

Care Quality Commission

Inspection Evidence Table

Norvic Family Practice (1-561382719)

Inspection date: 6 June 2018

Date of data download: 05 July 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Safe

Safety systems and processes

Safeguarding	Y/N
Disclosure and Barring Service checks were undertaken where required	N*
Explanation of any 'No' answers: We looked at four personnel files of staff members, including a member of clinical staff employed since the last inspection. The practice had not completed a DBS check as part of the recruitment process, and had relied upon DBS check from a previous employer. This had not been risk assessed by the practice to ensure potential risks were considered and a clear rationale given for the decision not to complete a new check. We looked at the personnel file of a staff member who undertook the role of a chaperone. We saw a standard DBS check had been completed and not an enhanced check which included a check of the barred list for children and vulnerable adults. (Enhanced DBS with a barred list check will 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). The practice had a DBS policy in place which outlined the process for obtaining DBS checks for staff and the level of check required. The practice policy for DBS checks stated an enhanced check would be completed for staff undertaking chaperoning duties. There was also a historical disclosure recorded on the DBS check. This had not been risk assessed by the practice to ensure any potential risks were considered and a clear rationale given for the decision to appoint. Following the inspection, the practice provided evidence of a completed risk assessment.	

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N*
Staff who require medical indemnity insurance had it in place	Y*
<p data-bbox="70 439 474 472">Explanation of any answers:</p> <p data-bbox="70 573 1516 864">We looked at four personnel files of staff members. There was no record of professional indemnity for the clinical staff member. This was provided to us following the inspection, it was not available on the day as we were told the information was with the member of staff and had not been recorded in their file. The practices recruitment policy did not include requirements for professional indemnity checks. For another clinical member of staff there was no evidence of registration with their professional body, immunity status, proof of identity, a DBS check or a second reference. This was all provided following our inspection as we were told the information was with one of the GP partners who was not present on the day.</p>	

Safety Records	Y/N
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	Y
Fire risk assessment Date of completion 18/1/2018 and again 1/2/2018 (branch practice Norman Road)	Y
Actions were identified and completed Identified actions including clearing entrance to door, two additional fire alarms have been fitted and fire doors could now be closed fully. Local fire officer inspected the practice to offer advice. Following recommendation from the fire service the practice changed the fire assembly point at the branch practice site to a safer location.	Y
Health and safety Premises/security risk assessment? Date of last assessment: February 2018 (branch practice Norman Road)	Y
Health and safety risk assessment and actions Date of last assessment: February 2018, concerns about that the reception door was not lockable were actioned, a key code lock was fitted in March 2018. (branch practice Norman Road)	Y
<p>Additional comments:</p> <p>22/5/2018- External contractor carried a test of fire alarms and this was satisfactory. There were plans to undertake a yearly check of fire equipment, a fire drill was carried out on the 23rd May 2018. The practice completed personal evacuation plans for those who would need assistance in the event of a fire.</p> <p>A building compliance folder was in the reception area at the main practice site Norvic to ensure important information was accessible to staff. Meetings were taking place with NHS Property Services which provided the opportunity for the practice and other services based in the building to raise issues.</p>	

Infection control	Y/N
Date of last infection control audit: 18/1/2018 (at main site Norvic)	Y
The practice acted on any issues identified	Y
Detail: The practice manager carried out an infection prevention and control (IPC) audit on 18/1/2018 at the main site Norvic. Areas for improvements identified included the quality	

<p>of cleaning by external cleaning contractors which was raised with NHS properties who managed the contract. Another action was the need for a lockable bin to store clinical waste safely this had now been put in place. Action from the previous IPC audit identified at the last inspection had also been addressed, the vaccine fridge now had a key and was lockable.</p> <p>IPC audit for Norman Road was carried out last 31/5/2017 by the Clinical Commissioning Group (CCG) and no action were identified.</p>	
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Appropriate and safe use of medicines

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). (01/07/2016 to 30/06/2017) (NHS Business Service Authority - NHSBSA)	1.22	1.00	0.98	Comparable to other practices
Percentage of antibiotic items prescribed that are Co-Amoxiclav, Cephalosporins or Quinolones. (01/07/2016 to 30/06/2017) (NHSBSA)	8.2%	6.0%	8.9%	Comparable to other practices

Medicines Management	Y/N
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
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
Up to date local prescribing guidelines were in use.	Y
<p>Explanation of any answers:</p> <p>High risk medications policy had been updated by medicine management team at the Clinical Commissioning group (CCG). All patients on high risk medicines had their prescription changed from a repeat to an acute prescription and were issued 28 days supply as a maximum. This was reduced to</p>	

seven days if the patient did not attend monitoring then removed if they continue to attend. Each high risk medicine had an individual search on the practices computer system and this was reviewed on monthly basis by GP. The practice had set up a system on EMIS Web where they could access hospital results more easily, blood results were printed off, highlighted and given to receptionist to code on to the computer to ensure a clear audit trail

Examples of high risk medicines reviewed during the inspection

- Methotrexate- Of the 14 patients on the medicine all 14 had the relevant monitoring done. One patient was identified on the hospital blood test site and the procedure for coding was implemented
- Azathioprine - Of the 19 patients 16 had appropriate monitoring. Of the three that had not had monitoring recorded, one patient had the medicine removed to a seven days script as per protocol. The second patient had letter sent and prescription stopped as they continued to not attend. The third patient had letter sent 8/5/2018 and the script was stopped as per protocol
- Ciclosporin- One patient on this medicine had the relevant monitoring
- Carbimazole- Of the 16 patients who were prescribed the medication two had not undergone monitoring, one had not been issued with the medicine since the 2/2/2018 and GP was following up their hospital appointment. The second had a blood test requested on 18/3/2018 and patient did not attend, as a result the medication was removed to an acute prescription and an urgent task was sent to the practice manager to follow up the patient.
- Leflunomide- One patient was on the medication and was up to date and had appropriate monitoring.
- Sulphasalazine- All nine patients on the medication and was up to date and had appropriate monitoring.
- Warfarin- New system in place, when warfarin is prescribed by the GP, an alert comes up on the patient's records, and prescribed as an acute prescription. The GP checks the patients' blood levels (INR) before issuing. This was coded individually so could be searched. Patients were issued with the exact requirement for that month (evidence seen in notes).
- Lithium- Of the five patients presently on lithium four had bloods and were within the range. One patient had a blood test requested and the patient had not attended, the script was therefore reduced to a seven day script day. As the patient had not attended recent monitoring the script removed from system as per protocol.
- A search on patients on anti-hypertensive meds called ACE inhibitors revealed only 10 out of 931 were overdue a U/E blood test. However, of the 10 we saw in the patient notes these patients were only a few days over the 12 months period. We also saw that when the medicine had been issued they were within the acceptable range, except one patient where it was a new

prescription and a form had been given to them for a blood test.

Medication reviews

A search of the practices computer system showed that 94% of patients on four or more medication had now been reviewed and 89% of patients on repeats had been reviewed. The practice had employed a clinical pharmacist who had been coming in on weekends and reviewing 200 patients a week. The practice anticipated that all reviews will have been completed by August 2018.

A protocol was in place for reviewing patients with long term conditions (LTC) to ensure their medications remained relevant for their health need LTC. The practice had recently recruited a nurse who was is being trained to review LTC patients such those with diabetes. Each LTC had an individual search on EMIS Web and these searches were carried out monthly looking for patients whose birthdays were due the following month. These patients were then invited that month for a review by the practice nurse and a blood test was arranged in advance if needed. The practice was in the process of recruiting an asthma nurse and hope who would commence post in July 2018. The practice had a meeting on July 2018 with a COPD nurse from pharmaceutical company who would be carrying out searches and reviewing patients with COPD.

The practice has addressed the issue of over issuing of authorised repeats, now re configured EMIS prescribing so that unauthorised prescribing can no longer be done.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y*
There was evidence of learning and dissemination of information	N
Number of events recorded since the last inspection in January 2018.	Two
Number of events that required action	Two

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

Event	Specific action taken
Abnormal blood test not acted on	Immediate actions taken to ensure the patient was reviewed. Audit to be completed of abnormal results to ensure compliance of process.
Patient unhappy with consultation	Patient apologised to and consultations to be monitored to ensure quality.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y
<p>Comments on systems in place:</p> <p>Medicines and Healthcare products Regulatory Agency (MRHA). A protocol was in place for staff to follow. There were two staff members who were signed up for alerts. Alerts were cascaded to a GP via email, the GP then undertook relevant searches and informed one of the GP partners who actions them. Patients safety alerts were discussed at the next meeting and all clinical staff. Evidence seen for example following an alert for the medicine Esmya in February 2018 all 18 patients had this medication removed and two alerts were put on patients notes one historic and one triggered if the medication initiated. A random search of four patients which showed this was evidence.</p>	

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice
The practice had made significant improvements to the medicine managements systems to ensure all areas identified in the last inspection were addressed. However, we saw there gaps and inconsistencies in areas such as recruitment and significant events which had not been identified by the practices own quality assurance systems.

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies DBS	DBS check stated that staff undertaking chaperone duties would have an enhanced DBS check completed. However, we saw that a staff member who the manger confirmed undertook chaperoning duties had only a standard check and a historical disclosure recorded which had not been risk assessed. A new member of staff had been appointed with a DBS check from a previous employer, this had not been risk assessed and there was no guidance for staff to follow in the DBS policy
Recruitment	A newly appointed member of staff did not have any details of their professional indemnity insurance as this information was not stored in their file. The information was provided to us following the inspection. The recruitment policy did not include any requirements for indemnity insurance.

Managing risks, issues and performance

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Infection Control	Audit completed and actioned
Fire	Risk assessment completed and actioned
Medicine management	Revised protocol, procedures and audits improvements identified during the inspection

Any additional evidence

There remained gaps in the recruitment process and the recording and learning of significant events which were not robust and did not provide assurance that monitoring was in place to improve quality and safety in the service.

Any additional evidence

DO NOT DELETE THE NOTES BELOW

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, a statistical tool which shows the deviation from the England average. It gives us a statistical measurement of a practice's performance in relation to the England average, and measures this in standard deviations. We calculate a z-score for each indicator, thereby highlighting the practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are +2 or more or -2 or less are at significant levels, warranting further enquiry.

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

The following language is used for banding variation:

- Significant variation (positive)
- Variation (positive)
- Comparable to other practices
- Variation (negative)
- Significant variation (negative)

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95%.

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: <http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ([See NHS Choices for more details](#)).