

Care Quality Commission

Inspection Evidence Table

Dr Raina Patel (1-530861743)

Inspection date: 3 December 2019

Date of data download: 04 December 2019

Overall rating: Good

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

At our inspection conducted 24 April 2019 we rated the practice as requires improvement for providing safe services, we issued a requirement notice in relation to breaches of Regulation 12 of the Health and Social Care Act 2008. At our inspection 3 December 2019 we found that these breaches of regulation had been addressed.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes
Explanation of any answers and additional evidence: During our inspection of 24 April 2019: We examined four recruitment files for one locum GP, one practice nurse and two members of administration/reception staff. We noted that most of the information required under Schedule 3 of the Health and Social Care Act (HSCA) was present. Some files lacked evidence that staff had completed declarations to confirm they were mentally and physically able to perform their roles. The assistant practice manager told us that these would be obtained as soon as possible and the practice recruitment policy updated to include this requirement. We were provided with an updated recruitment policy containing the relevant information shortly after the inspection. All clinical staff were up to date with their professional registrations, however there was no management oversight of this and the practice relied on each individual to ensure this was renewed in a timely manner or by manually examining each staff member's recruitment file. There was no formal system in place for ensuring that patient consent was obtained and recorded	

appropriately.

The practice whistleblowing policy did not contain the national NHS whistleblowing freephone number and the nominated speak up guardian's contact number was not included.

We saw evidence of audit taking place, this took place in an unstructured manner, with no overall plan.

At our inspection 3 December 2019:

We noted that all staff files now contained declarations of medical fitness. The practice recruitment policy now contained a protocol to obtain these declarations before new staff commenced work. We saw that the practice now maintained a spreadsheet detailing all professional registrations and calendar reminders were set up to identify when registrations were due for renewal.

We saw that a new system of auditing patient records to monitor consent had been introduced. We noted that in the audits conducted patient consent had been obtained and recorded.

We noted that the practice whistleblowing policy had been updated to include the information not present at the previous inspection. Staff we spoke with were familiar with the updated policy and knew how to make referrals and obtain advice should they have the need.

We spoke to the lead GP about their approach to audit, we saw examples of both clinical and non clinical audit taking place, for example a cancer diagnosis audit on 16 patients and vitamin B12 management. Audits were now based on local and national priorities and themes.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.82	0.95	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	6.4%	6.5%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed	4.39	5.68	5.60	Tending towards variation (positive)

Indicator	Practice	CCG average	England average	England comparison
for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) <small>(NHSBSA)</small>	1.43	2.00	2.08	No statistical variation

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Yes
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>During our inspection 24 April 2019 we found:</p> <p>Whilst blank prescriptions were stored securely, the system in place to monitor their use was not effective. There were inconsistencies in the way staff recorded serial numbers of prescription stationery, and it was not possible to determine how many had been used from the records we were shown.</p> <p>There was an effective system in place for the safe handling of requests for repeat medicines which was supported by a written policy, however we were not assured there was an effective system in place for conducting medication reviews. Following the inspection, we were sent a protocol which identified how these reviews were conducted and which patients were prioritised for medication review.</p> <p>Staff we spoke with were unaware who the NHSE CDAO (controlled drug accountable officer) was, or how to raise concerns about controlled drugs with them. Following the inspection we were informed by the practice that staff had been reminded of the contact details for the accountable officer and a circulation completed to all relevant staff with this information.</p> <p>The practice had access to the local antimicrobial formulary. They had conducted a recent audit of a 5% sample of antimicrobial prescribing which had identified approximately 50% of prescriptions may not have been in line with guidance. However, no outcome or recommendations had been generated from the audit results to drive improvement in prescribing practice.</p>	

Whilst a system was in place to monitor the expiry dates of emergency medicines, medicines kept in the doctor's home visit bag were not part of these checks. During our inspection we found a medicine in this bag which did not contain a batch number or expiry date.

The medical oxygen and defibrillator on-site were shared with a neighbouring practice. Staff relied on the other practice to carry out checks which meant they could not be assured these would be available and fit for use in the event of a medical emergency.

Staff made daily records of vaccine refrigerator temperatures in line with guidance. However, the same maximum and minimum temperature had been recorded on every day since July 2018. Staff we spoke with were unsure how to reset the thermometer correctly or what the safe temperature range should be.

We noted that the lead GP had in one case not been prescribing in line with latest national institute for clinical excellence (NICE) guidance.

During our inspection 3 December 2019 we found:

The practice had introduced a new system for the safe storage and recording of all prescription stationary, staff were confident in using the new system.

We saw the practice had introduced a new medication review protocol which prioritised patients. GPs were now supported by a pharmacist from the Stockport GP Federation who assisted in some medication reviews and conducted audits to check reviews were timely and appropriate.

Staff were now aware who the NHSE CDAO (controlled drug accountable officer) was, and how to raise concerns about controlled drugs with them, should the need arise.

We saw that antibiotic prescribing was audited on a monthly basis and the practice was performing at a high level. We were told that the input of the federation pharmacist has assisted greatly in achieving this success.

We looked at the doctors' bag and saw that all contents were within the manufacturers recommended expiry date. The practice had introduced a system for checking the contents of doctors' bags to ensure they were appropriate and within date.

On site emergency oxygen and defibrillator were now checked by practice staff on a daily basis to ensure they were ready for use, staff maintained a comprehensive record of these checks.

Staff had received additional training on fridge temperature monitoring and records maintained by staff indicated that the thermometer was reset and checked on a daily basis. The practice had also introduced an additional internal thermometer which was monitored remotely and would alert the practice if the fridge went out of its temperature range. The system also produced a management report for review.

The lead GP had ensured they received regular updates in NICE guidance by attending seminars and clinical updates and also regularly referring to on-line national and local guidance.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
Explanation of any answers and additional evidence: During our inspection 24 April 2019: We spoke to the lead GP about an event which had not been recorded as a significant event, we were told that this would be recorded retrospectively and that it should have been identified as such at the time. At our inspection 3 December 2019 we spoke to the lead GP about how they ensured significant events were identified, recorded and actioned. We were satisfied that an appropriate system was in place and the failure to record one event had been an oversight. We noted that several new significant events had been recorded and actioned since the previous inspection.	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence: During our inspection 24 April 2019: There was no established system to log incoming alerts or record the action taken in response. The practice could not demonstrate they had effectively dealt with recent alerts we asked them about. Staff we spoke with were aware of some alerts, however their approach to dealing with them was variable. The practice manager showed us a new system for recording and managing safety alerts which they were in the process of introducing, when embedded this would provide appropriate management oversight. During our inspection 3 December 2019, we saw that the system for recording and actioning safety alerts was now embedded, staff were familiar with the new system and managers had oversight of alerts to ensure they had been dealt with appropriately.	

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > -1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.