

Care Quality Commission

Inspection Evidence Table

Dr M Aslam's Practice (1-495180256)

Inspection date: 29 June 2022.

Overall rating: Good

Safe

Rating: Good

We completed a focused inspection on 24 June 2021 and we rated the provider as requires improvement for providing safe care and treatment. This inspection was completed to follow up on the breaches of regulation identified at our previous inspection. A requirement notice had been issued for the breach of regulation 17 Good Governance.

At our last inspection we found issues with:

- The repeat prescribing and appropriate monitoring processes for patients on high risk medicines.
- The process for recording the outcome of monitoring tests for patients subject to shared care agreements.
- The high prescribing data for urinary tract infections.
- The absence of risk assessments for the emergency medicines that were not stocked.

We also identified areas where the provider should make improvements. These were:

- Improve the new system for policies and procedures once established, to check its effectiveness, also review policies and procedures generally to check that they account for staff absence and cover arrangements.
- Improve the recruitment procedure regarding the checks on immunisation of staff and implement a system for recording clinical status checks for staff.
- Continue to promote prevention activities such as cervical screening and childhood immunisations.
- Improve the timely management of pathology results

At this inspection we found that improvements had been made in all these areas.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the previous inspection we found that policies and procedures had been reviewed but did not reflect the change in intercollegiate guidance for the safeguarding of children. At this inspection we found there was a system to update policies and procedures, the compliance manager at the practice was responsible and we saw evidence that policies were regularly reviewed and updated. We reviewed the staff training spreadsheet and found that clinical and non-clinical staff had completed adult safeguarding and children safeguarding training at the appropriate level. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We reviewed two clinical and two non-clinical staff files. We found the practice had an effective system to conduct immunisation checks and record regular professional registration checks of staff. We identified that one locum staff at the practice did not have a Disclosure and Barring Service (DBS) check in place and had some outstanding training. Following the inspection, the provider sent evidence that a DBS application was completed, and the training spreadsheet was updated. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes ¹
Explanation of any answers and additional evidence: <p>¹ We accessed the providers remote clinical system and found there were some outstanding test results which were part of the practices daily tasks to complete. We found test results were being managed effectively and there was a system in place to ensure these were reviewed if the delegated staff responsible was absent.</p>	

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) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	0.88	0.80	0.76	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). (01/01/2021 to 31/12/2021) (NHSBSA)	5.5%	8.0%	9.2%	Tending towards variation (positive)
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)	5.82	5.73	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	172.9‰	116.4‰	129.2‰	No statistical variation
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)	0.78	0.72	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	11.5‰	6.8‰	6.8‰	Tending towards variation (negative)

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

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.	Yes ¹
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.	Yes ¹
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 ²
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.	Yes ³
Explanation of any answers and additional evidence: ¹ Prior to the site visit, we completed searches relating to high risk medicines that required monitoring and review.	

Medicines management

Y/N/Partial

We reviewed the records of four patients prescribed Methotrexate who were identified as not having the required monitoring. We found one patient needed to have their dosage reviewed however the other four patients had no issues with the monitoring required, the prescriber had also checked that monitoring was up to date prior to issuing a prescription. We identified the practice did not document the day of the week the patient took the medication in accordance with National Institute for Health and Care Excellence guidance. Following the inspection, the provider informed us this was actioned with immediate effect.

We reviewed the records of five patients prescribed Potassium sparing diuretic and found these patients were being monitored appropriately.

We reviewed the practices process on managing patients on disease modifying anti rheumatic drugs as they were subject to a shared care agreement with secondary care. There was a system integration issue which meant the clinical system used by the practice did not recognise that blood test results had been downloaded and checked. However, we reviewed the patients notes and it was clear the prescriber had checked that monitoring was satisfactory or appropriate action was taken if required.

² In the previous inspection we found prescribing of medication for uncomplicated urinary tract infections was slightly higher than averages. During this inspection we found the practice had improved in their prescribing and this was lower than the local and national averages.

³ The practice held appropriate emergency medicines on site and risk assessments were in place for medicines that were not stocked.

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
<p>Explanation of any answers and additional evidence:</p> <p>Our clinical searches identified thirty five patients on teratogenic drugs. We reviewed five of these patients and did not see evidence that patients were informed of the risk of birth defects or developmental disorders associated with these drugs. The clinical searches also found there was no evidence that risks of cardiac problems were informed to patients aged over 65 on Citalopram 40mg or escitalopram 20mg. The overall level of risk for these patients was low and there were no issues found with monitoring or evidence of potential patient harm. However, the system for acting on these alerts required strengthening.</p> <p>The provider informed us safety alerts were previously managed by staff employed by the Primary Care Network who had left the practice and a nurse had recently taken this role. We spoke to the nurse during our onsite visit and found there was a system in place to regularly review all safety alerts and action accordingly. There was an audit trail and a review date to ensure all alerts were being handled effectively.</p> <p>Following the inspection, the provider contacted all patients identified by the searches and took appropriate action. The principal GP informed us they would take the lead role in reviewing all safety alerts with the assistance of the nurse. There was a plan to review this system on a weekly basis and discuss the outcomes of these reviews at the staff meetings.</p>	

Effective

Rating: Good

At our last inspection we rated the practice as Requires Improvement for providing effective care for the working age population due to lower cancer screening data. Due to a change in the way we inspect and rate CQC does not rate individual population groups.

At this inspection we found there was some quality improvement activity linked to the performance of childhood immunisation and cervical screening uptake.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England)	78	85	91.8%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England)	82	92	89.1%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England)	83	92	90.2%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England)	81	92	88.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England)	98	107	91.6%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Any additional evidence or comments

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At the previous inspection we found the percentage of children aged 5 who have received immunisation for measles, mumps and rubella (MMR) was 77% between April 2019 and March 2020. At this inspection we found the practice had met the 90% Public Health England target for this.

During our onsite visit we spoke with the provider about the percentage of children aged 2 who have received immunisation for MMR and the percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection as this was below the 90% Public Health England target. We saw evidence of a list that was regularly used and updated to contact parents of these children, the provider reviewed this list on a monthly basis.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/09/2021) (Public Health England)	57.8%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	35.0%	51.8%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	51.1%	62.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (PHE)	42.3%	51.6%	55.4%	No statistical variation

Any additional evidence or comments

At the previous inspection we found the performance of cervical screening was 58.9% at the snapshot date in December 2020. At this inspection we found the performance was still below the 70% uptake rate. On the day of the site visit, the provider informed us of unverified data which showed a slight increase to 62.5% for cervical screening uptake at the practice. The provider continued to contact and educate patient's through texts, letters and provide opportunistic screening for patients attending the surgery.

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.
- **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.
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- $\%$ = per thousand.