

## Inspection Evidence Table

Dr Maassarani and Partners

(1-1413205263)

**Inspection Date: 18 & 22 January 2024**

Date of data download: 17/01/2024

## Overall rating: Inspected not rated

## Context

This practice is situated within Cheshire and Merseyside integrated care system (ICS) and delivers General Medical Services (GMS) to a patient population of 16000. This is part of a contract held with NHS England.

Information published by office for Health Improvement Disparities shows that deprivation within the practice population group is the lowest decile (1 out of 10). The lower the decile, the more deprived the practice population is relative to others. A lower level of deprivation can indicate challenges in providing healthcare. The supply of healthcare services tends to be lower in more deprived areas due to a number of factors but has increased demand. The population tends to have poorer health status among individuals with a greater need for health services. For example, there may be higher levels of long-term conditions such as those affecting the cardiovascular system and respiratory system. Data available to us showed that the practice has a higher than average number of patients who have a long-standing health condition compared to national averages. For example, a higher proportion of patients have conditions such as; chronic obstructive pulmonary disease, depression and obesity compared with other practices nationally.

According to the latest available data, the ethnic make-up of the practice area is 0.7% Asian, 0.8% Black, 1.5% mixed, 0.5% other and 96.5% white.

The age distribution of the practice population is similar to local and national averages.

## Safe

## Rating: Inspected but not rated

### Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	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.	Y
Explanation of any answers and additional evidence:  Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients.	

### Appropriate and safe use of medicines

**The practice had systems for the appropriate and safe use of medicines, although we found some examples where they hadn't worked fully as intended. .**

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.68	0.95	0.91	Tending towards 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). (01/10/2022 to 30/09/2023) (NHSBSA)	6.7%	7.2%	7.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r	5.18	5.35	5.19	No statistical variation

capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2023 to 30/09/2023) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	206.7‰	260.9‰	130.7‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2022 to 30/09/2023) (NHSBSA)	0.50	0.82	0.53	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2023 to 30/09/2023) (NHSBSA)	9.5‰	11.8‰	6.8‰	No statistical variation

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 effective 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 medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. These searches were visible to the practice.</p> <p>The searches identified that all patients reviewed on the disease-modifying antirheumatic drugs (DMARD's) methotrexate (used to treat conditions such as rheumatoid arthritis) had received the appropriate monitoring.</p> <p>The searches of patients prescribed the high-risk drug Angiotensin converting enzyme (ACE) inhibitor or Angiotensin II receptor blocker (used to treat high blood pressure) identified some patients were overdue a blood monitoring test and blood pressure check.</p> <p>The practice reviewed our clinical searches following the inspection and provided evidence they had identified patients for follow up monitoring and review.</p>	

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y

Explanation of any answers and additional evidence:

We saw examples of actions taken on recent alerts, for example, regarding SGLT-2 inhibitors (a medicine that helps to lower blood glucose levels) Not all patient records had evidence to confirm the clinician prescribing the medication had discussed the risks and potential side effects of the medicine. Following our inspection, the provider confirmed they had reviewed patients on the medicine and informed them of the risks, potential side effects and who to contact if they had concerns.

## Effective

## Rating: Inspected not rated

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

### Management of people with long term conditions

#### Findings

As part of our inspection, we conducted a series of patient clinical record searches to review the practice’s procedures for the management of patients with long term conditions.

- The clinical searches identified 46 patients out of 500 on thyroid replacement had not had a monitoring blood test in the last 18 months. We reviewed 5 patient records, and 3 patients were overdue monitoring.
- The clinical searches identified 10 out of 59 patients with chronic kidney disease stage 4 or 5 had not had a monitoring blood test in the last 9 months. We reviewed 5 patient records and found 1 patient was overdue monitoring.
- The clinical searches identified 180 out of 931 patients who had poor control of their diabetes documented. We reviewed 5 patient records and found their condition was being appropriately reviewed.
- Patients with long-term conditions were offered an effective annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Patients with COPD were offered rescue packs.

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.	120	132	90.9%	Met 90% minimum

three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)				
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	129	153	84.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenzae type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	129	153	84.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	126	153	82.4%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	109	128	85.2%	Below 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

The practice had continued to work with the improving immunisation team to improve uptake for childhood immunisations.

Cancer Indicators	Practice	SICBL average	England	England comparison
Breast screening coverage: aged 53 to 70 years old (01/04/2022 to 31/03/2023) (UKHSA)	61%	N/A	66.6%	N/A
Bowel cancer screening coverage: aged 60 to 74 years old (01/04/2022 to 31/03/2023) (UKHSA)	64.4%	N/A	72%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	49.0%	46.9%	54.9%	No statistical variation
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). (6/30/2023 to 6/30/2023) (UKHSA)	76.0%	N/A	80.0%	Below 80% target

### Any additional evidence or comments

The GP federation had completed a pilot audit at another location for cervical screening. The focus was on poorer uptake for persons aged 25 to 49. Feedback was focused on improving the patient experience. The improvements found from the pilot were planned to start in the practice in the following months.

### Effective staffing

**The practice was unable to demonstrate that staff were supported and supervised to carry out their roles.**

	Y/N/Partial
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
Explanation of any answers and additional evidence:  The provider was aware appraisals and supervision had not been carried out as planned. At the time of the inspection there was an interim operations manager who had been in post for a short period of time. Staff appraisals and supervision records showed gaps for the last 12 months and a plan was in place to complete these with staff.	

## Well-led

**Rating: Inspected not rated**

### Leadership capacity and capability

**There were gaps in the practice management and recruitment was in progress.**

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:  The provider had appointed a registered manager to work across several of the GP federation locations. The  We did not receive any feedback from staff in relation to the leadership and their visibility.	

**Culture****The practice culture did not effectively support high quality sustainable care.**

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection the practice did not have a Freedom to Speak Up Guardian. At this inspection we found a Freedom to Speak up Guardian had been appointed since December 2023. The representative had been nominated by colleagues.</p> <p>Relationships between managers and staff had been strained following the merge with another practice. We found a number of administration staff had left the practice for different reasons and managers reported current vacancies in the management structure which had impacted on the practice culture. In the absence of a practice development manager, leadership and managerial roles and responsibilities were shared between the interim practice operations manager and registered manager.</p> <p>Managers told us they had reviewed staff terms and conditions to aid in the recruitment and retention of staff.</p>	

**Governance arrangements****There were responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found the governance structure was under review at the time of the inspection in the absence of a management post.</p> <p>Staff we spoke to were clear about their roles and responsibilities.</p>	

**Managing risks, issues and performance****There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In the absence of a manager post some systems were not reviewed as regularly as planned. For example, staff appraisals and supervision.</p> <p>A quality improvement programme and action plan were in place with a named lead and planned time scales.</p>	

### Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had continued to identify areas of improvement for the practice and held staff to account since the last inspection.</p> <p>The registered manager had completed statutory notifications to The Care Quality Commission.</p>	

### Continuous improvement and innovation

**There was evidence of systems and processes for continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The provider had continued to develop improvements to the service which included updating the practice website and patient information leaflet which were still in development at the time of the inspection.</p> <p>Other plans included:</p>	



- nurse led expert patient groups for diabetes and respiratory patients to improve patient outcomes.
- Healthy lifestyle pathway to screen high risk patients for the prevention of chronic disease.

### 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 practices 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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 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 those aged 25 to 49, and within 5.5 years for those 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.