

Dr Ishtiaq Gilkar

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?

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 Ishtiaq Gilkar practice on 20 November 2015. Overall the practice is rated as good.

Specifically we rated the practice as good in providing safe, effective, caring, responsive and well-led care for all of the population groups it serves.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

- 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.
- 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 management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw two areas of outstanding practice:

- The practice supported clinical staff in their training by ensuring one week paid leave each year for training.
- The practice ran a Contraceptive and Sexual Health Clinic for people in the inner city area of Bradford.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should:

Summary of findings

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all complaints are managed and responded to appropriately.

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. Staff understood and fulfilled their responsibilities to raise concerns, to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed, care planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles. There was evidence of annual appraisals and staff had received training appropriate to their roles. Staff worked with multidisciplinary teams.

Good



Are services caring?

The practice is rated as good for providing caring services. Data showed patients rated the practice higher than others for several aspects of their care. Patients said they were treated with compassion, dignity and respect and were involved in decisions about their care and treatment. Care planning templates were available for staff to use during consultation. Information to help patients understand the services was available and easy to understand. We saw staff treated patients with kindness, respect and maintained confidentiality.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It 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 said they found it easy to make an appointment with a preferred GP, there was continuity of care and urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. Learning from complaints was shared with staff.

Good



Summary of findings

Are services well-led?

The practice is rated as good for being well-led. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures in place and held regular practice meetings. There were systems in place to monitor and improve quality and identify risk. Staff received induction, regular performance reviews and attended staff meetings. The practice proactively sought feedback from patients and staff which it acted upon.

Good



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. Nationally reported data showed outcomes for patients were good for conditions commonly found in older people. All patients over 75 years of age had a named GP. There were systems in place for older people to receive regular health checks. The practice was responsive to the needs of older people, offering home visits and longer appointments. The practice working closely with other health and social care professionals.

Good



People with long term conditions

The practice is rated as good for the care of people with long term conditions. Nursing staff had lead roles in chronic disease management such as diabetes and chronic obstructive pulmonary disease (COPD). There were structured annual reviews in place to check the health and medications needs of patients were being met. Those patients with multiple conditions were offered an hour long review appointment to address their needs in one visit. Longer appointments and home visits were available when needed. Staff worked with relevant health and social care professionals to deliver a multidisciplinary package of care.

Good



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. The practice provided a Contraception and Sexual Health Service (CASH) for patients registered at the practice and all patients in the Bradford City area. Appointments were available outside of school hours and the premises were suitable for children and babies.

Good



Working age people (including those recently retired and students)

The practice is rated as good for the population group of the working-age patients including those recently retired. They helped to ensure care for these patients was safe, caring, responsive and effective. The practice had extended hours to facilitate attendance for patients who could not attend appointments during normal surgery hours. There was a full range of health promotion and screening which reflects the needs of this population group.

Good



Summary of findings

People whose circumstances may make them vulnerable

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances, including those with learning disabilities. These patients received an annual health check and longer appointments were available where required. Access to translation services were available when needed.

Good



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). Data showed 97% of patients with a physical and/or mental health condition had been offered support or treatment within the preceding 15 months.

The practice had access to professional support such as the local mental health team and psychiatric support as appropriate. Information was readily available through the practice advising patients of various support groups and organisations.

Good



Summary of findings

What people who use the service say

We received 37 completed CQC patient comments cards where patients and the public shared their views and experiences of the service. We also spoke with two patients on the day of our inspection.

The patients who had completed the CQC comments cards and those spoken with were complimentary about the level of care and treatment they had received.

However, 16 people raised issues about some aspects of the service. We reviewed these and found there to be a theme around accessing appointments and getting through to the practice on the telephone.

Most of the patients we spoke with told us they were treated with dignity and respect. They felt staff at the practice took time to listen to them and involve them in decisions about their care.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.

- Ensure all complaints are managed and responded to appropriately.

Outstanding practice

- The practice supported clinical staff in their training by ensuring one week paid leave each year for training.

- The practice ran a Contraceptive and Sexual Health Clinic for people in the inner city area of Bradford.

Dr Ishtiaq Gilkar

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a second CQC inspector, a GP and a practice manager.

Background to Dr Ishtiaq Gilkar

Dr Ishtiaq Gilkar operates from two sites within the inner city area of Bradford. The main site is Little Horton Medical Centre and the branch site at Birch Medical Practice. The practice serves a population of approximately 7,939 patients who can access services at any of the two sites.

The practice has one male general practitioner (GP) who is registered with CQC as the provider and one female salaried GP. Working alongside the GPs are seven long term locum GPs (two female and five male), two advanced nurse practitioners, a practice nurse, a clinical pharmacist and three health care assistants. The clinical team are supported by a practice business manager and a team of administrative and secretarial staff.

The practice has a General Medical Services (GMS) contract. This is the contract between general practices and NHS England for delivering services to the local community.

Little Horton Medical Centre offers a range of appointments between 8.30am and 6pm Monday to Friday. With extended hours being provided between the hours of 6.30pm to 8.30pm on Monday evening and between 6.30pm to 8pm on Thursday evenings.

Birch Medical Practice offers a range of appointments between 9 am and 5.30pm Monday to Friday. With extended hours being provided from 6.30pm to 8pm on Thursday evenings.

In addition to this, the practice opens on Saturday mornings from 9.00-11.30am during the winter period.

When the practice is closed, out of hours cover for emergencies is provided by the NHS 111 service.

A wide range of services are available at the practice and these include: vaccinations and immunisations, cervical smears, and chronic disease management such as asthma, chronic obstructive pulmonary disease (COPD) and diabetes.

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. This 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.

Please note when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the Care Quality Commission (CQC) at that time.

Detailed findings

How we carried out this inspection

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

We carried out an announced inspection at Little Horton Medical Centre and Birch Medical Practice on 20 November 2014. During our inspection we spoke with staff including two GPs, an Advanced Nurse Practitioner, a Practice Nurse, a Health Care Assistant, the Practice Business Manager and two members of the reception team.

We spoke with two patients on the day of our visit and we observed how patients were being spoken with on the telephone and within the reception area. We also reviewed 37 CQC comment cards where patients had shared their views and experiences of the practice.

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)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, they reported incidents and national patient safety alerts, as well as comments and complaints received from patients.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We spoke with the practice business manager and members of the reception team who told us incidents and complaints were discussed at monthly practice meetings.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events and complaints and evidence the practice had learned from these. For example; an incident had occurred when patient notes were scanned onto the wrong patient's medical records.

As a result of the incident the practice had implemented a three check system prior to scanning notes onto medical records. We reviewed minutes from a meeting held in July 2014 and saw these contained a record of learning from this incident.

We spoke with two members of the reception team who told us incident forms were available behind reception and these would be completed and escalated to the lead GP or practice manager.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed staff had received relevant training on safeguarding. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to escalate any safeguarding concerns.

The practice had a dedicated lead for safeguarding vulnerable adults and children. They had been trained to

level 3 and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to within the practice if they had a safeguarding concern.

The practice had a system in place to highlight any vulnerable patients on the clinical system and this information could be accessed by the health visitors.

There was a chaperone policy which was visible at reception and on the door of each clinical room. 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.

The health care assistant and practice nurse had been trained to be a chaperone so provided this service. The practice were also considering training reception staff to enable them to assist during busy periods.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This described the action to take in the event of a potential failure.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

The practice received delivery of medication on a fortnightly basis and stock was rotated to minimise waste. Expired and unwanted medicines were disposed of in line with regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We spoke with two members of the reception team who told us the checks undertaken by the practice prior to dispensing a prescription. They told us they checked the name, address and medication prescribed. If the prescription was collected by a representative of the patient then the reception staff documented who this was collected by, the relationship to the patient and time of collection.

Are services safe?

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. We spoke with two patients who told us they found the practice clean and had no concerns about cleanliness or infection control.

We reviewed training records and saw staff had received appropriate infection control training. The practice also had dedicated clinical and non-clinical leads for infection control who could support staff with infection control issues.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy.

We spoke with the practice manager who told us annual infection control audits were undertaken by Bradford Council and the practice were currently working through recommendations.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

We saw spillage kits were available in the practice to support the safe and effective clean-up of bodily fluid spillages. For example blood or vomit.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can grow in contaminated water and can be potentially fatal). At the time of our inspection the practice were awaiting the outcome of the latest assessment which had been undertaken by an external company.

Equipment

We saw equipment was available to meet the needs of the practice and this included a defibrillator which was readily available for use in a medical emergency. Routine checks had been carried out to ensure they were in working order.

We saw, portable appliance testing had been completed annually and systems were in place for routine servicing and calibration of medical equipment where required. The sample of portable electrical equipment we inspected had been tested and was in date.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff. We reviewed two staff files and saw these contained proof of identification, employment history and contracts of employment.

However, at the time of our inspection the provider was in the process of undertaking disclosure and barring checks for staff members.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice had developed clear lines of accountability for all aspects of patient care and treatment.

Areas of individual risk were identified and steps taken to address the issues. For example; posters relating to safeguarding were displayed throughout the practice. All staff had access to a panic button to alert other members of staff should they encounter a difficult situation.

There was evidence the practice learned from incidents and responded to identified risk. The practice looked at safety incidents and where concerns had been raised. They looked at how this could have been managed better or avoided.

Are services safe?

We saw emergency equipment was available in the surgery which included emergency medicines. All staff were aware of the location..

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of practice meetings where new guidelines were disseminated. The implications for the practice's performance and patients were discussed and required actions agreed.

The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurses' that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs and Advanced Nurse Practitioner told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. This allowed them to focus on specific conditions.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice held multiple clinics to meet the needs of the practice population. These helped to ensure each patient's condition was monitored and their care was regularly reviewed. Staff at the practice had recently streamlined reviews for long term conditions. They offered patients with multiple conditions, such as asthma and diabetes, an hour long appointment. All conditions were reviewed during one appointment.

The practice had registers for patients needing palliative care, diabetes, asthma and COPD. This helped to ensure each patient's condition was monitored and their care was regularly reviewed. Additionally, regular palliative care meetings were held and they included other professionals involved in the individual patient's care.

Staff at the practice told us they promoted health initiatives during consultations with patients'. We noted health promotion information available in practice waiting areas and on the practice website.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included; the use of strong opioid use for non-cancer pain, use of pregabalin for pain management and use of anti-psychotics in dementia patients. The practice had recruited a pharmacist to carry out regular medication audits.

We saw the practice had a system in place for monitoring patients with long term conditions and this included learning disabilities.

We found clinical staff had a good awareness of recognised national guidelines. For instance they used National Institute for Health and Care Excellence (NICE) quality standards and best practice in the management of conditions such as diabetes.

The practice aimed to deliver high quality care and participated in the Quality and Outcomes Framework (QOF) targets and had achieved a total of 94.3% against the clinical outcomes. This was higher than the CCG and NHS England average.

The QOF aimed to improve outcomes for a range of conditions such as diabetes. The practice used information they collected to help monitor outcomes for patients and the quality of services they provided.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with mandatory courses such as annual basic life support.

We spoke with two members of the reception team who told us they had received induction training when starting the job. They told us they felt supported to carry out their role when left unsupervised and always had access to support when necessary.

All staff undertook annual appraisals which identified their learning needs. Our interviews with staff confirmed the

Are services effective?

(for example, treatment is effective)

practice was proactive in providing training and funding for relevant courses. For example; one member of the reception team had been supported to undertake a phlebotomy course.

We spoke with the lead GP who told us clinical staff receive one week paid leave to undertake relevant training.

Working with colleagues and other services

We saw evidence that practice staff worked with other services and professionals to meet patients' needs and manage complex cases. Multidisciplinary meetings were held to discuss patients on the palliative care register and those at risk. The QOF data showed these meetings were held at least three monthly and all patients on the register were discussed.

The lead GP was the Deputy Chair of the local Clinical Commissioning Group (CCG). They were the CCG lead for a number of areas including infection control, cancer and end of life care.

The practice was also part of a local integrated care team with six other GP practices. This involved working closely with other sectors for example; the district nursing team and CCG managers.

Information sharing

Staff had access to electronic systems relevant to their role and access to all up to date practice policies and procedures. Staff told us they were kept informed by the practice manager if there had been any changes to policies and procedures.

Staff told us they had regular monthly meetings. We were able to review minutes of these meetings and saw they covered a range of topics. For example; patient recalls, complaints and significant events.

We saw evidence the practice staff worked with other services and professionals to meet patients' needs and manage complex cases. There were regular meetings with the multi-disciplinary team within the locality. These included palliative care nurses, community matrons and the safeguarding teams.

We saw the practice website was used to provide and receive information from patients. For example; patients could update their address and telephone number held by the practice electronically.

The practice also produced a patient newsletter to share information about the practice and the services offered. We reviewed a copy and saw it contained information about patient engagement and advice on flu vaccinations.

Consent to care and treatment

We found the healthcare professionals understood the purpose of the Mental Capacity Act (2005) and the Children Act (1989) and (2004). All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

They also spoke with confidence about Gillick competency assessments of children and young people, which were used to check whether these patients had the maturity to make decisions about their treatment.

Health promotion and prevention

All new patients were required to complete a new patient registration form and attend a medical appointment with the health care team. This was to ensure any existing health issues or medication requirements were identified and managed.

All patients over 75 years had a named GP and received an annual health check. Patients with a long term condition (LTC) or mental illness had an annual review of their treatment, or more often where appropriate.

A GP and nursing team led on the management of LTCs of patients in the practice. They proactively gathered information on the types of LTC patients presented with and had a clear understanding of the number and prevalence of conditions being managed by the practice.

The practice were involved in a number of local initiative including Bradford Beating Diabetes (BBD). BBD is a local initiative aiming to identify patients who are at risk of developing diabetes and ensuring they received the appropriate advice and support to prevent the condition.

The practice were also involved in the Hep 'free' Study, a screening programme for hepatitis C in the practice population.

Additional clinics and services were available for patients within the practice. These included dietary and weight management advice. This had the benefit of providing local, accessible services for patients.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients completed CQC comment cards to tell us what they thought about the practice. We received 37 completed cards and the majority were positive about the service they experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. However, 16 comment cards noted issues with accessing an appointment and getting through to the practices on the telephone.

We spoke with two patients on the day of our inspection. They told us they were satisfied with the care provided by the practice and said their privacy and dignity was respected.

Staff were familiar with the steps they needed to take to protect people's dignity. There was an electronic booking system for those who did not wish to announce their name to reception staff and this was available in different languages. There were rooms available for patients who required a conversation with reception staff in private.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice good in these areas. For example data from the national patient survey showed 80% of respondents said the GP involved them in care decisions 89% felt the nurse was good at how they explained treatment and results.

The patients we spoke with on the day of our inspection told us health issues were discussed with them in a way they could understand. They felt involved in decision making about their care and treatment. They told us they felt listened to and had enough time during a consultation to make an informed decision about the choice of treatment they wished to receive.

Care plans were in place for patients with specific health needs and these included patients with long term conditions such as, asthma. They were adapted to meet the needs of each individual. This information was designed to help patients to manage their own health care and wellbeing to maximise their independence and also helped reduce the need for hospital admission.

Patient/carer support to cope emotionally with care and treatment

We saw information in the practice about advocacy, and bereavement support services. Staff were also aware of contact details for these services when needed.

The patients we spoke to on the day of our inspection told us staff were caring and understanding when they needed help and provided support where required. The CQC patient comments cards also confirmed the practice staff were very supportive to them and their families.

Palliative care meetings with clinical staff and community health professionals were held to discuss patient treatment, care and support. We were told this ensured patients' received co-ordinated care and support.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The practice had a predominately younger population, with 75% of patients registered at the practice being under 40 years of age. The practice had considered this when planning services. For example; a Contraception and Sexual Health Clinic was run from the practice for all patients in the Bradford inner city area.

We reviewed results of the patient participation group survey and saw the practice had taken steps to address the issues around accessing appointments by introducing a new telephone system with additional lines. The practice also had dedicated lines for test results to enable the appointments lines to be more accessible.

The practice had also introduced a minor ailments clinic run by a pharmacist to ensure GP appointments were used appropriately.

Tackling inequity and promoting equality

The practice had recognised the needs of the different population groups in the planning of its services. They had systems in place which alerted staff to patients with specific needs or who may be at risk. For example; a system had been introduced for patients with long term conditions and a colour coded letter was sent out to invite patients for review. A blue letter was sent to patients who needed a 15 minute appointment, and a pink letter for those who were invited for a 30 minute appointment.

The practice premises and consulting rooms were accessible to all patients and we noted pushchairs and wheelchairs were accommodated. Accessible toilet facilities were available for all patients and mother and baby feeding /nappy changing facilities.

Interpretation services were provided by staff at the practice and any patient requiring an interpreter was identified on the clinical system and a double appointment booked.

The practice website had a function to enable all information to be available in a variety of languages.

Access to the service

Information regarding the practice opening times and how to make appointments was available in the reception area, the practice leaflet and on the website. Patients could book appointments by telephone or in person at the reception. Some appointments were pre-bookable and some were allocated to be booked on the same day. Home visits were offered for patients who needed it.

A duty doctor was on call each day to see or advise patients with urgent needs.

Little Horton Medical Centre offered a range of appointments between 8.30am and 6pm Monday to Friday. Extended hours were provided between the hours of 6.30pm to 8.30pm on Monday evening and between 6.30pm to 8pm on Thursday evenings.

Birch Medical Practice offered a range of appointments between 9am and 5.30pm Monday to Friday. Extended hours were provided from 6.30 to 8pm on Thursday evenings.

In addition to this, the practice opened on Saturday mornings from 9am to 11.30am during the winter period.

Information was available in the practice and on their website regarding out of hours care provision when the practice was closed.

Listening and learning from concerns and complaints

The practice had a 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.

We spoke with the practice manager who told us how complaints were handled. This included acknowledging the complaint within three days of receipt. However, acknowledgement of complaints was made verbally by telephone and not in writing.

We reviewed a copy of the complaints response template and saw this did not signpost patients to the Patient Advice and Liaison Service or The Parliamentary and Health Service Ombudsman.

Are services responsive to people's needs?

(for example, to feedback?)

We saw information was available to help patients understand the complaints system both in the reception area and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. They also felt they would be listened to.

We reviewed a complaint received by the practice in 2014 and saw they were responded to in line with the practice

procedure. We were also told by the practice manager the outcomes of complaints, actions required and lessons learned were shared with the staff during their team meetings where appropriate. This was confirmed by the staff we spoke to.

Are services well-led?

(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 vision and practice values were documented in the practice statement of purpose. Staff we spoke with told us that patient care was the top priority.

There was an established management structure within the practice. The GP, practice manager and staff were clear about their roles and responsibilities and the vision of the practice. The GP was also a member of the local Clinical Commissioning Group and the practice were committed to the delivery of a high standard of service and patient care.

Staff spoke positively about the practice, told us there was good teamwork and they felt valued as employees.

Governance arrangements

The practice had management systems in place. They had policies and procedures to govern activity and these were accessible to staff. We saw the policies incorporated national guidance and legislation.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. It also showed they were achieving in the upper quartile in having regular palliative care meetings and maintaining a register of patients needing palliative care.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, the GP was the safeguarding lead and the practice had appointed a dedicated administrator to lead on the Bradford Beating Diabetes initiative.

All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Staff we spoke with told us all members of the management team were approachable, supportive and

appreciative of their work. They had a proactive approach to incident reporting. Meetings were held and this included those with clinicians, nursing staff, and information was shared with the non-clinical staff where appropriate.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals in meeting patient's needs.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. Patient survey results and action plans were available on the practice website.

The practice had an active Patient Participation Group (PPG) but numbers had dropped and only one active member remained. We spoke with the practice manager who told us they were looking to form a virtual PPG. A receptionist was given time to co-ordinate this to try and increase the membership.

We saw the practice had acted upon feedback from patients via the national survey and findings from the PPG. For example, the practice had installed a new telephone system due to feedback from patients regarding difficulties getting through on the telephone.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they felt comfortable in giving feedback or raising any concerns. Staff told us they felt involved and engaged in the practice to improve outcomes for both patients and staff.

Management lead through learning and improvement

We saw there was a system in place for staff appraisals and staff had mandatory training and additional training to meet their role, specific needs. Mandatory training included: safeguarding vulnerable adults and children and cardio pulmonary resuscitation training (CPR). The practice had clear expectations of staff attending refresher training and this was completed in line with national expectations. Staff we spoke with told us they felt supported to complete training and could request additional training which would benefit their role.

Are services well-led?

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

The practice had completed reviews of significant events and other incidents and shared the information at staff meetings to ensure the practice improved outcomes for patients. We saw evidence of this in minutes of meetings and logs of events.