

Care Quality Commission

Inspection Evidence Table

C.B. Patel & Partners (1-551034159)

Inspection date: 03 and 04 May 2022

Date of data download: 03 May 2022

Overall rating: Good

Safe

Rating: Requires improvement

At the previous inspection in August 2021, we rated the practice as requires improvement for providing safe services because:

- Recruitment checks including Disclosure and Barring Service (DBS) were not always carried out in accordance with regulations or records were not kept in staff files.

At this inspection in May 2022, we found improvements had been made, however, we found additional concerns and the practice was required to make further improvements. We rated the practice as **requires improvement** for providing safe services because:

- Our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including high risk medicines. This issue was highlighted as a '**should**' in the previous report.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • All staff had received up-to-date safeguarding and safety training appropriate to their role. • There was a Female Genital Mutilation (FGM) policy in place. The clinical staff members we spoke with demonstrated a satisfactory understanding to report cases of FGM and considering the potential risk to other girls in the family as they may need to be safeguarded from harm. • Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). All clinical staff had received an 'enhanced' DBS check. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • We reviewed three staff files and noted that appropriate recruitment checks had been undertaken prior to employment. • All clinical staff had appropriate medical indemnity insurance in place. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 June 2021.	Y
There was a fire procedure.	Y
Date of fire risk assessment: 22 April 2022. Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The fire risk assessment was carried out recently by an external contractor. The practice had addressed the immediate risks identified in the risk assessment and an action plan was in place to complete other recommended actions. • The fire system was regularly serviced and there was a record of fire alarm checks. • Fire drills were carried out quarterly. • There was a documented fire evacuation plan specific to the service, which included how staff could support patients with limited mobility to vacate the premises. • Fire marshals had received enhanced fire safety training relevant to their role. • Emergency lighting was inspected regularly. • Fire extinguishers were inspected annually. • All staff had received fire safety training. 	

- There were records of equipment calibration and portable appliance testing which was carried out in February 2022.
- A gas safety check was carried out in May 2021.
- The fixed electrical installation checks of the premises had been carried out on 26 January 2019.
- An asbestos survey was carried out on 13 December 2019.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 19 March 2022.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Clinical equipment was cleaned on a regular basis and records were maintained. • We saw a cleaning schedule was in place and records were maintained. • The practice had up to date legionella risk assessment (21 April 2022) in place and regular water temperature checks had been carried out. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). 	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice operated a system to organise annual leave and cover for unexpected absences. • All requests for home visits were triaged by the duty GP. • There was public awareness information on the practice's website. • All staff had received sepsis awareness training. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment. However, some improvements were required.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none">• Routine test results and referrals were managed and checked on a regular basis to ensure all were appropriate and actioned. Any abnormal or concerning test results were actioned by one of the clinicians in a timely manner. However, our clinical records searches showed that the practice did not always carry out required tests in a timely manner. Our findings are discussed in detail in the 'appropriate and safe use of medicines' section below.• During the inspection, we noted that not all the GPs had access to Coordinate My Care (CMC). CMC is an innovative NHS service that records patient wishes and then shares them, electronically, with all the medical professionals who will be involved.• The practice had a failsafe system in place to manage and monitor cervical smear screening.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimization. However, some improvements were required.

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.51	0.55	0.76	Variation (positive)
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). (01/01/2021 to 31/12/2021) (NHSBSA)	8.9%	9.7%	9.2%	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 for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)	5.20	5.51	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	31.2‰	58.3‰	129.2‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.22	0.48	0.62	Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	2.7‰	4.8‰	6.8‰	Variation (positive)

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> During the inspection, our clinical records searches showed that the practice did not always have an effective process for monitoring patients' health in relation to the use of medicines including some high risk medicines. Whilst monitoring was completed appropriately for some high risk medicines (including Methotrexate), there were issues identified for other medicines. For example, we found that five out of five patients prescribed angiotensin-converting enzyme (ACE) inhibitors/ angiotensin receptor blockers (ARBs) were overdue for their blood tests. ACE inhibitors and ARBs are medicines prescribed to treat high blood pressure and heart problems (e.g. heart failure). We noted the blood test forms were generated for all five patients but blood tests were not carried out. The practice informed us they had sent multiple reminders to the patients. We reviewed five patients taking Lithium (used to treat mood disorders) and found that four patients did not have their blood tests done in a timely manner. In addition, we found four patients did not have calcium levels checked in a timely manner. We reviewed five patients being prescribed medicine used to treat thyroid hormone deficiency, which required patients to receive regular blood test monitoring. We found that five patients did not have their blood test in a timely manner. We noted the blood test forms were generated for three patients but blood tests were not carried out. The practice informed us they had sent multiple reminders to the patients. 	

Medicines management**Y/N/Partial**

- We reviewed five patients with recorded raised HbA1c on two or more occasions and found issues with coding/ potential missed diagnosis of diabetes for two of these patients. In addition, we found two patients did not have their blood test in a timely manner. The practice informed us they had sent multiple reminders to the patients.
- Following the inspection, the practice provided assurance that the findings have been acted on.
- The practice employed two clinical pharmacists. In addition, a clinical pharmacist (employed by the primary care network) was offering 40 hours per week at the practice. This had a positive impact to ensure effective management of long-term conditions and medicines safety.
- We found that blank prescription forms for use in printers were recorded and tracked through the practice. The practice had implemented an excellent monitoring system.
- The practice had an effective system to support vulnerable patients with requesting and collecting prescriptions. This involved checking the prescription box regularly and contacting the patient to check if they still required the medication or if a new prescription was issued.
- The practice had an effective system to identify and monitor who was collecting the repeat prescriptions for controlled drugs from the reception.
- The practice worked closely with the local CCG medicines management team regarding the safe prescribing of antibiotics, within national guidance, and medicines optimisation.
- The practice offered travel vaccination.
- The practice was registered as a yellow fever vaccination centre. The practice had carried out an annual audit. The staff had completed the relevant training.
- The practice had secondary thermometers in all the fridges used to store vaccines, which logged all the data and provided assurance that temperatures had been within the required range, as recommended in Public Health England 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
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	10
Number of events that required action:	10
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We saw in staff meeting minutes significant events were discussed and documented. Staff we spoke with informed us that learning from significant events had been shared with them on a regular basis. 	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Laboratory reports were not downloading due to technical issue	The practice identified the technical issue which was communicated to all clinicians in a timely manner. The practice took immediate steps to escalate and report the incident. They allocated additional time to the clinicians to ensure all backlogs had been cleared. They had implemented a protocol to ensure continued monitoring of the information technology system.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There was an effective system in place to receive and share all safety alerts. If the action was required, this was assigned to an appropriate member of staff and it was recorded when this action was completed. 	

Notes: CQC GP Insight

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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- **%** = per thousand.