Dr J Sullivan & Partners

Quality Report

Moorside Surgery
370 Dudley Hill Road
Bradford
BD2 3AA
Tel: 01274 643576
Website: www.moorsidesurgery.nhs.uk

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

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 Dr J Sullivan & Partners, known as Moorside Surgery, on 3 November 2016. Overall the practice is rated as good, with the provision of effective services being rated as outstanding.

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

- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients' needs were assessed and care was planned and delivered following local and national care pathways and National Institute for Health and Care Excellence (NICE) guidance.
- Patient comments we received were overwhelmingly positive about the practice. The national patient survey had shown that patient scores for positive experiences were consistently higher than local and national averages. For example, 90% said they could easily get through to the practice by telephone (local 61%, national 73%) and 100% said they had confidence and trust in the last GP they saw or spoke to (local and national 95%).
- The practice staff had a good understanding of the needs of their practice population and were flexible in their service delivery to meet patient demands.
- The practice provided intensive support and interventions for those patients who had learning disabilities, complex mental health problems or were high users of NHS services. For example, some patients were given regular two weekly appointments to help maintain a stable lifestyle. Patients had direct access to regular support from a psychologist, psychiatrist or physiotherapist as needed, to prevent an inappropriate hospital admission.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice sought views on how improvements could be made to the service, through the use of patient surveys, the NHS Friends and Family Test and

Summary of findings

engagement with patients and their local community. For example, a children's play area had been developed in conjunction with the patient participation group
- Risks to patients were assessed and well managed and there were effective safeguarding systems in place to protect patients and staff from abuse.
- The practice promoted a culture of openness and honesty. All staff were encouraged and supported to record any incidents using the electronic reporting system. There was evidence of good investigation, learning and sharing mechanisms in place.
- There was a clear leadership structure, staff were aware of their roles and responsibilities and told us the GPs were accessible and supportive.
- The practice complied 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.)

We saw several areas of outstanding practice:

- The practice participated in the Bradford Health Hearts programme and could evidence that 100% of patients who had atrial fibrillation were being monitored for their anticoagulation (blood clotting) rates. This is essential for the safe management of this disease and the prevention of strokes. We saw evidence that the practice was the highest achieving in this area across Bradford and had received an award from the Clinical Commissioning Group (CCG) in recognition of their work.
- The practice facilitated many services to effectively manage and improve outcomes for patients. For example, newly diagnosed diabetic patients had access to the unique practice developed 'getting started' programme. Sessions were run with the practice nurse and a dietician to educate patients regarding dietary and lifetstyle choices to support positive self-management of their care. The practice had also participated in the Early Arthritis research project and they were one of three pilot sites in the CCG for Physio First (a self-referral direct access service to physiotherapy interventions). One of the GPs (who was on the advisory group for the National Institute for Health and Care Excellence) led a specialist headache management clinic which patients from other areas could also access.
- The practice worked within the local community and had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw evidence of very positive feedback received from participants with regard to these interventions.

However, there was an area of practice where the provider should make improvements:

- The practice should reassure themselves that all vaccines are transported to patients' homes in accordance with the most recent public health guidelines.

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.

- Risks to patients were assessed and well managed
- There were systems in place for reporting and recording significant events and near misses. There was evidence of investigation, actions taken to improve safety in the practice and shared learning with staff.
- There was a nominated GP lead who reviewed all incidents. Quarterly audits were undertaken of all significant events. The practice had a dedicated significant events meeting.
- Embedded systems and processes were in place to keep patients and staff safeguarded from abuse. We saw there was safeguarding information and contact details available for staff. There was a nominated GP lead for safeguarding children. The adult safeguarding lead was also the named GP lead for adult safeguarding across Bradford.
- There were processes in place for safe medicines management. The practice employed a clinical pharmacist to support effective prescribing. They undertook a review of all discharge summaries to ensure medication changes were updated as appropriate.
- There were systems in place for checking that equipment was tested, calibrated and fit for purpose.
- There were regular checks and risk assessments undertaken, which included those relating to health and safety, such as infection prevention and control.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

- Staff had the skills, knowledge and experience to deliver effective care and treatment. They assessed the need of patients and delivered care in line with national guidance and local pathways.
- The practice participated in the Bradford Health Hearts programme and could evidence they had achieved a 100% anticoagulation rate for those who have atrial fibrillation, which could have resulted in fewer strokes in patients. We saw evidence that the practice was the highest achieving in this area across Bradford and had a received an award in recognition of their work.

Summary of findings

- The practice participated in the Campaign to Reduce Opioid Prescribing (CROP). By working with those relevant patients they were able to evidence a 4% reduction in the prescribing of these drugs. (Opioids are most often used medically to relieve pain and can cause long term problems with addiction).
- The practice worked within the local community and had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw evidence of very positive feedback resulting from these interventions.
- Data from the national GP patient survey showed that 100% of respondents had confidence and trust in the last GP they saw or spoke to (compared to CCG average of 95% and national average of 95%).
- We saw evidence of appraisals and up to date training for staff.
- There was evidence of working with other health and social care professionals, such as the mental health team, to meet the range and complexity of patients' needs.
- Clinical audits were carried out which could demonstrate quality improvement.
- The practice had monthly palliative care meetings. End of life care was delivered in a compassionate and coordinated way.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were consistently higher than local and national averages. The most recent published results showed the practice had achieved 100% (CCG and national averages 97%) of the total number of points available.
- The practice had a proactive programme of clinical and non-clinical audits which were used to improve quality and outcomes. For example, an audit of demand and capacity regarding appointments.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Clinical and administrative staff demonstrated a commitment to providing good care for their patients. We observed that staff treated patients with kindness, dignity, respect and compassion. Patients' comments aligned with these observations.

Summary of findings

- Data from the National GP Patient Survey showed patients rated the practice higher than local and national averages regarding the provision of care. Comments we received from patients on the day of inspection were very positive about their care.
- We were given examples where staff went over and above their expected duties, for example delivering prescribed medicines for older patients to their home.
- There was a variety of health information available for patients, relevant to the practice population, in formats they could understand.
- The practice maintained a register of those patients who were identified as a carer and offered additional support as needed. Individuals who were at risk of carers' stress had an identification 'flag' on their record, to alert clinicians to offer additional support as needed.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked with Bradford Districts Clinical Commissioning Group (CCG) and other local practices to review the needs of their population. For example, they participated in the Bradford Integrated Care pilot for patients who were at a high risk of an unplanned admissions.
- Patients' individual needs and preferences were central to the planning and delivery of care. Intensive support and interventions were provided for those patients who had learning disabilities, complex mental health problems or were high users of NHS services. For example, some patients were given regular two weekly appointments to help maintain a stable lifestyle. Patients had direct access to regular support from a psychologist, psychiatrist or physiotherapist as needed.
- The practice facilitated many services to respond to the needs of patients in order to effectively manage and improve outcomes. For example, they participated in the Early Arthritis research project and they were one of three pilot sites in the CCG for Physio First. One of the GPs led a specialist headache management clinic which patients from other areas could also access. All newly diagnosed diabetics had access to the practice 'getting started' programme.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- The practice had developed an access plan, where they regularly reviewed demand and capacity. This had included routine appointment bookings and daily open access clinics.

Summary of findings

- Patients could access appointments and services in a way and a time which suited them. The practice offered pre-bookable, same day and online appointments. They also provided extended hours appointments during the week. National GP patient survey responses regarding access were positive. For example, 90% of respondents said they could get through easily to the surgery by phone (CCG average 61%, national average 73%)
- All patients requiring urgent care were seen on the same day as requested.
- Home visits and longer appointments were available for patients who were deemed to need them, for example housebound patients or those with complex conditions.
- There was an accessible complaints system. Evidence showed the practice responded quickly to issues raised and learning was shared with staff.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions, including people with dementia or a condition other than cancer.
- The practice was a designated 'place of safety' for people as appropriate (this is a place where a person can be safely and effectively assessed under the Mental Health Act or whilst awaiting urgent intervention by another service such as social services). We were given examples to reflect this service.

Are services well-led?

Good

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

- There was a clear leadership structure and a vision and strategy to deliver high quality care and promote good outcomes for patients.
- There were safe and effective governance arrangements in place. These included the identification of risk and policies and systems to minimise risk.
- The provider complied with the requirements of the duty of candour. There were systems in place for reporting notifiable safety incidents and sharing information with staff to ensure appropriate action was taken.
- The practice promoted a culture of openness and honesty. Staff were encouraged to raise concerns, provide feedback or suggest ideas regarding the delivery of services. Annual 'team building' events took place outside of the practice.
- The practice proactively sought feedback from service users through engagement with patients and their patient participation group.

Summary of findings

- We saw comprehensive evidence of formal minutes for meetings, such as practice, multidisciplinary, palliative care and safeguarding.
- Staff at all levels were encouraged to develop their skills and progress in their roles.
- The GPs had specialist interests and used their knowledge and skills in these areas to benefit the practice and the patients, for example musculoskeletal, neurology (including headache management) and anti-coagulation.
- The practice supported graduate doctors, who were undertaking additional training to become a GP (GP registrars). They also provided mentorship for nurses who were undertaking independent prescribing courses. We saw evidence of very positive feedback the practice had received from the GP registrars
- In addition, GPs held lead roles within the CCG and nationally. For example, clinical board member of Bradford Districts CCG, Bradford adult safeguarding lead and elected fellow of the Royal College of General Practitioners (RCGP).

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.

- Proactive, responsive care was provided to meet the needs of the older people in its population. The practice participated in the integrated care pilot in Bradford to support the care of elderly patients and avoid unplanned admissions.
- They offered rapid access appointments to those patients with enhanced needs and those who could not access the surgery due to ill health or frailty.
- Medication reviews were undertaken every six months or earlier if needed.
- The practice worked closely with other health and social care professionals, such as the district nursing team, to ensure housebound patients received the care and support they needed.
- Patients were signposted to other local services for additional support, particularly those who were isolated and lonely.
- GPs provided treatment and medication reviews to meet the needs of those patients who were registered in residential care settings.

People with long term conditions

Outstanding

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

- The practice nurses led on the management of long term conditions, supported by the GPs. Annual or six monthly reviews were undertaken to check patients' health care and treatment needs were being met. There was an effective system for the follow-up of non-compliant patients.
- Longer appointments were available for this group of patients, and a 'one stop' approach was used with those who had multiple conditions; to reduce the need for several appointments.
- Home visits for these patients were undertaken by the practice nurses to support continuity of care and a holistic approach to their health and wellbeing.
- The practice participated in the Bradford Healthy Hearts programme and could evidence a proactive approach and a 100% anticoagulation rate for those patients who have atrial

fibrillation (a type of arrhythmia, which means that the heart beats fast and irregularly). (Atrial fibrillation increases the risk of stroke and the use of anticoagulation medicines used to prevent blood clots can help to decrease that risk.)

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were consistently higher than local and national averages. The most recent published results showed the practice had achieved 100% (CCG and national averages 97%) of the total number of points available.
- QOF results also showed the practice was comparable to others for undertaking reviews of patients' long term conditions. For example:

79% of patients diagnosed with asthma had received an asthma review in the last 12 months (CCG average 76%, national average 76%).

93% of patients diagnosed with chronic obstructive pulmonary disease (COPD) had received a review in the last 12 months (CCG average 91%, national average 90%).

92% of newly diagnosed diabetic patients had been referred to a structured education programme in the preceding 12 months (CCG average 90%, national average 92%).

- The practice facilitated many services to effectively manage and improve outcomes for patients, particularly those who had a long term condition. For example, newly diagnosed diabetic patients had access to the unique practice developed 'getting started' programme. Sessions were run with the nurse and a dietician to educate patients regarding dietary and lifestyle choices to support positive self-management of their care.

Families, children and young people

Good

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

- Appointments were available outside of school hours and the premises were suitable for children and babies. Same day access was available for all children who required medical attention.
- There was a dedicated play area to help parents keep their children occupied whilst waiting for their appointment.
- The practice worked with midwives, health visitors and school nurses to support the needs of this population group. For example, the provision of ante-natal, post-natal and child health surveillance clinics.

Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk.
- Childhood immunisations were offered in line with the public health immunisation programme. Uptake rates were generally higher than the CCG and national averages.
- Sexual health, contraceptive and cervical screening services were provided at the practice, which included coil fitting and implants.
- The practice promoted cancer screening programmes. For example, 87% of eligible patients had received cervical screening (CCG average 85%, national average 82%).
- The practice had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw evidence of very positive feedback from participants who attended these sessions.

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 these patients 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 provided extended hours from 7.30am on weekdays, online booking of appointments, ordering of prescriptions and SMS text reminders.
- The practice offered a range of health promotion and screening that reflected the needs for this age group. For example, cardiovascular disease and diabetes prevention screening and advice. NHS health checks were offered to patients aged between 40 and 74 years who did not have a pre-existing condition.
- Nurse-led in-house smoking cessation clinics were available for patients.
- Travel health advice and vaccinations were available. The practice was a designated Yellow Fever Centre.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- Staff knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them

vulnerable. They 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.

- Patients were signposted to other agencies for additional care and support as needed. We saw there were notices displayed in the patient waiting area informing patients how they could access various local support groups and voluntary organisations.
- The practice held a register of patients living in vulnerable circumstances including those who had a learning disability and patients who acted in the capacity of a carer.
- A 'flag' was used in the electronic patient record to alert clinicians to those carers who may be at risk of 'carer stress'.
- Patients who had a learning disability were offered longer appointments and an annual health check. Care plans had been developed for patients to take home with them, they incorporated easy read language and the use of pictures to aid understanding. Patients were also referred to the Bradford Healthy Living Project. This was a self-advocacy group which was run for and by people who had a learning disability.

People experiencing poor mental health (including people with dementia)

Good

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

- The practice regularly worked with multidisciplinary teams in the case management of people in this population group, for example the local mental health crisis intervention team.
- Patients and/or their carer were given information on how to access various support groups and voluntary organisations.
- Patients who were at risk of developing dementia were screened and support provided as necessary.
- Annual health reviews were undertaken for people who had dementia or complex mental health conditions. For example, 86% of patients diagnosed with dementia had received a face to face review of their care in the preceding 12 months (CCG average 83%, national average 84%); 94% of patients who had a complex mental health problem, such as schizophrenia, bipolar affective disorder and other psychoses, had received a review of their care in the preceding 12 months (CCG 94%, national 89%).
- Staff could demonstrate a good understanding of how to support patients with dementia or mental health needs. Some staff had undertaken additional training such as Dementia Friends.

Summary of findings

- The practice was one of three pilot sites for the primary care wellbeing service. Through this service, intensive support and interventions were provided for patients who had learning disabilities or complex mental health problems.

Summary of findings

What people who use the service say

The national GP patient survey distributed 234 survey forms of which 196 were returned. This was a response rate of 84% which represented less than 3% of the practice patient list. The results published in July 2016 showed the practice was performing higher than local CCG and national averages, for the majority of questions. For example:

- 83% of respondents described their overall experience of the practice as fairly or very good (CCG 80%, national 85%)
- 79% of respondents said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG 73%, national 79%)
- 74% of respondents described their experience of making an appointment as good (CCG 63%, national 73%)
- 89% of respondents said they found the receptionists at the practice helpful (CCG 84%, national 87%)
- 100% of respondents said they had confidence and trust in the last GP they saw or spoke to (CCG 95%, national 95%)
- 97% of respondents said they had confidence and trust in the last nurse they saw or spoke to (CCG 97%, national 97%)

As part of the inspection process we asked for Care Quality Commission (CQC) comment cards to be completed by patients. We received 45 comment cards, which were overwhelmingly positive. Respondents said the practice delivered a 'very high standard of care' and the service was 'first class'. They found staff to be helpful, caring and professional. They liked the environment and facilities and said they would recommend the practice to others.

We also spoke with six patients on the day who were very positive about the staff and the practice. They gave us positive examples where they had felt cared for and supported by both clinical and non-clinical staff in the practice. Three of the patients were members of the Friends of Moorside Surgery, which was the name of the patient participation group. They informed us their involvement and engagement with the practice was positive.

Areas for improvement

Action the service SHOULD take to improve

- The practice should reassure themselves that all vaccines are transported to patients' homes in accordance with the most recent public health guidelines.

Outstanding practice

- The practice participated in the Bradford Health Hearts programme and could evidence that 100% of patients who had atrial fibrillation were being monitored for their anticoagulation (blood clotting) rates. This is essential for the safe management of this disease and the prevention of strokes. We saw evidence that the practice was the highest achieving in this area across Bradford and had received an award from the Clinical Commissioning Group (CCG) in recognition of their work.
- The practice facilitated many services to effectively manage and improve outcomes for patients. For example, newly diagnosed diabetic patients had access to the unique practice developed 'getting started' programme. Sessions were run with the

practice nurse and a dietician to educate patients regarding dietary and lifetstyle choices to support positive self-management of their care. The practice had also participated in the Early Arthritis research project and they were one of three pilot sites in the CCG for Physio First (a self-referral direct access service to physiotherapy interventions). One of the GPs (who was on the advisory group for the National Institute for Health and Care Excellence) led a specialist headache management clinic which patients from other areas could also access.

- The practice worked within the local community and had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw evidence of very positive feedback received from participants with regard to these interventions.

Dr J Sullivan & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector, a GP specialist advisor and a second CQC inspector.

Background to Dr J Sullivan & Partners

Dr J Sullivan & Partners' practice is a member of the Bradford Districts Clinical Commissioning Group (CCG). Personal Medical Services (PMS) are provided under a contract with NHS England. They offer a range of enhanced services, which include:

- extended hours access
- improving patient online access
- delivering childhood, influenza and pneumococcal vaccinations
- facilitating timely diagnosis and support for people with dementia
- identification of patients with a learning disability and the offer of annual health checks
- identification of patients at a high risk of an unplanned admission and providing additional support as needed.

The practice is located in purpose built premises at 370 Dudley Hill Road, Bradford, BD2 3AA, which is situated on the northern outskirts of Bradford city centre. There are good disabled access and facilities onsite. There is car parking with three designated disabled spaces and a bicycle shed. There is an external pharmacy attached to the premises which can be accessed from the waiting area of the practice. There are an extensive number of consulting/clinic rooms. Access to the first floor of the building is via stairs or a lift.

The patient list size is currently 7,450. The ethnic origin of patients is approximately 80% white British and 20% from mixed ethnic backgrounds. The majority of patient demographics are comparable to CCG and national averages, with some variables. For example:

- 65% of patients have a long standing health condition (CCG 56%, national 54%)
- 57% of patients are in paid work or full-time education (CCG 60% and national 61%)
- 6% of patients are unemployed (CCG 7%, national 5%)
- The deprivation score overall is 31% (CCG 32%, national 22%)

There are seven GP partners (three male and four female) and a female salaried GP. Nursing staff consist of three practice nurses and two health care assistants; all of whom are female. The clinicians are supported by a business manager, an office manager and a team of administration staff who oversee the day to day running of the practice, some of whom also work on the reception desk. In addition there is a female pharmacist employed by the practice.

The practice is open Monday to Friday 7.30am to 6pm, with extended hours opening until 8pm on Monday and Wednesday. Appointments are available from 8.30am to 10.30am and 3pm to 5.30pm. Appointments can be pre-booked or made on the same day. Urgent care appointments and telephone consultations are also available outside of the usual appointment times. When the practice is closed out-of-hours services are provided by Local Care Direct, which can be accessed via the surgery telephone number or by calling the NHS 111 service.

The practice has good working relationships with local health, social and third sector services to support the provision of care for its patients. (The third sector includes a very diverse range of organisations including voluntary, community, tenants' and residents' groups.)

Detailed findings

Dr J Sullivan & Partners is a teaching and training practice. They are accredited to train qualified doctors to become GPs (registrars) and to support undergraduate medical students with clinical practice and theory teaching sessions.

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 and inspection programme. The inspection was 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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations, such as NHS England and Bradford Districts CCG, to share what they knew about the practice. We reviewed the latest 2015/16 data from the Quality and Outcomes Framework (QOF) and the latest national GP patient survey results (July 2016). QOF is a voluntary incentive scheme for GP practices in the UK, which financially rewards practices for the management of some of the most common long term conditions. We also reviewed policies, procedures and other relevant information the practice provided before and during the day of inspection.

We carried out an announced inspection on 3 November 2016. During our visit we:

- Spoke with a range of staff, which included two GP partners, a salaried GP, a GP registrar, a clinical pharmacist, a practice nurse, a healthcare assistant, the business manager, office manager and administration staff.
- Reviewed CQC comment cards and spoke with patients regarding the care they received and their opinion of the practice.
- Reviewed questionnaires given to reception/ administration and nursing staff prior to the inspection.
- Observed in the reception area how patients, carers and family members were treated.
- Looked at templates and information the practice used to deliver patient care and treatment plans.

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

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

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

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting, recording and investigating significant events (SEAs).

- There was a strong culture of openness, transparency and honesty.
- There was an electronic incident recording form on the practice computer system which staff would complete in addition to informing the practice manager or lead GP. All incidents and SEAs were discussed at the partners' and staff meetings. There was a nominated GP lead who reviewed all incidents and quarterly audits were undertaken of all significant events. The practice had a dedicated significant events meeting. We looked at some incidents in detail and saw there was good evidence of investigation, actions taken to improve safety in the practice and shared learning with staff. For example, as a result of a delay in changes to a patient's medication, all GPs were advised to ensure changes were actioned upon as appropriate. It was also agreed this area would be subject to ongoing review.
- The practice was aware of their wider duty to report incidents to external bodies such as Bradford Districts CCG and NHS England. This included the recording and reporting of notifiable incidents under the duty of candour.
- When there were unintended or unexpected safety incidents, we were informed patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.
- There was a system in place to ensure all safety alerts were cascaded to staff and actioned as appropriate.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse. We saw evidence of:

- Arrangements which reflected relevant legislation and local requirements were in place to safeguard children and vulnerable adults from abuse. Policies clearly outlined whom to contact for further guidance if staff had concerns about a patient's welfare. Staff had received training relevant to their role. We were informed of several examples which demonstrated their understanding of safeguarding. There was a nominated GP lead for safeguarding children. The adult safeguarding lead was also the named GP lead for adult safeguarding across Bradford. Both GPs had received level three safeguarding training to undertake these roles. All other practice staff had undertaken the level of safeguarding training appropriate to their roles. Patients who were vulnerable or at risk of safeguarding were identified on their patient record to alert staff as appropriate. The practice held monthly safeguarding meetings. The health visitor regularly attended the practice and any child safeguarding issues or concerns were communicated to them. Referrals were made to other health and social care agencies as appropriate.
- A notice was displayed in consulting and treatment rooms advising patients that a chaperone was available if required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service 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.) It was recorded in the patient's record when a chaperone had been in attendance or declined.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was a nominated lead for infection prevention and control (IPC). All staff had received up to date training in IPC. We saw evidence that an IPC audit had taken place in October 2016. Actions had been taken to address any issues raised, such as having hand hygiene signs displayed in all clinical rooms and toilet areas and using disposable or wipeable pillow covers. There was an IPC policy in place and the practice liaised with the local IPC team as necessary.
- There were safe and effective arrangements in place for managing medicines, including emergency drugs and vaccinations, to keep patients safe. These included obtaining, prescribing, recording, handling, storage and security. However, the cool bag which was used to

transport vaccines to patients' homes was not in accordance with public health guidelines. We were assured that the practice would obtain the appropriate equipment.

- Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Prescription pads and blank prescriptions were securely stored and there were systems in place to monitor their use. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines, in line with legislation. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment.) The health care assistant was trained to administer vaccines or medicines against a patient specific direction (PSD). (PSDs are written instructions for medicines to be supplied and/or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Regular medication audits and reviews of discharge summaries were carried out with the support of the clinical pharmacist, to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. A medication review checklist devised by the practice was used on a daily basis by staff to ensure that recalls, reviews and tests were up to date, any medication changes had been updated on the patient records as needed and patients informed as appropriate.
- There were systems in place to review blood results and tests for patients and contact them for follow up. These included ensuring results were received for all samples sent for the cervical screening programme. The practice also followed up women who were referred to secondary care services as a result of abnormal results.
- We reviewed three staff personnel files. We found appropriate recruitment checks had generally been undertaken prior to employment. However, a record of all DBS checks undertaken was not routinely kept in the personnel files. We were assured that these would be rectified.

Monitoring risks to patients

The practice had procedures in place for assessing, monitoring and managing risks to patient and staff safety. We saw evidence of:

- Risk assessments to monitor the safety of the premises, such as the control of substances hazardous to health and legionella. (Legionella is a bacterium which can contaminate water systems in buildings.)
- A health and safety policy and evidence that a health and safety site inspection had been undertaken in the preceding 12 months.
- All electrical and clinical equipment was regularly tested and calibrated to ensure the equipment was safe to use and in good working order.
- 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. Staff worked flexibly to cover any changes in demand, for example annual leave, sickness or seasonal.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents. We saw:

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff were up to date with fire and basic life support training.
- There was a defibrillator and oxygen available on the premises.
- Emergency medicines were stored in a secure area and there was also an emergency 'grab bag' which was easily accessible for staff. All the medicines and equipment we checked were in date and fit for use.
- The practice had a business continuity plan in place, which identified what should be done and who to contact in the event of a major incident, such as power failure or building damage.

Outstanding ☆

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. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. We saw evidence where latest guidance was discussed at clinical meetings.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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). Outcomes for patients were consistently better than expected when compared to other similar services.

At the time of inspection the most recent published results (2015/16) showed the practice had achieved 100% (CCG and national averages 97%) of the total number of points available, with 10% exception reporting. This was comparable to the CCG average of 11% and the national average 10%. (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). Data showed:

- Performance for diabetes related indicators were higher than CCG and national averages. For example, 96% of patients on the diabetes register had a recorded foot examination completed in the preceding 12 months (CCG 78% and national averages of 88%).
- Performance for mental health related indicators were comparable to CCG and national averages. For example, 94% of patients with schizophrenia, bipolar affective disorder and other psychoses had a record of blood pressure in the preceding 12 months (CCG average 94%, national average 89%).

The practice participated in the Bradford Healthy Hearts programme and could evidence a proactive approach. They had reviewed every eligible patient who had atrial fibrillation (a type of arrhythmia causing the heart to beat faster and more irregularly). Atrial fibrillation increases the risk of stroke and the use of anticoagulation medicines to prevent blood clots can help to decrease that risk. As a result they had achieved a 100% anticoagulation rate for those who have atrial fibrillation, which could reduce the risk of a stroke. We saw evidence that the practice was the highest achieving in this area across Bradford and had received an award from the CCG in recognition of this.

The practice facilitated many services to effectively manage and improve outcomes for patients. For example, newly diagnosed diabetic patients had access to the 'getting started' programme. There were effective in-house warfarin management and alcohol treatment services. The practice participated in the Early Arthritis research project and they were one of three pilot sites in the CCG for Physio First. This service provided patients with direct access to physiotherapy interventions without the need for a referral.

One of the GPs led a specialist headache management clinic which patients from other areas could also access. We saw evidence of the comprehensive assessment form, protocol and pathway used in the management of these patients.

The practice used clinical audit, peer review, local and national benchmarking to improve quality. We saw there was a proactive programme of clinical and non-clinical audits, which had been undertaken over the previous two years, including quarterly audits relating to antibiotics; which were shared with the CCG and other practices.

We reviewed a two cycle audit of hypertension management. We saw that all stages of the audit had been completed and could demonstrate where improvements had been identified and sustained. We saw evidence where the audit had been shared within the practice. In response to the audit, a blood pressure machine had also been installed in a private area within the waiting area, to enable patients to take their own blood pressure. A printout was then given to a member of reception, which was then

recorded onto the patient's record for a clinician to evaluate and follow up as appropriate. Any abnormalities which were identified, as per practice protocol, were given directly to a clinician to be actioned.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Evidence we reviewed showed:

- The learning and development needs of staff were identified through appraisals, meetings and reviews of practice performance and service delivery.
- Staff were supported to access e-learning, internal and external training. They were up to date with mandatory training which included safeguarding, fire procedures, infection prevention and control, basic life support and information governance awareness. The practice had an induction programme for newly appointed staff which also covered those topics.
- Staff who administered vaccines and the taking of samples for the cervical screening programme had received specific training, which included an assessment of competence. We were informed staff kept up to date of any changes by accessing online resources or guidance updates.
- The GPs were up to date with their revalidation and appraisal.
- The practice nurses were up to date with their nursing registration.

Coordinating patient care and information sharing

The practice had effective systems in place which supported the management and sharing of information to plan and deliver care and treatment for patients. They could evidence how they followed up patients who had an unplanned hospital admission or had attended accident and emergency (A&E); particularly children or those who were deemed to be vulnerable.

Staff worked with other health and social care services, such as community matron, district nursing team and mental health services, to understand and meet the complexity of patients' needs and to assess and plan ongoing care and treatment. With the patient's consent, information was shared between services using a shared care record.

Care plans were in place for those patients who had complex needs, were at a high risk of an unplanned hospital admission or had palliative care needs. These were reviewed and updated as needed. Information regarding end of life care was shared with out-of-hours services, to minimise any distress to the patient and/or family.

Consent to care and treatment

Staff understood the relevant consent and decision-making requirements of legislation and guidance, such as the Mental Capacity Act 2005. Patients' consent to care and treatment was sought in line with these. Where a patient's mental capacity to provide consent was unclear, the GP or nurse assessed this and, where appropriate, recorded the outcome of the assessment.

When providing care and treatment for children 16 years or younger, assessments of capacity to consent were also carried out in line with relevant guidance, such as Gillick competency and Fraser guidelines. These are used to decide whether a child is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

We saw evidence that when a patient gave consent it was recorded in their notes. Where written consent was obtained, this was scanned and filed onto the patient's electronic record.

Supporting patients to live healthier lives

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion. The practice identified patients who may be in need of extra support and signposted those to relevant services. These included patients:

- who were in the last 12 months of their lives
- at risk of developing a long term condition
- required healthy lifestyle advice, such as dietary, smoking and alcohol cessation
- who acted in the capacity of a carer

We were informed (and saw evidence in some instances) that the practice:

- Had encouraged patients to attend national screening programmes for cervical, bowel and breast cancer. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening

test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice uptake rates were higher than CCG averages. For example, cervical screening in the preceding five years was 87% (CCG and national 81%); breast screening of females aged 50 to 70 in the last 36 months was 75% (CCG 67%, national 72%); bowel screening of patients aged 60 to 69 years in the last 30 months was 57% (CCG 55%, national 58%).

- Carried out immunisations in line with the national childhood vaccination programme. Uptake rates for children aged eight weeks to five years ranged from 71% to 99%; which were in line with the CCG averages of 60% to 97% (these included the Meningitis C vaccine which had lower rates of uptake across the CCG as a whole).
- Patients had access to appropriate health assessments and checks. These included NHS health checks for people aged 40 to 75. Where abnormalities or risk factors were identified, appropriate follow-ups were undertaken.
- Pre-diabetes checks and screening for chronic obstructive pulmonary disease were undertaken with those patients who were deemed most at risk of developing those conditions.
- Provided comprehensive sexual health advice and contraception services, such as coil fittings and implants.
- The practice had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw very positive written feedback regarding the sessions from pupils and staff. Comments also included an increased awareness of those issues as a result of the sessions.
- Patients who had a learning disability were offered longer appointments and an annual health check. Care plans had been developed for patients to take home with them, they incorporated simple language and the use of pictures to aid understanding. Patients were also referred to the Bradford Healthy Living Project. This was a self-advocacy group which was run for and by people who had a learning disability.
- Nurse-led in-house smoking cessation clinics were available.
- Patients had access to an in-house alcohol misuse counsellor and a GP with a specialist interest in that area.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that:

- Members of staff were courteous and helpful to patients and treated them with dignity and respect.
- There was a private room should patients in the reception area want to discuss sensitive issues or appeared distressed.
- Curtains were provided in consulting and treatment rooms to maintain the patient's dignity during examinations, investigations and treatment.
- Doors to consulting and treatment rooms were closed during patient consultations and that we could not hear any conversations that may have been taking place.
- Chaperones were available for those patients who requested one and it was recorded in the patient's record.

Data from the national GP patient survey showed respondents rated the practice higher than the CCG and national averages for many questions regarding how they were treated. For example:

- 96% of respondents said the last GP they saw or spoke to was good at listening to them (CCG 88%, national 89%)
- 95% of respondents said the last GP they saw or spoke to was good at giving them enough time (CCG 86%, national 87%)
- 93% of respondents said the last GP they spoke to was good at treating them with care and concern (CCG 85%, national 85%)
- 96% of respondents said the last nurse they saw or spoke to was good at listening to them (CCG 90%, national 91%)
- 95% of respondents said the last nurse they saw or spoke to was good at giving them enough time (CCG 90%, national 92%)
- 96% of respondents said the last nurse they spoke to was good at treating them with care and concern (CCG 91%, national 91%)

All of the 45 comment cards we received were positive about the care they had received, many described the practice as being 'excellent'. They stated they felt listened to and cited staff as being caring, helpful, respectful and professional.

Patients we spoke with were all very positive about the staff and the practice. They gave us several examples to demonstrate how they had been cared for and treated. Patients said they didn't feel rushed, they felt listened to and that all staff were friendly and caring. We were given examples where administration/reception staff went over and above their expected duties. For example, delivering prescribed medicines for older patients to their home or going and checking on a patient at their home due to staff having difficulty in contacting that patient by telephone.

Care planning and involvement in decisions about care and treatment

The practice provided facilities to help patients be involved in decisions about their care:

- The choose and book service was used with all patients as appropriate.
- Interpretation and translation services were available for patients who did not have English as a first language.
- There were information leaflets and posters displayed in the reception area available for patients.

Data from the national GP patient survey showed respondents rated the practice higher than other local and national practices. For example:

- 89% of respondents said the last GP they saw was good at involving them in decisions about their care (CCG 81%, national 82%)
- 97% of respondents said the last GP they saw was good at explaining tests and treatments (CCG 86%, national 86%)
- 93% of respondents said the last nurse they saw was good at involving them in decisions about their care (CCG 84%, national 85%)
- 92% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments (CCG 89%, national 90%)

Patients comments we received on the day aligned with these responses.

Patient and carer support to cope emotionally with care and treatment

The practice maintained a register of patients who were carers and had identified 168 (over 2% of the practice population). Individuals who were at risk of carers' stress had an identification 'flag' on their record, to alert clinicians

Good

Are services caring?

to offer additional support as needed. All carers were offered a health check and influenza vaccination. They were also signposted to support groups or carers' resource organisations.

The practice worked jointly with palliative care and district nursing teams to ensure patients who required palliative care, and their families, were supported as needed. We were informed that if a patient had experienced a recent bereavement, a bereavement card would be sent to the family and support offered as appropriate.

We saw there were notices and leaflets in the patient waiting area, informing patients how to access a number of support groups and organisations. There was also information available on the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice engaged with NHS England and Bradford Districts CCG to identify and secure provision of any enhanced services or funding for improvements. Services were provided to meet the needs of their patient population, which included:

- Extended hours appointments during weekdays.
- Home visits for patients who could not physically access the practice and were in need of medical attention.
- Urgent access appointments for children and patients who were in need.
- Longer appointments as needed.
- Online services such as booking of appointments and reordering of prescriptions.
- Travel vaccinations which were available on the NHS and privately.
- Interpretation and translation services.
- Onsite physiotherapy services three days a week

The practice was a designated 'place of safety' for people as appropriate (this is a place where a person can be safely and effectively assessed under the Mental Health Act or whilst awaiting urgent intervention by another service such as social services).

The GPs in the practice had specialised interests and used their knowledge and skills in these areas to benefit the practice and the patients. Some of these areas included musculoskeletal, neurology, medicines management and anti-coagulation. This supported a reduced need for patients to attend secondary care services and a quicker access to care and treatment for patients.

As part of the wellbeing service, intensive support and interventions were available for those patients who had learning disabilities, complex mental health problems or were high users of NHS services. Patients had direct access to regular support from a psychologist, psychiatrist or physiotherapist as needed. Some patients had been given regular two weekly appointments to help them to maintain a stable lifestyle. We saw evidence that five patients had gone through this programme of support. This had resulted in a reduction in the 'ad hoc' use of primary and secondary care services.

All newly diagnosed diabetic patients had access to the 'getting started' programme. This programme had been developed by the practice nurse to support and advise patients and their families about living with diabetes. Quarterly group sessions were run with the nurse and a dietician to educate patients regarding dietary and lifestyle choices to support positive self-management of their care. A variety of food was provided to support what could be eaten and information was given for patients to take away with them. Approximately 10 people attended each session.

The practice had increased engagement with local health champions and signposted patients to them for support with individual needs and self-management of care.

The practice had facilitated a young people's 'eating for exams' workshop and had also funded a drama group to work in the local secondary school focusing on healthy lifestyle awareness, such as bullying, sexual health, drug use and mental health. We saw evidence of very positive feedback from participants who attended these sessions.

Access to the service

The practice was open Monday to Friday 7.30am to 6.30pm, with extended hours until 8pm on Monday and Wednesday. Appointments were available from 8.30 to 10.30am and 3pm to 5.30pm.

There was a responsive appointment system, where appointments could be pre-booked or made on the same day. Urgent care appointments and telephone consultations are also available outside of the usual appointment times. When the practice was closed out-of-hours services were provided by Local Care Direct, which could be accessed via the surgery telephone number or by calling the NHS 111 service.

Data from the national GP patient survey showed satisfaction rates were higher than CCG and national averages. For example:

- 74% of respondents were fairly or very satisfied with the practice opening hours (CCG 71%, national 76%)
- 90% of respondents said they could get through easily to the surgery by phone (CCG 61%, national 73%)
- 90% of respondents said the last appointment they got was convenient (CCG 89%, national 92%)

The practice had developed an access plan, where they regularly reviewed demand and capacity. This had

Good

Are services responsive to people's needs?

(for example, to feedback?)

included routine appointment bookings and daily open access clinics. One of the GPs had lead for looking at 'pressures' in the appointment system and reviewed how GP clinic sessions were being covered and utilised. The practice had also increased the use of technology, reviewed the skill mix of non-clinical staff and reorganised the reception service to support the practice in becoming more responsive to patients' needs.

Listening and learning from concerns and complaints

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

- The 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.
- The practice kept a record of all written complaints.
- All complaints and concerns were discussed at the practice meeting.
- There was information available in the practice, in the patient information leaflet and on the practice website, to help patients understand the complaints system.

There had been seven complaints received in the last 12 months. We reviewed the complaints and found they had been satisfactorily handled, lessons had been learned and action taken to improve quality of care. One of the complaints had related to secondary care services, rather than the practice itself. There were no themes identified.

Are services well-led?

Good

(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 and strategy to deliver high quality, safe and effective care in response to the needs of patient within their community. The GP partners and management team had attended an 'away day' in May 2016, to discuss the progress and achievements of the preceding 12 months, the development of the practice and future plans. The findings had then been incorporated into the business strategy plan. Information had been cascaded to staff through meetings.

All staff knew and understood the practice vision and values. There was a strong patient-centred ethos amongst the practice staff and a desire to provide high quality care. This was reflected in their passion and enthusiasm when speaking to them about the practice, patients and delivery of care.

Governance arrangements

There were good governance processes in place which supported the delivery of good quality care and safety to patients. We saw evidence of:

- A comprehensive understanding of practice performance. Practice meetings were held where practice performance, significant events and complaints were discussed.
- Clinical audit being used to monitor quality and drive improvements.
- Arrangements for identifying, recording, managing and mitigating risks.
- A good understanding of staff roles and responsibilities. Staff had lead key areas, such as safeguarding, dealing with complaints and significant events, data and recall of patients, and infection prevention and control.
- Business continuity and comprehensive succession planning in place, for example the recruitment of GPs and the development of staff.

Leadership and culture

There was clear leadership and staff told us the GPs and managers were very visible in the practice, approachable and could be easily accessed when needed. They described good working relationships between the GP partners and staff.

On the day of inspection the partners in the practice could demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. All staff told us they prioritised safe, high quality and compassionate care. We saw evidence of:

- Practice and clinical meetings being held.
- Formal minutes from a range of multidisciplinary meetings held with other health and social care professionals to discuss patient care and complex cases, such as palliative care.
- An inclusive team approach to providing services and care for patients.
- Systems in place to ensure compliance with, the requirements of the duty of candour.

The GPs had specialised interests and used their knowledge and skills in these areas to benefit the practice and the patients. Some of these areas included musculoskeletal, neurology, medicines management and anti-coagulation. These had supported a reduced need for patients to attend secondary care services, a reduced waiting time for patients to be seen and treated and improved outcomes for patients

In addition, GPs held lead roles within the CCG and nationally, for example clinical board member of Bradford Districts CCG, Bradford adult safeguarding lead, Local Medical Council (LMC), elected fellow of the Royal College of General Practitioners (RCGP), GP retainer scheme and involvement in GP appraisal at national level.

Dr J Sullivan & Partners was a training practice. They were accredited to train qualified doctors to become GPs and to support undergraduate medical students, with clinical practice and theory teaching sessions. The GP trainer was involved in the GP appraisal process at a national level. They also mentored GPs who were returning to work (nationally) after a lengthy period of absence. We saw evidence of very positive feedback the practice had received from the registrars

The practice promoted a culture of openness and honesty. The GPs and practice manager were complimentary of their staff and valued their commitment to providing good quality care and services for their patients. We were informed of the annual 'team building' events which took place outside of the practice. These were attended by all staff and promoted the sharing of ideas and supportive working relationships.

Are services well-led?

Good

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

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

The practice encouraged and valued feedback from patients and staff. The patient participation group was known as the Friends of Moorside Surgery. This group had been established for nine years and were actively involved in the practice. Minutes from meetings could evidence areas where the group had been involved. For example, issues regarding access, supporting appropriate use of services and agreement regarding the use of a sum of money which had been allocated to the practice.

There was evidence the practice used information from the national patient survey, responses from the NHS Friends and Family test and feedback from NHS Choices. In 2015, they had felt they could improve service delivery, as a result the practice had reviewed their appointment system, embedded a referral safety net system in their computer and reviewed the use of 'tasks' to one another via the computer system. They had also provided a children's play area and blood pressure monitor in the patient waiting area. Patients and staff had reported an increase in satisfaction as a result of these changes.

Feedback from staff was obtained through meetings, discussions and the appraisal process. Staff told us they would not hesitate to raise any concerns and felt involved and engaged within the practice to improve service delivery and outcomes for patients.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking. They informed us they would continue to embrace new and innovative practice to support improvements to patients outcomes and service delivery.

The practice promoted sharing and learning through links with a number of organisations in this country and around the world. For example, they had hosted several visits by Chinese delegates from the field of medical management, who were interested in the private and public sector of medicine in the UK.