

Silverdale & Ryecroft Practice

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at 12 September 2016 on Silverdale & Ryecroft Practice. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients could access appointments and services in a way and at a time that suited them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by the management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour
- As part of the NHS England General Practice Forward View to transform and stabilise the future of general practice, the practice was one of the first practices in the country to lead on a pilot to drive efficiencies in the workforce to free up GP time to see more patients.

We saw two areas of outstanding practice:

Summary of findings

- The practice was proactive in working with the Patient Participation Group (PPG) to improve health outcomes for patients. For example, in collaboration with the PPG, the practice had developed an in-house series of health promotion booklets called 'Let's Talk about...' that covered issues such as diabetes, healthy eating and substance misuse; established a monthly walking group called 'Silverdale Steppers' to help to reduce social isolation, reduce the risk of falls and promote healthy lifestyles and established 'Silverlink', a befriending service for patients who were lonely and isolated.
- Patients of no fixed abode and patients with substance misuse issues who were unable to adhere

to the appointment system were provided with appointments out of standard appointment times to ensure they had access to health care when they needed it.

The areas where the provider should make improvement are:

- Ensure that all reception staff who chaperone stand in a position where they can clearly observe the intimate procedure taking place.
- Ensure blank printable prescriptions are stored securely.

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?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Non-clinical staff who chaperoned had received appropriate training however not all staff who chaperoned stood in a position where they could clearly observe the intimate procedure taking place.
- Prescription pads were stored securely and their use was tracked through the practice. However, blank printable prescriptions were not always stored securely.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse.
- Risks to patients were assessed and well managed.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey published in July 2016 showed patients rated the practice in line with others in aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 348 patients as carers (3% of the practice list). Patients who had been identified as carers were offered flu immunisations and health checks.
- The practice had worked in partnership with the Patient Participation Group (PPG) and the voluntary sector to establish services to reduce social isolation.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs.
- The practice was proactive in working with the Patient Participation Group (PPG) to improve health outcomes for patients. In collaboration with the PPG, the practice had developed an in-house series of health promotion booklets called 'Let's Talk about...' that covered issues such as diabetes, healthy eating and substance misuse; established a monthly walking group called 'Silverdale Steppers' to help to reduce social isolation, reduce the risk of falls and promote healthy lifestyles and established 'Silverlink', a befriending service for patients who were lonely and isolated.
- 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. The practice had developed a 'You said, We did...' poster which was displayed in the waiting area informing patients what they had done to address the issues patients had raised.
- Patients could access appointments and services in a way and at a time that suited them. Patients of no fixed abode and patients with substance misuse issues who were unable to adhere to the appointment system were provided with appointments out of standard appointment times to ensure they had access to the health care they needed.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Good



Summary of findings

- 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.
- The practice had identified their 2% most vulnerable and elderly patients who were at increased risk of unplanned hospital admissions. The practice's elderly care facilitator contacted, visited and monitored 221 elderly patients. Ninety-eight per cent of these patients who responded to a survey said they found the visit helpful.
- The practice provided two GP clinical sessions per week to two large nursing homes to review and monitor patients' needs.
- Throughout 2015/16 two GPs at the practice had provided a substance misuse service to 260 patients. The practice had an open door policy and had registered patients which other practices did not feel able to support.

Are services well-led?

The practice is rated as outstanding for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. The vision was clearly displayed for staff and patients to see. Staff we spoke with were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by the management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. There was an annual review of the practice's five year business plan with an emphasis on succession planning to ensure the practice was responding to the challenges it faced.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice was strongly responsive to patient feedback and had systems in place to monitor and improve the services they provided. The practice proactively sought feedback from staff and patients, which it acted on. The PPG was very active.

Outstanding



Summary of findings

- There was a strong focus on continuous learning and improvement at all levels. The practice, in keeping with its ethos of continuous learning, participated in research activities in collaboration with the University of Keele.
- The practice had recruited a paramedic to train as an advanced practitioner. The support and training provided by the GP partners mirrored that provided to junior doctors.
- Members of the practice management team held lead roles outside of the practice to shape and influence the future of general practice. For example, the practice manager was the locality lead for the CCG and a mentor for the development of practice managers and administrative staff, one of the GP partners was the chair of North Staffordshire Local Medical Committee (LMC) and another GP partner the co-chair of the local GP federation. We saw that the knowledge and experiences they gained from these roles were embedded into the practice's culture.
- As part of the NHS England General Practice Forward View to transform and stabilise the future of general practice, the practice was one of the first practices in the country to lead on this pilot to drive efficiencies in the workforce to free up GP time to see more patients.

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

The practice is rated as good for the care of older people.

Good



- The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice had identified their 2% most vulnerable and elderly patients who were at increased risk of unplanned hospital admissions. The practice's elderly care facilitator (ECF) contacted, visited and monitored 221 patients to assess their physical, mental, medical and social needs. Each of these patients had an individual care plan in place.
- The ECF offered visits to patients over the age of 85 years old. Eighty-eight per cent of this group of patients had been reviewed.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided two GP clinical sessions per week to two large nursing homes (93 patients in total) to review and monitor patients' needs. The GPs that provided this care had additional knowledge and skills to meet the needs of this population group. For example, one GP had a diploma in palliative care and another GP worked in a local hospice.

People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

Good



- The practice had identified higher than expected numbers of patients with long-term conditions. The percentage of patients with a long-standing health condition registered with the practice was 60%. This was above the Clinical Commissioning Group (CCG) average of 57% and national average of 54%.
- Performance for all five diabetic indicators was in line with the CCG and national average. For example, the percentage of patients with diabetes whose last measured total cholesterol was within normal limits was 82%. This was similar to the CCG average of 80% and the national average of 81%.
- Patients with more than one long term condition were offered extended appointments to facilitate an annual review of all of their conditions within one appointment.

Summary of findings

- All these patients were offered a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Practice nurses reviewed housebound patients with long term conditions in their own home.

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.
- Standard childhood immunisation rates for children were higher than local and national averages.
- The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG and national averages of 82%. Their exception reporting rate was 3% which was lower than the CCG average of 5% and the national average of 6% which meant more people were included.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- The practice had worked with the Patient Participation group (PPG) to develop Healthy Lifestyle booklets which covered issues such as 'Developing Adolescent Sexual Health'.

Good



Working age people (including those recently retired and students)

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.

Good



Summary of findings

- The practice offered extended opening hours on Monday evening until 9.30pm for working aged patients who could not attend during normal opening hours. This included practice nursing appointments for smears, asthma reviews and other long term condition monitoring.

People whose circumstances may make them vulnerable

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 of no fixed abode, patients with substance misuse problems and those with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- 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.
- The practice informed vulnerable patients how to access various support groups and voluntary organisations. With the support of the practice and North Staffordshire AgeUK, the PPG had established a monthly walking group called 'Silverdale Steppers' to help to reduce social isolation.
- One of the GPs at the practice worked in partnership with a local church and the PPG and had established 'Silver link', a befriending service for patients who were lonely and isolated. Patients were referred to the service by the practice and Linkline (a local telephone Befriending Service).
- The practice worked with the PPG and had identified 348 patients as carers (3% of the practice list). The practice had won an award from the North Staffordshire Carer's Association for putting carers first and for their work in providing carer and support to patients who were carers. Patients who had been identified as carers were offered flu immunisations and health checks to assess their physical and mental health wellbeing to enable them to continue to provide care.
- In collaboration with the PPG, the practice had developed an in-house series of booklets called 'Let's Talk about...'. Topics covered for example included healthy eating and substance misuse.

Outstanding



Summary of findings

- The practice gave examples of how they had supported patients of no fixed abode to register and receive treatment at the practice. Reception staff was aware of these patients and where necessary, appointments were provided out of standard appointment times.
- Throughout 2015/16 two GPs at the practice had provided a substance misuse service to 260 patients. The practice had an open door policy and had registered patients which other practices did not feel able to support. If patients with substance misuse issues were unable to adhere to the appointment system, appointments were provided out of standard appointment times to ensure they had access to the care they required.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Eighty-four per cent of patients with a diagnosed mental health condition had a comprehensive, agreed care plan documented in their record, in the preceding 12 months. This was in line with the CCG average of 87% and national average of 88%.
- Eighty-seven per cent of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months compared with the CCG and national averages of 84%.
- The practice had increased the estimated diagnosis rate of patients with dementia from 69% in 2014 to 86% in 2015.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice 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.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. Clinical and non-clinical staff had received specialised training appropriate to their role to support this group of patients.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with local and national averages. Two hundred and sixty-three survey forms were distributed and 118 were returned. This represented 45% return rate.

- 88% of patients found it easy to get through to this practice by phone compared to the Clinical Commissioning Group (CCG) average of 72% and the national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 92% of patients described the overall experience of this GP practice as good compared to the CCG average of 88% and the national average of 85%.
- 89% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the CCG average of 81% and the national average of 78%.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. We received 82 comment cards of which all but two were positive about the standard of care received. Fifteen of the comment cards said that they had to wait for two to three weeks to get an appointment with a GP but were positive about the standard of care they received from the practice. Patients told us staff were professional, very caring, helpful, friendly and respectful. Several of the cards included comments thanking the practice for the high level of care and treatment the GPs, nurses and receptionists had provided.

We spoke with 10 patients during the inspection and three members of the Patient Participation Group (PPG). These patients told us they were satisfied with the care they received and thought staff were approachable, compassionate, willing to listen and explained things in a way they understood. The NHS Friends and Families test results for 2015/16 showed that 92% of respondents were extremely likely or likely to recommend the practice to friends and family.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure that all reception staff who chaperone stand in a position where they can clearly observe the intimate procedure taking place.

- Ensure blank printable prescriptions are stored securely.

Outstanding practice

- The practice was proactive in working with the Patient Participation Group (PPG) to improve health outcomes for patients. For example, in collaboration with the PPG, the practice had developed an in-house series of health promotion booklets called 'Let's Talk about...' that covered issues such as diabetes, healthy eating and substance misuse; established a monthly walking group called 'Silverdale Steppers' to help to reduce social

isolation, reduce the risk of falls and promote healthy lifestyles and established 'Silverlink', a befriending service for patients who were lonely and isolated.

- Patients of no fixed abode and patients with substance misuse issues who were unable to adhere to the appointment system were provided with appointments out of standard appointment times to ensure they had access to health care when they needed it.

Silverdale & Ryecroft Practice

Detailed findings

Our inspection team

Our inspection team was led by:

a Care Quality Commission (CQC) lead inspector. The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to Silverdale & Ryecroft Practice

Silverdale & Ryecroft Practice is registered with the Care Quality Commission (CQC) as a partnership provider in Newcastle-under-Lyme, Staffordshire. The practice holds a Personal Medical Services (PMS) contract with NHS England. A PMS contract is a locally agreed alternative to the standard General Medical Services (GMS) contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

Overall, the practice area is one of moderate deprivation when compared with the national and local Clinical Commissioning Group (CCG) area. However there are pockets of high deprivation and low deprivation in the geographical area the practice serves. At the time of our inspection the practice had 12,279 patients. The practice has a higher proportion of patients aged over 65 (21%) and 75 (11%) when compared with the national averages of 17% and 8% respectively. The percentage of patients with a long-standing health condition is 60% which is above the local CCG average of 57% and national average of 54%. This may mean increased demand for GP services.

Silverdale & Ryecroft Practice provide services from two separate sites and patients can attend either of these. Silverdale Village Surgery is open between 8am to 6pm Monday to Friday except Thursday when it closes at

5.30pm. The practice offers extended opening hours on Mondays until 9.30pm. Ryecroft Surgery is open between 8am to 6pm Monday to Friday except Thursday afternoons when it closes at 1pm. Patients can book appointments four weeks in advance. The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, Staffordshire Doctors Urgent Care when the practice is closed.

The practice staffing comprises of:

- Three male GP partners and one female partner
- Six female salaried GPs
- A paramedic training to be an Advanced Practitioner
- Four female practice nurses
- A practice manager and assistant practice manager
- A team of administrative staff working a range of hours.

The practice provides a number of specialist clinics and services. For example long term condition management including asthma and diabetes. It also offers services for family planning, childhood immunisations, travel vaccinations and cervical smears. The practice is a training practice for GP registrars, doctors who are undertaking the two year general postgraduate medical training programme and medical students to gain knowledge, experience and higher qualifications in general practice and family medicine.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was

Detailed findings

planned to check whether the 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.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We carried out an announced comprehensive inspection on 12 September 2016. During our inspection we:

- Spoke with a range of staff including GPs, nurses and administrative staff and spoke with patients who used the service. Prior to and during our inspection we spoke with members of the patient participation group.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked 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).

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 Care Quality Commission at that time.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they informed the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Significant events had been thoroughly investigated. When required, action had been taken to minimise reoccurrence. We saw that learning had been shared within the practice team and were a standard item on the clinical meeting agenda.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out an overarching annual analysis of significant events to identify trends and monitor the effectiveness of the changes they had made.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. The practice had a process in place to act on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). Following an alert being received the practice checked to ensure that patients were not affected by the medicines or equipment involved and they were discussed at clinical meetings. Clinical staff we spoke with were aware of recent alerts that had been sent. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an error in the prescribing of medicines for a patient receiving end of life care occurred due to a computer malfunction. To reduce this occurring again a template for palliative care prescribing was produced for GPs to keep and refer to.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from the risk of abuse. These arrangements reflected relevant legislation and local requirements. 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 provided reports where necessary for safeguarding meetings and other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three. The practice held regular meetings with the Health Visitor service to discuss children of concern.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS)
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. A practice nurse was the infection control clinical lead. 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 arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Staff were able to accurately describe the processes to follow to maintain the cold chain when flu immunisations were taken from the practice to be administered to patients in care homes, however there was no cold chain policy within the practice for staff to refer to. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local Clinical Commissioning Group (CCG) pharmacy teams, to ensure prescribing was in line with best

Are services safe?

practice guidelines for safe prescribing. Blank prescription pads were securely stored and there were systems in place to monitor their use. Blank printable prescriptions were not always stored securely. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that they were signed and in date.

- We reviewed six personnel files and found 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 DBS. We saw that professional registrations were in date but there was no formal system in place to review this annually. Before the end of the inspection the practice manager had put in place a system to ensure this was proactively managed.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments which it acted on. 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 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. Water temperature checks were carried out at regular intervals and water samples were taken to test for legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). We saw evidence that a legionella risk assessment was to be carried out at the practice on 30 September 2016.
- 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 enough staff were on duty. The practice was proactive in forward planning for staff vacancies such as retirement and maternity leave. This was monitored and planned for in their annual review of the practice's five year business plan. For example, the practice had recruited a paramedic who was undertaking a three year advanced practitioner qualification to support GPs in appointments for acute conditions and home visits.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had an automated external defibrillator (AED), (which provides an electric shock to stabilise a life threatening heart rhythm), oxygen with adult and children's masks and pulse oximeters (to measure the level of oxygen in a patient's bloodstream).
- 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 stored securely. Two GPs at the practice provided a substance misuse service for patients with alcohol and drug related problems. We saw that a medicine used for the reversal of the effects of opioid medicines was kept at the practice. This meant that if a patient attending the practice was experiencing an overdose they could receive rapid and effective treatment.
- 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.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with 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 keep all clinical staff up to date. A designated lead within the practice cascaded NICE guidelines to all the clinical staff who used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and discussion at clinical meetings.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98% of the total number of points available which was above the Clinical Commissioning Group (CCG) average of 93% and national average of 95%.

This practice was not an outlier for any QOF clinical targets. Data from 2014/15 showed:

- Performance for all five diabetic indicators was similar to the CCG and national average. For example, the percentage of patients with diabetes whose last measured total cholesterol was within normal limits was 82%. This was in line with the CCG average of 80% and the national average of 81%.
- Performance for mental health related indicators was similar to the CCG and national average. Eighty-four per cent of patients with a diagnosed mental health condition had a comprehensive, agreed care plan documented in their record, in the preceding 12 months. This was in line with the CCG average of 87% and national average of 88%.

- Eighty-seven per cent of patients diagnosed with dementia had had their care reviewed in a face-to-face review in the preceding 12 months compared with the CCG and national averages of 84%.
- The percentage of patients with asthma, on the register, who had had an asthma review in the preceding 12 months was 84%. This was higher than the CCG average of 71% and the national average of 75%. However, the practice exception reporting rate of 22% was above the CCG rate of 6% and the national rate of 8% meaning fewer patients had been included.

Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects. Generally lower rates indicate more patients have received the treatment or medicine. A system of three recall letters was in place for patients who failed to attend for a review of their long term condition, such as asthma. If a patient failed to attend after three letters they were exceptioned. We reviewed the recall letter and saw it was a generic letter for all types of long term conditions. After discussion with a GP they informed us that they would develop condition specific letters to ensure that patients fully understood the need for the review.

We looked at 2014/15 data from the QOFXL which is a local framework used by NHS North Staffordshire CCG to improve the health outcomes of local people. The data showed that:

- The number of emergency admissions per 1000 patients was 117 which was higher than the CCG average of 100.
- The number of A&E attendances per 1000 patients was 291 which was higher than the CCG average of 237.
- The number of A&E attendances during GP opening times per 1000 patients was 125 which was higher than the CCG average of 101.

The practice had looked at why the A&E attendance rates and emergency admissions were higher. They told us this was due to:

- The close proximity of the local A&E department.
- The high number of patients in the two care homes they provided care for.

Are services effective?

(for example, treatment is effective)

- There were 260 patients registered with the practice who had received care and treatment from the practice throughout 2015/16 for substance misuse issues. This group of patients were not always able to adhere to the standard appointment system. Appointments were provided out of standard appointment times to ensure they had access to the care when they needed it.

The practice had participated and part led in the development of a nationally recognised elderly care facilitator project. As a result of this project, the report 'A Practice Based Screening of the Over 75 Population in Newcastle South Locality for the Support of the Development of the Elderly Care Facilitator' showed that this practice had the lowest percentage growth rate of admissions to A&E and emergency admissions to hospital when compared to the CCG. Estimated dementia diagnosis rates had increased from 69% in 2014 to 86% in 2015.

There was evidence of quality improvement including clinical audit.

- The practice had completed 12 clinical audits in the last year. These audits were either completed two cycle audits where the improvements made were implemented and monitored or had re-audit dates planned.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, an audit of patients with polycystic ovary syndrome had been carried out. Following an initial audit, changes in practice and a second audit, we saw that the percentage of these patients who had documented menstrual cycles recorded in their notes had increased from 80% to 96% and the percentage of patients with a recorded BMI had increased from 92% to 96%.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff we spoke with told us that the induction programme was effective and supported them in their learning needs.

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, clinical and non-clinical staff had received role specific training to support patients who were dependent on alcohol and/or drugs in meeting the needs of this group of patients and techniques to resolve conflict.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- 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 their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring and clinical supervision. For example, we saw review sessions were in place following each patient seen by a paramedic (who was training as an advanced practitioner) to enable the practitioner to reflect and discuss the care provided with the on-call duty GP. Facilitation and support for revalidating GPs was in place. All staff had received an appraisal within the last 12 months.
- The practice manager maintained an overarching staff training matrix for all staff. Where updates were needed, it was clearly documented on the matrix. Staff had received training that included: safeguarding children and vulnerable adults, fire safety awareness, cardiopulmonary resuscitation, infection control and information governance. Staff had access to and made use of e-learning training modules and in-house training.

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 investigation and test results.

Are services effective?

(for example, treatment is effective)

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. They used special notes to share information with the out of hours services for patients nearing the end of their life.
- The practice provided us with statements from two care homes they provided care and treatment to. The statements demonstrated that the practice proactively worked with appropriate professionals sharing relevant information in a professional and supportive manner to improve outcomes for patients. For example, if a patient had nursing needs

they were reviewed by a GP within 72 hours of admission to the home following a hospital discharge.

- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. The practice provided us with written feedback from the community rehabilitation team and the district nurses that demonstrated the practice was open to constructive feedback, were helpful and worked effectively with them to safely meet the needs of patients.

Consent to care and treatment

Staff sought patients' consent to care and treatment 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. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- There was a practice policy for documenting consent for specific interventions. For example, for the insertion of

contraceptive devices, patients were informed of the benefits and complications of the procedure and signed consent forms which were scanned into their care records.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.
- The practice had worked with the patient participation group (PPG) to develop, produce and fund Healthy Lifestyle Booklets for patients which covered issues such as healthy lifestyle, eating and exercise and substance misuse.
- Sixty three per cent of patients with a learning disability had received a health review however they had only been provided with the standard 10 minute appointment time. After discussion with the practice they informed us they planned to review the length of time allocated to carry out these reviews to ensure the health needs of this population group were met.
- With the support of the practice, the PPG carried out seasonal cancer awareness campaigns within the practice. For example, during the summer campaigns were carried out highlighting the risk of skin cancer.

The practice's uptake for the cervical screening programme was 81%, which was comparable to the CCG and national averages of 82%. Their exception reporting rate was 3% which was lower than the CCG average of 5% and the national average of 6% which meant more people were included.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Data collected by NHS England for the time period 1 April 2015– 31 March 2016, showed that childhood immunisation rates for the vaccinations given were above national averages. For example, childhood immunisation

Are services effective?

(for example, treatment is effective)

rates for the vaccinations given to under two year olds ranged from 96% to 99% (national average of 73% to 95%) and five year olds from 95% to 98% (national average of 81% to 95%).

Patients had access to appropriate health assessments and checks. These included health checks for new patients and

NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations. 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.
- We observed reception staff providing compassionate care when offering a glass of water to a patient with a persistent cough.

Eighty of the 82 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients told us staff were professional, very caring, helpful, friendly and respectful. Several of the cards included comments thanking the practice for the high level of care and treatment the GPs, nurses and receptionists had provided. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

We spoke with three members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and that the management team valued and respected the role the PPG had within the practice.

Results from the national GP patient survey published in July 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 85% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) and national averages of 89%.
- 85% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.

- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 82% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG and national averages of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 from the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey published in July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 84% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 81% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and the national average of 82%.
- 84% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%.

The practice provided facilities to help patients to be involved in decisions about their care. For example, translation services were available for patients who did not have English as a first language. Alerts were put on the practice's computer system to inform staff if a patient was deaf and if they were able to lip read.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. In collaboration with the PPG, the practice had developed an in-house series of booklets called 'Let's Talk about...'. Topics covered for example included diabetes, healthy eating and substance misuse. Each of these booklets included a section that sign-posted patients to local and national sources of support. Information about support groups was also available on the practice website. With the support of the practice and North Staffordshire AgeUK, the PPG had established a monthly walking group called 'Silverdale Steppers' to help to reduce social isolation, reduce the risk of falls and promote a healthy lifestyle to patients. One of the GPs at the practice worked in partnership with a local church and the PPG and in December 2015 had established 'Silverlink', a befriending service for patients who were lonely and isolated. Patients were referred to the service by the practice and Linkline (a local telephone Befriending Service).

The practice's computer system alerted GPs if a patient was a carer. The practice worked with the PPG and had identified 348 patients as carers (3% of the practice list). Written information was available to direct carers to the various avenues of support available to them. There was a dedicated notice board in the practice waiting room promoting the North Staffordshire Carers Association. The practice had won an award from the support group for putting carers first and for their work in providing care and support to patients who were carers. Patients who had been identified as carers were offered flu immunisations and health checks to assess their physical and mental health wellbeing to support them to continue to provide care.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Patients that needed additional support were referred to the Dove service, a local service that provides support and counselling for life changing illness and bereavement. The practice hosted Dove service sessions making it easier for patients and carers to access.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- Patients had feedback that there were not enough appointments available at the practice. In response to this, the practice had employed an additional practice nurse and a paramedic to train as an Advanced Practitioner who saw acute, on the day minor illnesses and carried out home visits. This had released the availability of GP appointments. Data from the national patient survey published in July 2016 showed there had been an increase from 68% (January 2016) to 77% of respondents who described their experience of making an appointment as good. This was above the national average of 73%.
- The practice offered extended opening hours on Monday evening until 9.30pm for working patients who could not attend during normal opening hours. This included practice nursing appointments for smears, asthma reviews and other long term condition monitoring.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Practice nurses reviewed housebound patients with long term conditions in their own home.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Patients were able to receive travel vaccinations available on the NHS.
- There were facilities for patients with a disability, a hearing loop and translation services available.
- Patients with more than one long term condition were offered extended appointments to facilitate an annual review of all of their conditions within one appointment.
- The practice had participated and part led in the development of a nationally recognised elderly care facilitator (ECF) project. The ECF offered visits to patients over the age of 85 years old. Eighty-eight per cent of this group of patients had been reviewed.
- The practice had identified their most vulnerable and elderly patients who were at increased risk of unplanned hospital admissions. The practice's ECF contacted, visited and monitored 221 elderly patients to assess their physical, mental, medical and social needs. An individual care plan was created for each patient and patients were provided with useful contact numbers, guidance on benefits and general advice. The practice had provided questionnaires to all 221 patients and received 54 replies giving a response rate of 24%. We saw that 98% of these patients said they found the visit helpful
- The practice provided two GP clinical sessions per week to two large nursing homes to review and monitor patients' needs. They also provided patient primary reviews and admission and hospital discharge reviews. Many of the 93 patients living at the homes were frail and/or nearing the end of their life. The GPs that provided this care had additional knowledge and skills to meet the needs of this population group. For example, one GP had a diploma in palliative care and one worked in a local hospice.
- The practice had worked with the Patient Participation group (PPG) to develop Healthy Lifestyle Booklets which covered issues such as 'Developing Adolescent Sexual Health' and 'Substance Abuse and Alcohol'.
- The practice gave examples of how they had supported patients of no fixed abode to register and receive treatment at the practice. Reception staff were aware of these patients and where necessary, appointments were provided out of standard appointment times.
- One of the GPs at the practice worked in partnership with the local church and the PPG and had established 'Silverlink', a befriending service for patients who were lonely and isolated. Patients were referred to the service by the practice and Linkline (a local telephone Befriending Service). Between the period of December 2015 and September 2016 the service received 14 referrals. Eight patients had received regular visits, three patients were in the process of undergoing an initial risk

Are services responsive to people's needs?

(for example, to feedback?)

assessment and three patients decided not to proceed with the service. Feedback from the patients and family members demonstrated how this collaborative service had made a positive difference to patients and their relatives.

- Two GPs at the practice provided a substance misuse service to 27 patients with an opiate dependence and 233 patients with alcohol dependence. One GP was trained to level two and the other to level one in substance misuse. This ensured that when one GP was on annual leave there was a continuity of service for patients. The GPs provided three monthly appointments for patients and worked in partnership with the community substance misuse team. The practice had an open door policy and had registered patients which other practices did not feel able to support. If patients were unable to adhere to the appointment system, appointments were provided out of standard appointment times to ensure they had access to the care they required. Receptionists were aware of this and had received specialised training in meeting the needs of this group of patients and techniques to resolve conflict.

Access to the service

Silverdale & Ryecroft Practice provided services from two separate sites and patients could attend either of these. Silverdale Village Surgery was open between 8am to 6pm Monday to Friday except Thursday when it closed at 5.30pm. The practice offered extended opening hours on Mondays until 9.30pm. Ryecroft Surgery was open between 8am to 6pm Monday to Friday except Thursday afternoons when it closed at 1pm. Patients could book appointments four weeks in advance. The practice did not routinely provide an out-of-hours service to their own patients but patients were directed to the out of hours service, Staffordshire Doctors Urgent Care when the practice was closed.

Results from the national GP patient survey published in July 2016 showed that patient's satisfaction with how they could access care and treatment was above local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 76%.
- 88% of patients said they could get through easily to the practice by phone compared to the CCG average of 72% and the national average of 73%.
- Patients of no fixed abode and patients with substance misuse issues were provided with appointments out of standard appointment times to ensure they had access to health care.

Listening and learning from concerns and complaints

The practice had an effective 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 on the practice's website and in the complaints leaflet to help patients understand the complaints system.

We looked at 18 complaints received between April 2015 and March 2016 and found these were satisfactorily handled and dealt with in a timely manner. There was openness and transparency when dealing with a complaint. Lessons were learnt from individual concerns and complaints, and also from an annual analysis of trends and actions taken, to improve the quality of care received by patients.

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 demonstrated the practice's commitment to providing high quality, non-discriminatory, responsive, effective and safe care to their patients. It was displayed in the waiting areas and staff knew and understood the values.
- The practice had a development strategy and supporting five year business plan which reflected their vision and values. We saw that it was reviewed annually or as required. A GP partner and practice manager proactively lead on succession planning to ensure the practice was responding to the challenges the practice faced.

Governance arrangements

The leadership, management and overarching governance framework of the practice assured the delivery of high quality person centred care, supported learning and drove innovation. The structures and procedures in place ensured that:

- There was strong collaboration and support for all staff and a common focus on improving the quality of care for patients within the practice.
- There was a sharing of learning with other practices within the Clinical Commissioning Group (CCG) to drive improvements for patients in surrounding practices. For example, the practice had been one of six practices in North Staffordshire CCG that had first implemented and evaluated the role of an elderly care facilitator in meeting the needs of older patients. This had been rolled out to other practices in the CCG.
- There were effective systems in place to promote working with other organisations to improve patients care outcomes and tackle inequalities. For example, the practice had worked closely with the voluntary sector to support vulnerable patients.
- Governance arrangements were proactively reviewed and reflected best practice. There was a programme of continuous clinical and internal audit to monitor quality and to make improvements. When GPs completed

clinical audits or attended training courses, they presented the results or knowledge gained at weekly clinical meetings to ensure learning and improvements were shared throughout the practice.

- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by the management.

- Staff told us the practice held regular team and clinical meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. All members of staff were encouraged to add to the meeting agendas.
- There were high levels of staff satisfaction. Staff said they felt respected, valued and supported by the GP partners and were proud to work at the practice. Staff spoke highly of the culture within the practice. Staff at all levels were actively involved in discussions about

Are services well-led?

Outstanding



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

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.

Members of the practice management team held lead roles outside of the practice to shape and influence the future of general practice:

- The practice manager was the locality lead for the CCG and a mentor for the development of practice managers and administrative staff.
- One of the GP partners was the chair of North Staffordshire Local Medical Committee (LMC). They were involved in facilitating NHS England pilots as part of the General Practice Forward View which focused on future investment, workforce, workload, infrastructure and care redesign within GP practices.
- Another GP partner was the co-chair of the local GP federation and held a leadership role in developing the federation over the last 15 months.
- We saw that the knowledge and experiences they gained from these roles was embedded in the practice's culture. For example, there was a strong emphasis on working collaboratively with not only other professionals but the voluntary sector to meet the needs of their patients.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice was strongly responsive to patient feedback and had systems in place to monitor and improve the services they provided. For example, the practice had gathered feedback from patients regarding the quality of the service patients at risk of unplanned hospital admissions received from the elderly care facilitator. It showed that 98% of respondents said they found the service helpful. We saw that the practice had not only responded to patient feedback but had developed a 'You said, We did...' poster, which was clearly displayed in the waiting area, informing patients what they had done to address issues raised by patients.
- The practice had gathered feedback from patients through the patient participation group (PPG) and

through surveys and complaints received. For example, patients had feedback that there were not enough appointments available. In response to this, the practice had employed a paramedic to train as an Advanced Practitioner who saw acute, on the day minor illnesses and carried out home visits. This had released the availability of GP appointments.

- The practice had gathered feedback from staff 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 the management. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a 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. The practice had recruited a paramedic who was undertaking a three year advanced practitioner qualification to support GPs in appointments for acute conditions and home visits. The support and training provided by the GP partners mirrored that provided to junior doctors.

There was a clear proactive approach to seeking out and leading in new ways of providing care and treatment. As part of the NHS England General Practice Forward View to transform and stabilise the future of general practice, the practice was one of the first practices in the country to lead on a pilot to drive efficiencies in the workforce to free up GP time to see more patients. The practice had started to implement the Brighton model which involved the training and supporting of administrative staff to triage letters received by the practice that did not require a medical review.

The practice, in keeping with its ethos of continuous learning, participated in research activities in collaboration with the University of Keele. For example, the practice actively recruited patients for a research project looking at the psychological impact of musculoskeletal disorders. The clinical team at the practice had undergone research governance training and operated under the supervision of the academic unit at Keele University.