card site in Sept 2015 (13-25 year olds were issued with a card which allowed for condom issuing discretely and signposting services).

A C-Card site is a surgery that has been approved to provide sexual health services to young people aged 13 years and above. It provides advice and support, access to contraceptive devices including condoms. A C-Card site is a specific service offered to 13-25 year olds for them to be able to obtain condoms in a convenient, safe and discrete environment. Two members of the reception staff have been trained by NHS Wakefield to be advisors to offer this service. The service was only launched in September 2015 so the number of patients thus far will be low.

The practice was an accredited surgery for young people by the CCG national scheme. Also all contraception appointments were in house, screening was conducted for sexually transmitted diseases by nurses rather than being sent elsewhere.

Success had been achieved with flu vaccination uptakes through the use of weekend and late evening flu clinics. The practice had also used the village hall as a flu vaccination site to allow for easier access to flu clinics for the local population.

Patients who had learning disabilities, dementia or autism and were registered with the 'Wakefield Safer Places' scheme and were able to come to the practice if they were out in the community and were lost or disorientated. All the

Good

Are services effective?

(for example, treatment is effective)

surgeries were registered as Safer Places and displayed the Safer Places logo. Staff knew to check that the patient has a card on which there will be several people or organisations that can be contacted and to ensure the person is protected. The Safer Place scheme is a voluntary scheme to assist vulnerable people with learning difficulties, autism and dementia to feel safer when travelling independently in the community. The practice is registered by Wakefield Council.

The practice offered specialist long term condition (LTC) clinics for Respiratory and Diabetes. This structured and methodical recall system for patients with a diagnosed LTC which operates by means of inviting the patient on the date of their birthday for a full assessment. Patients and staff were secure in the knowledge that there was explicit, auditable and easily understandable systems in place to manage LTCs.

As part of the 'Network Development Framework' commissioned by Wakefield CCG 65% of patients who were registered as having three or more LTCs have a care plan, created in a face-to-face consultation, wherever possible, to empower them to manage their care. There were weekly reports presented to the clinical and practice meetings to ensure that the correct percentage of patients were reviewed.

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 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 two members of the patient participation group (PPG) on the day of our inspection. They also 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 happy with how they were treated and that this was with compassion, dignity and respect. The practice was well above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 94% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 92% said the GP gave them enough time compared to the CCG average of 88% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 99% 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%.
- 98% patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of 87%.

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.

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 in line with local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 86%.
- 89% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 81% and national average of 81%.

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.

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. There was a practice register of all people who were carers and 1% of the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for social services support via 'Wakefield Carers'. Written information was available for carers to ensure they understood the various avenues of support available to them.

Good

Are services caring?

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. We saw a copy of the 'Deceased Patients Review' dated 31 July 2015. The conclusion of the death review meeting held on 31st July 2015 was that the patients reviewed who had diedin normal circumstances in the audited time period had died in an appropriate manner with the required care and attention. These meetings are held on a monthly basis.

The practice was accredited as a "Safer Place" which is a scheme to provide a safe haven for vulnerable people lost in the community. The Safer Place scheme is a voluntary scheme to assist vulnerable people with learning difficulties, autism and dementia to feel safer when travelling independently in the community. The practice is registered by Wakefield Council.

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 appointment to be completed in the persons own home.

Good

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 on Saturday and Sundays, 11am to 4pm for patients to improve access and reduce the burden on the local accident and emergency service. They had written the business case, managed the pilot and assumed information governance responsibility. GPs and ANPs from the practice had staffed the rota for these clinics.

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

- Recruited a specialist advanced nurse practitioner (ANP) with a deeper knowledge and experience of the elderly in order to improve service to older people.
- This ANP lead in ensuring that patients on the 'Unplanned Admissions' register who were over 75 have a personalised care plan. The practice conducted face-to-face reviews. We saw a copy of the review for June 2015. If the patient was not able to attend the practice then a visit in their home or care home to ensure involvement in developing the care plan was conducted. Weekly reports to the clinical and practice meetings to ensure that the care plans were in place were shown to us.
- A GP palliative care lead, who looked after patients towards the end of their lives, held Gold Standard meetings with a multi-disciplinary team of clinicians, including Macmillan Nurses on a quarterly basis to manage the care for patients. A GP chaired the gold standard team meeting and was the practice lead for palliative care. The gold standard meeting was effective at making sure a holistic approach was maintained for end of life care patients.
- The practice offered an ANP Call-back service which benefited older people as they could have queries that occur around prescriptions resolved over the phone by speaking to a clinician. This then avoids them having to arrange transport and the inconvenience of attending the surgery.
- The Flu vaccination take up rate for those who were at risk, including patients with LTC for 2014/15 was in the top 10 in Wakefield CCG, giving these patients additional protection during the winter.
- For young people aged 13 -25, the practice had registered to become a C-Card venue which means that young people, on showing their C-Card can be given free condoms. This was intended to provide a quick, easy and discrete method of ensuring young people can obtain free condoms. National research has shown that young people are more confident in attending a GP surgery for such services as they could be there for a variety of reasons and therefore there is less stigma and embarrassment attached to it.
- There were longer appointments available for people with a learning disability.
- Home visits were available for older patients / 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.

Access to the service

The practice was open between 8:30am and 6pm Monday to Friday. Appointments were from 8:30am to 6pm daily except Wednesday when the appointments were until 12pm. In addition to pre-bookable appointments that could be booked up to five weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher to local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 75%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 96% patients said they could get through easily to the surgery by phone compared to the CCG average of 72% and national average of 73%.
- 91% patients described their experience of making an appointment as good compared to the CCG average of 72% and national average of 73%.
- 90% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 71% and national average of 65%.

From February to April 2015, the practice took part in a pilot to provide extended GP hours at the local Hospital for patients. This service, available from 11.00am to 4.00pm on Saturday and Sunday was staffed by local practice GPs, not locums.

Through a sustained programme of work led by the GPs, the practice had almost doubled the dementia diagnosis rate from second quarter 2014 to the fourth Quarter 2014. The analysis conducted by the GPs was that the diagnosis rate would probably rise further as the patients most highly at risk were currently in the assessment process.

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 e.g. posters displayed and summary leaflet available. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

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

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. The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

This is part of the process of evolving the group Practice, of which Park View is a part, as they have chosen to move towards a federated model of working. Park View is one of six practices who have agreed to work as a federation, called the Five Towns Federation. They have arranged a business planning event in November to further define the Vision, Values, Mission and Milestones of the federation which Park View will join. They are working with an outside expert management consultancy, Capita, who will be facilitating this event. In this way we will have further updated the Park View business planning as it evolves into a federated model.

This planning included:

Improving existing services and adding new services for patients using the federation e.g. Park View, as part of the federation was, working on proposals to provide an advice line for patients across the federation and a model of providing late afternoon visits for patients sourced from all the practices in the federation, as opposed to just Park View. This would mean that there would be a wider pool of clinicians from the federating practices to help provide that service on a rota basis, as opposed to the GPs from Park View surgery on its own. This will make the service more sustainable, robust and be able to cover a wider group of patients.

Addressing work force planning issues through participating in a programme of training and education which recruits new employees to primary care e.g. Park View has agreed to employ a health care assistant Apprentice. A previous employee at Park View was employed as a business administration apprentice, became a receptionist, then a dispensing receptionist and has just been employed as a health care assistant at Leeds General Infirmary, all achieved within three years. The opportunities that the practice were able to provide her as an employee of Park View and as part of a group meant that she could develop her career and that the practice retained her within the health care sector.

The practices vision over the next 12 months included refining the GP call-back service. The practice was currently planning to expand the GP call back service to include ANPs and also to standardise the approach to GP telephone triage, with reduction in waiting times to answer the telephone. We were told about the acquisition of 'Queens Health Centre', the practice plans to provide joint cover with 'Park View Surgery' and aim to ultimately pool appointments collectively. There is also a plan to procure an integrated nursing team, via outsourcing from 'Mid Yorkshire NHS Trust' via a federation, and also to introduce further extended hours over weekends.

Governance arrangements

The practice had an 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. Individual leaders were outstanding and when they came together as a leadership team they were also outstanding and they worked exceptionally well together.
- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- The practice carried out proactive succession planning
- There was excellent team work and the practice worked well with others
- 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 was 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

Are services well-led?

Outstanding ☆

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

The partners in the practice have the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held every 12 months. 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. There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, removal of frosted glass windows at reception and lowering of the reception desk to accommodate disabled patients.

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 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. Recent asthma update training for a staff member was paid for by the practice.

There is an effective culture of improvement at the practice. All staff encouraged to identify improvements both to the business and also to their own improvement. If staff take on new responsibilities and have extended their roles, they will also be offered a larger pay rise with other financial incentives. We discussed an example where non clinical staff suggested improvements with the prescription system as staff were unsure how prescriptions were logged. As a result a logbook was created and an improvement to tasks on the IT system for communication, with the creation of new inboxes was implemented. Another example included how a HCA had recently told all GPs about how to use sharp boxes appropriately.

The practice used feedback tools such as NHS Choices, PPG group, Friends and Family test and a suggestion box kept in reception for patients asking for feedback. The practice effectively used the complaints system to identify trends in learning, e.g. learning session resulting from delayed diagnosis of whooping cough leading to a practice learning session. We also discussed learning via a request for health records from a family member for a deceased patient; the practice sought advice from medical indemnity company and then made an amendment to the practice policy.

The adult nurse practitioner (ANP) has been invited nationally to present how to implement integrated nursing team systems.

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, Aspire Diabetes National study via the Leeds University which has resulted in Quality improvement programmes to better manage patients with diabetes.

- There has been improved accuracy of Atrial Fibrillation testing by introducing 'Mydiagnostick'. MyDiagnostick is very easy to use and has no buttons or parameters to be set. When picking up MyDiagnostick the device automatically switches on and is ready for use. After only one minute of ECG recording diagnosis is completed and shown to the patient or physician. MyDiagnostick will turn either red or green to indicate atrial fibrillation or non- atrial fibrillation.
- The lead nurse, as part of her masters' 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. These were staffed by the advanced nurse practitioner (ANP) and meant that patients could access clinical

Are services well-led?

Outstanding ☆

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

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 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 ANP appointments at Pontefract General Infirmary (A common venue where patients go to the accident and emergency department) Saturday and Sundays 11am to 4pm. They had written the business case, managed the pilot and assumed information governance responsibility. GPs and ANPs from the practice had staffed 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 disease such as chlamydia.
- 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.