Dr Iftekhar Majeed

Quality Report

Bloomsbury Health Centre
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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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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Dr Iftekhar Majeed's practice at Bloomsbury Health Centre on 16 October 2017. Concerns relating to the management of safety alerts, monitoring of patients on anticoagulation therapy, ineffective systems for the monitoring emergency equipment and the appropriate management of vaccines and the recording of fridge temperatures were identified. Under Section 29 of the Health and Social Care Act 2008 a warning notice was issued in respect of the following regulated activities: Treatment of Disease, Disorder or Injury and Diagnostic and Screening Procedures.

We carried out this focused inspection on 4 December 2017 to review the actions the practice had taken following the warning notice and focussed on the areas relevant to the notice only. As a result this there is no rating awarded following this inspection. Our key findings at this inspection were as follows:

- At the inspection in October 2017 we found the practice did not have an effective process in place to monitor patients on anticoagulation therapy. At this inspection the GP had reviewed all patients on anticoagulation medicines and had reviewed each patient appropriately.
- At the previous inspection, the practice was unable to confirm if alerts received from the Medicines and Healthcare Products Regulatory Agency (MHRA) had been acted on. The practice had introduced a system to ensure safety alerts including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned appropriately by clinical staff.
- At the first inspection we found vaccines were not being managed appropriately. Vaccine fridge temperatures were not recorded daily and temperatures exceeding the range were recorded with no action being taken to review the risk. We found at this inspection the practice had implemented check lists to monitor the fridge temperatures daily and the practice had also purchased a data logger to collect fridge temperature information continuously.
- At the previous inspection we found there was no system in place to monitor emergency equipment. At this inspection, the practice had introduced a monitoring system to ensure all emergency equipment was checked and monitored on a regular basis.

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?

- At this inspection the GP had reviewed all patients on anticoagulation medicines and had implemented a system to gain access to the hospital clinical systems to review patients' results to ensure effective monitoring was taking place before prescribing.
- The practice had introduced a web based system to ensure safety alerts including those received from the Medicines and Healthcare Products Regulatory Agency (MHRA) alerts were actioned appropriately by clinical staff and we were told that all alerts were to be discussed at team meetings to ensure all staff were aware of any changes made within the practice.
- The practice had implemented check lists to monitor the fridge temperatures daily and the practice had introduced a data logger to collect fridge temperature information continuously.
- At the previous inspection we found there was no system in place to emergency equipment. At this inspection, the practice had introduced a monitoring system to ensure all emergency equipment was checked and monitored on a regular basis.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Dr Iftekhar Majeed

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 GP specialist adviser and a specialist pharmacy adviser.

Background to Dr Iftekhar Majeed

Dr Iftekhar Majeed's surgery is located at Bloomsbury Health Centre in Nechells, central Birmingham. The surgery operates out of modern, purpose-built premises, which is shared with another GP practice and community teams.

The practice has a General Medical Services contract (GMS) with NHS England. A GMS contract ensures practices provide essential services for people who are sick as well as, for example, chronic disease management and end of life care and is a nationally agreed contract. The practice

also provides some enhanced services such as minor surgery, childhood vaccination and immunisation schemes.

The practice provides primary medical services to approximately 2,900 patients in the local community. The lead GP (male) has the support of a part time GP locum (female) and a part time practice nurse. The non-clinical team consists of administrative and reception staff and a part time practice manager. Based on data available from Public Health England, the levels of deprivation in the area served by the practice are below the national average, ranked at one out of ten, with ten being the least deprived.

The practice had a lower than national average of patients aged over 65 years, with the practice currently having registered 8% of its population in this age group in comparison to the national average of 17%.

The practice is open between 8am and 6.30pm Mondays to Fridays. Appointments with the male GP are from 9.30am to 12pm and 4pm to 6pm on Mondays, Tuesdays, Thursdays and Fridays and from 9.30am to 12pm on Wednesdays. The female GP is available on Wednesday afternoon. Extended hours appointments were not available. Telephone consultations are available if patients requested them; home visits were also available for patients who are unable to attend the surgery if they were within the practice boundaries.

The practice had recently joined an improved access scheme with a group of general practices within Sandwell and West Birmingham Clinical Commissioning Group (CCG). The practices had set up access 'hubs' across the locality so patients could access appointments during the evening between 6.30pm to 8pm and Saturday and Sunday mornings. These appointments could be booked in advance by the surgery for patients who were unable to attend the practice during the week. When the practice is closed, primary medical services are provided by Birmingham and District General Practitioner Emergency Room group (Badger), an out of hours service provider and the NHS 111 service. Information about this service is available on the practice website.

The practice is part of NHS Sandwell & West Birmingham CCG which has 91 member practices. The CCG serve communities across the borough, covering a population of approximately 559,400 people. (A CCG is an NHS Organisation that brings together local GPs and experienced health care professionals to take on commissioning responsibilities for local health services).

Are services safe?

Our findings

At our previous inspection on 16 October 2017, we rated the practice as inadequate for providing safe services as the arrangements in respect of effective systems to reduce the risk of harm to patients were not in place or embedded to ensure the delivery of safe care and treatment. Concerns relating to the management of safety alerts, monitoring of patients on anticoagulation therapy, ineffective systems for the monitoring emergency equipment and the appropriate management of vaccines and the recording of fridge temperatures were identified. A Warning Notice was issued on 1 November 2017 under Section 29 of the Health and Social Care Act 2008 where the provider was required to become compliant with Regulation 12 (1), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 above by 30 November 2017.

Improvements had been made when we undertook a follow up inspection on 4 December 2017. We have not amended the rating as we only reviewed the Warning Notice findings and the actions the practice had taken to reduce the risk to patients.

Safe track record and learning

We found that a web based system had been implemented to ensure all alerts were reviewed and acted on and we were told the practice planned to discuss all alerts at team meetings to ensure staff were aware of any changes that may affect the practice. We also found that the practice had acted on the alert concerning the combination of specific medicines for patients of child bearing age and had reviewed each patient within this group.

Overview of safety systems and processes

- We found the practice had implemented a daily checklist to ensure fridge temperatures were recorded and in the absence of the practice nurse each member of staff had a task list which included monitoring the fridges. The practice had also purchased a data logger to collect fridge temperature information continuously, with the results being reviewed on a daily basis.
- At the inspection in December 2017 we found the GP had reviewed all patients on anti-coagulant medicines and had implemented a system to access patient results from the hospitals to ensure the practice had up to date information and to ensure the appropriate monitoring had taken place before prescribing the medicines.

Arrangements to deal with emergencies and major incidents

- At this inspection we found the practice had implemented a check list to ensure that all emergency equipment was checked on a regular basis.