Dr Iftekhar Majeed

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.

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Summary of findings

Overall summary

Dr Iftekhar Majeed is based within Bloomsbury Medical Centre and provides primary care services for patients in the surrounding area.

All the patients we spoke with were highly complimentary about the service. We saw the results of a patient survey that showed patients were consistently pleased about the service they received.

Appropriate systems were in place to ensure patients were kept safe.

The practice regularly met with the local clinical commissioning group (CCG) to discuss service performance and improvement issues. The practice worked in partnership with the CCG and other health teams and was proactive in responding to people's needs.

The practice's leadership style was approachable and all staff we spoke with said the staff team worked very well together. The practice had appropriate governance and risk management measures in place.

We also examined patient care across the following population groups: Older people – the practice population aged 75 or over; people with long term conditions – those with on going health problems that cannot be cured; mothers, babies, children and young people; working age people and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. We found care was tailored appropriately to individual circumstances and needs throughout these groups.

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.

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 service was safe. The practice had appropriate safeguarding procedures in place. Staff were familiar with the procedures and knew who the safeguarding lead was. For child protection the practice used the child protection procedures produced and monitored by Birmingham City Council. All staff were checked through the Disclosure and Barring Service (DBS) before being allowed to work on their own with patients. Patients could be confident that the practice took their safety seriously. We saw evidence the practice learnt from incidents and medical emergencies. Appropriate risk assessments were in place.

Are services effective?

The service was effective. Care and treatment was being delivered in line with current published best practice. Treatment plans were based on guidance issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were consistently met in a timely manner. The practice had appropriate systems in place to assess the performance of its doctors and administrative staff. Patients received care that met their individual needs and the practice was engaged with health promotion activities.

Are services caring?

The service was caring. All patients we spoke with during our inspection were highly complementary about the service. The practice's own patient surveys produced consistently positive results. The practice's induction and training programmes emphasised the need for a patient centred approach to care. This was evident throughout our inspection. Patients could expect to be treated with compassion and respect. Patients who were bereaved were signposted to appropriate services with Bloomsbury Health Centre if they required support.

Are services responsive to people's needs?

The service was responsive to people's needs. There was a culture of openness throughout the organisation and a clear complaints policy. The practice acted on patients' suggestions for improving the service. The practice had an active Patient Participation Group (PPG) which was involved with decision making. The practice participated actively in discussions with the Clinical Commissioning Group (CCG) about how to improve services for patients in the area. The practice

Summary of findings

was aware of patients' individual needs and of the needs of the wider community they were situated in. All the patients we spoke with were happy with the access to appointments and had not experienced delays.	
Are services well-led? The service was well led. There was a strong leadership with a clear vision and purpose. Governance structures were robust and there were appropriate systems in place for managing risks. This gave a firm foundation to all aspects of the practice's work.	

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 tailored each patient's care to their individual needs and circumstances. The practice regularly reviewed the care provided and included family members and carers when appropriate. Planned and unplanned hospital admissions were reviewed and actions taken when necessary.

People with long-term conditions
The practice regularly reviewed patients with long term conditions. The practice's care plans had a multi-disciplinary approach and retained oversight of the care provided. Unplanned hospital admissions for older patients were reviewed and actions taken when necessary. The practice ran regular clinics for patients with a range of long term health conditions, for example, asthma and diabetes.

Mothers, babies, children and young people
The practice used the midwife service and health visitors located within Bloomsbury Health Centre to offer a full health surveillance programme for children aged under five. The practice made checks to ensure the maximum uptake of childhood immunisations.

The working-age population and those recently retired
The practice offered appointments outside of regular surgery times by arrangement with individual patients when needs arose. Patients could also make appointments for telephone consultations. The practice had previously introduced regular appointments outside of normal surgery hours, but had found no demand for them.

People in vulnerable circumstances who may have poor access to primary care
The practice enabled patients of no fixed abode to register at the practice. This meant those patients were able to access all NHS services. The practice understood and tailored its patient care to reflect the needs of the local population, for example, a high level of unemployment and a predominantly ethnic population.

People experiencing poor mental health
The practice worked with community psychiatric nurses and a local psychological therapy service to help ensure that people received the necessary mental health care and support.

Summary of findings

What people who use the service say

All the patients we spoke with during the inspection were highly complementary about the service they received. They told us they were respected and well cared for. People described the staff and doctor as excellent.

Patients completed 38 comment cards prior to our inspection. All comment cards complimented the service, staff and doctor. 12 patients said it could be difficult to obtain appointments at times, but they were happy with all other aspects of the service.

We also looked at the results of an annual survey that collected the views of patients who used the service. Patients were positive about all aspects of the service they received.

In October 2013, 56 patients completed a short questionnaire, issued by the practice. Of those patients who responded, 81% were able to get an appointment to see or speak to someone the last time they tried. 91% said the last appointment they were given was at a convenient time. 63% said the practice was very easy or fairly easy to contact by telephone. This sample represented 2% of the patient list.

Since the survey was carried out, the practice has made changes to improve the appointment and telephone system. It has also been monitored on an on-going basis

Areas for improvement

Action the service SHOULD take to improve

Improve the recording of when actions are taken in relation to complaints.

Dr Iftekhar Majeed

Detailed findings

Our inspection team

Our inspection team was led by:

Keith Briant

Background to Dr Iftekhar Majeed

Dr Iftekhar Majeed is a single handed GP based in Bloomsbury Health Centre and provides primary care services for patients in the surrounding area. The service is responsible for providing primary care for 2,800 patients. It is located in an area with a high level of unemployment, social deprivation and a large ethnic population.

The practice also employs a salaried GP for two sessions each week, a practice manager, practice nurse, four receptionists, a secretary and a staff member who provides administrative support. There are a total of ten GP sessions each week and eight sessions held by the practice nurse. Out of hours services are provided by another organisation at a nearby location.

Regulated activities are provided from Bloomsbury Health Centre, 63 Rupert St, Birmingham, B7 5DT which we visited for our inspection.

There have been no previous concerns about the practice.

Bloomsbury Health Centre provides a range of NHS services including blood testing, chiropody, physiotherapy and anti-coagulant testing. Bereavement and mental health counselling sessions are held there. The local district nursing team and health visitor team is also based within the building.

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our future approach to inspecting GPs. This practice had not been inspected before and that was why we included them.

How we carried out this inspection

The inspection team visited Dr Majeed at Bloomsbury Health Centre. This was an announced visit on 7 August 2014. We spoke with 10 patients and six staff. After our visit, we spoke with the chair of the patient participation group (PPG) over the telephone. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service.

We observed how staff dealt with patients in person and over the telephone. We discussed anonymised patient care plans. We spoke with and interviewed a range of staff including the GP, the practice manager, the practice nurse, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place.

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

- Is it safe?
- Is it effective?
- Is it caring?

Detailed findings

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

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

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

Are services safe?

Our findings

Safe track record

The practice had clear incident reporting procedures in place with clearly defined lines of responsibility. We were shown incident reporting forms which showed all incidents were recorded and investigated. Findings were analysed and discussed with the staff concerned and then at clinical and staff meetings as appropriate. Discussions were recorded in the staff meeting minutes. This ensured that there was on-going learning about how the service could improve. We saw the practice made changes as a result of these discussions. Staff were aware of their responsibilities with patient safety and were confident they would be fairly treated if they were to report anything. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind. Clear procedures were in place to deal with allegations of patient abuse. There had not been any concerns previously expressed about the practice.

Learning and improvement from safety incidents

The Practice has a system in place for reporting, recording and monitoring significant events. The practice held a regular meeting for clinical staff at which all complaints and incidents were discussed. Key learning points from the analysis of incidents were identified and shared with staff. We were shown minutes of meetings and staff confirmed such discussions took place. We saw evidence that all adverse events were fully recorded before being investigated by the GP.

The practice notified the local Clinical Commissioning Group (CCG) of individual events. The CCG is the NHS body responsible for commissioning local NHS services.

The local CCG monitored the practice's performance in relation to the standard and timeliness of significant adverse event reporting.

Reliable safety systems and processes including safeguarding

The practice had clear safeguarding policies and procedures in place to protect vulnerable patients. They provided guidance and training to all staff during their induction and reviewed this annually. We saw evidence in the training records that such training took place and the dates refresher training was due to take place. We saw a selection of training certificates which confirmed staff were trained to the appropriate level. Staff we spoke with knew how to recognise different types of abuse and the action they should take if they suspected abuse. Staff were aware who the safeguarding lead was and were familiar with the procedure for referring safeguarding concerns to the local authority. We saw this information was clearly displayed and appropriate action had been taken when needed.

The child protection policy was based on the child protection procedures produced by Birmingham City Council. We saw minutes that demonstrated there were regular safeguarding meetings which involved staff from other agencies when appropriate.

Appropriate policies were in place for infection control, medicines management, equipment, premises and staffing, this included staff recruitment. Risk based analysis had been used and risks had been regularly reviewed during staff meetings. Staff we spoke with had a good knowledge of what they should do if an event occurred, for example, if there had been a spillage of bodily fluid.

We saw there was a chaperoning policy in place for patients who required a sensitive examination by a doctor. There were posters displayed which informed patients of their right to be accompanied by a chaperone. Staff we spoke with demonstrated knowledge of their chaperoning responsibilities and were able to describe to us what they would do if they had any concerns regarding an examination.

Monitoring safety and responding to risk

Staffing levels were monitored to ensure levels of staff present met patient need and minimised risk. We saw evidence of how appointment trends were monitored and staffing levels adjusted to meet changes in demand. At the time of our visit, the practice planned to install a new telephone system. As a result, delays to patients accessing the service would be reduced.

Medicines management

The practice had up to date medicines management policies for use within practice. Staff we spoke with were familiar with them. Emergency medicines were kept in a secure store to which only appropriate staff had access. No controlled drugs were stored on the premises. The records showed that medicines were stored, recorded and checked safely. Chilled medicines were stored at the correct temperature which was monitored daily.

Are services safe?

Clear records were kept whenever any medicines were used. We saw evidence that medicines were regularly checked to ensure they were within date. There were standard operating procedures (SOP) for using certain drugs and equipment. We looked at a selection of these. Staff were appropriately trained to handle medicines.

Cleanliness and infection control

We saw the practice's buildings were clean and organised. Patients we spoke with said they were satisfied with standards of hygiene. There were systems in place to reduce the risk and spread of infection. We observed and staff told us personal protective equipment was readily available and was in date. Patients confirmed staff wore personal protective equipment when needed. Hand sanitation gel was available for staff and patients throughout the practice. We saw staff used this. We saw hand washing posters above each wash hand basin throughout the practice including the patients' toilet. We were shown infection control and decontamination policies. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others. We were shown evidence that the policies were regularly reviewed and updated when changes were necessary. We were shown the results of the most recent internal infection control audit which had been carried out in February 2014. This did not identify any areas of concern.

We spoke with the practice nurse. They told us they had received infection control training. We saw evidence of this in their staff file. They were also aware of the Department of Health guidance on the prevention and control of infections and knew how to apply it. Staff told us they were aware of the relevant policies and where to find them if they needed to refer to them. Staff had access to guidance for the protection of patients against the risks of infections. There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. This contract was managed by NHS Facilities who owned the building.

The practice used cleaners employed by NHS Properties for general cleaning of the practice. We were shown the cleaning schedules and checklists for this and saw there was a regular audit of cleaning undertaken. This contract was managed by NHS Properties. They had also undertaken legionella testing.

Staffing and recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota throughout the week and always a member of clinical staff on duty. Some administrative staff were part time, so staff cover was also available if a staff member was unexpectedly absent.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences. We saw how the practice would ensure staff absence was managed in a fair and consistent way to ensure the impact on the practice was minimised.

We saw how if a shortfall of doctors ever occurred, for example, as a result of sickness, locum doctors could be used. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be 'Incapacity of GPs and practice staff'. This would help to ensure sufficient availability of doctors to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a check with the Disclosure and Barring Service (DBS). We looked at a sample of recruitment files for doctors, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed.

Dealing with Emergencies

There was a defibrillator and oxygen available within Bloomsbury Health Centre for use in a medical emergency. This was maintained and monitored by another practice. All staff had been trained to use the equipment. We saw records which demonstrated the equipment was checked daily to ensure it was in working condition. The staff rota

Are services safe?

showed the practice ensured there was always a member of clinical staff available to deal with any medical emergencies. Staff we spoke with, including reception staff knew what to do if an emergency occurred.

Equipment

There were policies in place for the safe use and maintenance of equipment and we were also shown the practice's maintenance schedule. This was fully up to date and the required checks on equipment had been carried out.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care and treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment.

Procedures were in place to obtain patients' consent for treatment. The procedures highlighted care around obtaining consent for children and patients with mental health difficulties. Staff we spoke with had an awareness of the Mental Capacity Act 2005. They understood their responsibility for ensuring patients had capacity to make their own decisions and what to do if they needed support to do this. We saw evidence training had been provided and was regularly updated.

Clinical staff, in conjunction with the practice manager, managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours practice each weekend to ensure care would continue when the practice was closed

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided is based on latest evidence and was of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles (a quality improvement process). Examples of clinical audits included cholesterol medicines and Vitamin D injections. We found the monitoring the practice had carried out included chronic conditions and how the practice was organised. We saw evidence staffing levels had occasionally been changed as a result of the latter. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward doctors for implementing good practice. The practice demonstrated they were meeting the expected targets.

The practice was able to identify and take appropriate action on areas of concern. For example, the practice told us they had a large number of emergency admissions to hospital, but had identified this was due to a large number of patients who smoked and had other medical conditions. Appropriate health advice had been given by the practice and the admission rate monitored.

We also saw evidence the practice manager attended peer group meetings with other practice managers to identify and discuss best practice. We saw learning was shared in an appropriate way and recorded in the meeting minutes.

Effective staffing, equipment and facilities

We saw a comprehensive training plan for all staff employed by the practice. We were shown records which demonstrated how continuing professional development training for clinical staff was organised by the GP in conjunction with the practice manager and delivered by external experts. Topics were requested by staff or linked to learning from previous incidents in the service.

Staff records showed staff had the appropriate qualifications to care for patients to an appropriate standard set by their governing bodies.

Staff had regular individual supervision sessions and an annual appraisal. We saw examples of appraisals in staff files and staff confirmed they found the appraisal system was positive. Training needs were identified and then incorporated into this process. Staff were encouraged and supported to gain additional professional qualifications when appropriate. The practice made effective use of professional clinical audit tools to monitor and assess the performance of its doctors.

Additionally, staff told us they were encouraged to raise concerns at any time and management told us they had an 'open door' policy for management. Staff said the doctor and practice manager were always very approachable.

Are services effective?

(for example, treatment is effective)

The practice benefitted from a modern building and shared facilities with other NHS services. This meant access to other services was easily available and patients had a pleasant environment.

Working with other services

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Clinics were held for blood testing, chiropody, physiotherapy, anti-coagulant testing, bereavement and mental health counselling within Bloomsbury Health Centre to which patients were referred. There were regular multi-disciplinary team meetings.

Within the waiting room there was large range of information about local services, both in leaflet form and on a large visual display screen. Some of this information was available in other languages.

Details of patients with complex health needs or those who received end of life care were passed to out of hours practice when the surgery closed to ensure continuation of their care.

Information from other health care practices was clearly recorded and monitored to ensure patient appointments, hospital discharge notifications, clinical specimens and test results had not been missed. Staff we spoke with were fully trained with these procedures.

Health, promotion and prevention

We saw all new patients were offered a consultation with the practice nurse when they first registered with the practice. If any medical concerns were found, the patient was referred to the GP or another healthcare professional if more appropriate.

We were shown work the practice had carried out to identify and promote particular health needs within the area. This centred on the large Somali and unemployed population, for example, there were high levels of diabetes within the community.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff and patients told us patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment. All patients felt they were consistently treated with dignity and respect by all members of staff. During our inspection we observed, within the reception area, how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. Staff we spoke with told us patient care was at the centre of everything they did and their behaviours displayed this at all times.

We saw that patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

The practice was located in a modern building designed to ensure that appropriate care and treatment was provided to patients with a disability. We saw that the entrance to the practice was designed so that patients with mobility difficulties could access the practice easily. There were accessible parking places and step free access to the doors. The consultation rooms were situated on the ground floor and the waiting area, corridors and consultation rooms were spacious allowing easy access.

Patients who required support following bereavement were signposted to relevant services.

Involvement in decisions and consent

We looked at patient choice and involvement. Staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs. Staff we spoke with understood the requirements of the Mental Capacity Act 2005. Patients we spoke with fully understood the treatment choices that had been made available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. We were shown measures the provider had taken to reach both the elderly population and local Somali community. Patients aged over 75 had been written to with details of their named GP.

We looked at the measures in place to accommodate patients' equality, diversity and information needs. A wide range of health information was available. We were told the GP spoke a number of languages and patient information could also be obtained in a number of languages. In addition, there were also language interpretation facilities available to assist patients. These measures showed patients' equality and diversity needs could be supported to enable them to make an informed decision about their care and treatment. We saw evidence staff had been trained to assist patients with sensory impairments and learning difficulties.

Patients we spoke with who had been previously referred to hospital consultants told us referrals had been dealt with quickly and efficiently. Staff showed us how they followed up referrals with the relevant provider if a delay occurred. They showed us how they audited these referrals to ensure patients were given the best possible care. Referrals were made using the NHS 'Choose and Book' system. This ensured patients received a choice of where they wished to be referred to.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated weekly meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. Services were also reviewed in the wider context of the local health economy. Review meetings were held with the Clinical Commissioning Group (CCG) and the GP attended these.

The practice had an established Patient Participation Group (PPG) in place. This ensured patients' views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the provider's organisation. Regular meetings were held.

We saw how the PPG had been involved with discussions about the limitations imposed by the provider's telephone system and obtaining a replacement system with more capacity.

Access to the service

The practice opened from 8.30am to 6.30pm every weekday, except Wednesdays when it closed at 4.00pm. Patient appointments were held from 9.30am to 11.30am and from 4.00pm to 6.30pm. There was no afternoon session on Wednesdays. Outside of these times and during the weekend, an out of hours service was provided by another provider. Telephone calls were automatically directed to the NHS 111 service. This ensured patients had access to medical advice outside of the practice's opening hours.

Appointments could be booked for the same day, for within 48 hours and up to two months ahead. For patients who had an urgent medical condition that could not wait until the next routine appointment, the practice operated a triage system. Patient details were taken and the duty doctor would telephone the patient back the same morning or afternoon that they contacted the practice. The patient would then be given a same day appointment if necessary. Home visits were available for patients who were unable to go to the practice.

The practice had previously trialled extended surgery opening, but had found due to the high level of unemployment within the area, there was no demand for this service. Individual arrangements were sometimes made by the GP with patients to see them outside of regular surgery times.

Patients could make appointments and order repeat prescriptions through an on-line service.

Concerns and complaints

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

We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area and within the patient information pack. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be

Are services responsive to people's needs?

(for example, to feedback?)

dealt with. It also identified the timescales for responding to and dealing with complaints. The practice also had a complaints summary which summarised the complaints for each year. Details of the complaints procedure were displayed in the waiting room and within the patient information pack. Patients we spoke with knew how to make a complaint, but had not needed to do so. We looked to see whether the practice adhered to its complaints policy and we reviewed two patient complaints in detail. Only two complaints had been received within the last 12 months. It was evident the practice could have more clearly recorded dates actions had been taken to handle complaints, however despite this, we found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available.

Are services well-led?

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

Our findings

Leadership and culture

The practice had a stated aim of providing high quality care to patients. This was stated in its patient information. The appropriate behaviours were clearly evident from all staff throughout our visit and from comments received from patients. All staff openly spoke with us about how patient care was their priority and we saw patients treated with dignity and respect throughout our visit.

The practice manager and the GP (who was also the registered manager) were in day to day control of the service. The practice manager was 'hands on' and all staff we spoke with said both the practice manager and GP were very supportive and approachable. They actively checked on the well-being of every staff member each day.

The staff performance monitoring system was used as much to recognise and reward good performance as to identify any potential underperformance. All staff we spoke with said they felt valued and respected by the management, GPs and their peers. This was reflected in the length of time most of the staff members had worked for the provider. No recruitment had been necessary for over two years.

We looked at a number of human resources policies, including staff training, staff sickness, and planned absences. These balanced the need to put patient care first, whilst at the time had staff welfare in mind. Staff told us how supportive the provider was, for example, during times of personal difficulty. This also reflected the vision and values held by the provider.

There was a well-established management structure with clear allocations of responsibilities. We talked with the GP who held the lead roles within the practice and they clearly took an active role in ensuring that a high level of service was provided on a daily basis. We saw evidence in the staff meeting notes that staff reviewed challenges that had been facing the provider and potential challenges in the future, for example, economic conditions that could increasingly reflect a patient group with a high level of unemployment.

We saw evidence the practice engaged with the local Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people. The CCG is the NHS body responsible for commissioning local NHS services. The practice compiled a monthly report which was submitted to the CCG and the GP attended relevant CCG meetings. This ensured there was clear communication between the practice and the CCG and ensured the provider was fully aware of local issues within NHS services.

Governance arrangements

The practice had a clear corporate structure designed to provide complete assurance to the management team and local CCG that the service was operating safely and effectively. Within the governance arrangements there were clearly identified lead roles which included medicines management, complaints and incident management, and safeguarding.

Systems to monitor and improve quality and improvement

The practice had an effective system to regularly assess and monitor the quality of service that patients received. We saw the practice carried out regular audits. We found the practice had carried out monitoring which included long term medical conditions, minor surgery, incident reporting, and quality and productivity. All audits were evaluated and action plans to improve quality had been put in place when necessary. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice demonstrated they were meeting the targets.

In addition to monitoring and reporting its performance against the national quality requirements, the practice had developed and agreed quality indicators with the local CCG. The indicators were monitored and performance was reported to the CCG on a monthly basis. This enabled the management team and the CCG to see at a glance if any aspect of performance was below expectation and to put plans in place to improve the situation.

The practice had produced a comprehensive register of potential risks to its business. The risks identified were discussed at staff meetings and risk reduction plans were regularly reviewed and updated. The practice was also part of a 'buddy review group' with other local practices to identify and share best practice.

Patient experience and involvement

The practice asked patients who used the service for their views on their care and treatment and they were acted on.

Are services well-led?

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

This included the use of surveys to gather views of patients who used the service. We saw there were systems in place for the practice to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

In October 2013, 56 patients completed a short questionnaire, issued by the practice. Of those patients who responded, 81% were able to get an appointment to see or speak to someone the last time they tried. 91% said the last appointment they were given was at a convenient time. 63% said the practice was very easy or fairly easy to contact by telephone. This sample represented 2% of the patient list.

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG) in place. This ensured patients' views were included in the design and delivery of the service. The chair of the PPG told us the group played an active role and was a key part of the practice's organisation. The PPG had been involved in identifying difficulties with the current telephone system and choosing a replacement to increase call capacity and assist with improved accessibility to the service. Regular PPG meetings were held. Patient views were listened to and acted upon.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other.

There was a clear culture of openness and 'no blame' in place. This meant staff could raise concerns without fear of reprisals and the practice's whistleblowing procedure supported this. Staff told us they were actively encouraged to make suggestions and identify ways for the practice's service to improve. This included a new system for recording and monitoring patient's clinical samples which was introduced after a sample failed to be sent to the laboratory. Staff suggestions were listened to and acted upon.

Management lead through learning and improvement

We saw evidence that learning from significant events took place and appropriate changes were implemented. We saw that there were systems in place for the practice to audit and review significant events and that action plans were put in place to help to prevent them occurring again.

As part of the annual review process, staff had clearly defined goals for learning and development. Staff were also encouraged to train for further professional qualifications when appropriate. We saw details contained within staff records. This was in addition to the regular training provider to update learning and skills, along with to implement new developments within primary medical services. This ensured staff had up to date knowledge and skills.

Identification and management of risk

The practice had an effective system in place to identify, assess and manage risks to the health, safety and welfare of staff and patients who used the service. We saw risk assessments in place for fire hazards. There was a business continuity plan in place which had assessed the risk to patients in the event of such occurrences as an information technology failure, loss of domestic services or a flood. Action plans were in place to manage these risks.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

The practice tailored each patient's care to their individual needs and circumstances. The practice regularly reviewed the care provided and included family members and carers when appropriate. Planned and unplanned hospital admissions were reviewed and actions taken when necessary.

All patients over the age of 75 had a named accountable GP. The practice offered flu vaccinations and shingles vaccinations to older people who were most at risk. Planned and unplanned hospital admissions were reviewed and actions taken when necessary.

For patients at the latter stages of end of life care, the practice gave relevant information to the out of hours provider. We were shown how consent had been obtained when needed.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

The practice supported and regularly reviewed patients with long term health conditions, for example, asthma and diabetes. Their care was regularly reviewed and patients were followed up if they failed to attend.

The practice's care plans had a multi-disciplinary approach and retained oversight of the care provided. This was managed through meetings held with team members from other organisations. This included community nurses and Macmillan nurses. We were shown records to confirm this.

The practice offered regular nurse led clinics for patients with some long term conditions. This included diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Patients were identified by the clinical team and received personal invitations to attend. We saw samples of letters sent to patients.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The practice referred patients to the health visitor's baby clinic and supported the health visitors in their role. There was a comprehensive range of health care information available in the practice for new and expectant mothers.

We saw procedures that showed children and young people were treated in an age appropriate way and were recognised as individuals, with their preferences considered.

There were effective safeguarding procedures in place to help protect vulnerable children and clinical staff were aware how to assess the competency of children and young people to make decisions about their own treatment. Staff had an understanding of consent issues for children and young people.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

The practice offered appointments outside of regular surgery times by arrangement with individual patients when needs arose. The practice had previously introduced regular appointments outside of normal surgery hours, but had found no demand for them.

Patients were able to book telephone appointments if they wanted to speak to a doctor without having to attend the practice.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

The practice enabled patients of no fixed abode to register at the practice. This meant those patients were able to access all NHS services. The practice understood and tailored its patient care to reflect the needs of the local population, for example, a high level of unemployment and a predominantly ethnic population.

For patients with drug addictions and mental health problems, the practice worked closely with professional organisations and signposted patients when appropriate. These appointments were monitored by the practice to ensure patients received the most appropriate help in a timely way.

Local promotions were carried out to ensure all groups within the local population received information on other appropriate healthcare services, for example, smoking cessation and breast screening.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

The practice tailored care plans to the individual needs and circumstances of patients with poor mental health, including their physical health needs. Regular health checks were offered to people with serious mental illnesses when appropriate. Referrals were made to relevant local services, including the some of which held clinics within Bloomsbury Health Centre. This included the community psychiatric nursing team to help ensure that people received the necessary mental health care and support.

There was access available to a variety of treatments such as listening and advice and cognitive behavioural therapy (CBT). GPs were equipped to recognise and manage referrals of more complex mental health problems to the appropriate specialist services.