

Care Quality Commission

Inspection Evidence Table

The Three Shires Medical Practice - Wick (1-591106293)

Three Shires Medical Practice – Pucklechurch (1-2046989361)

The Three Shires Medical Practice - Colerne (1-591106340)

The Three Shires Medical Practice – Marshfield (1-591106309)

Inspection date: 03 July 2018

Date of data download: 27 June 2018

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

Note: The four services detailed above are all registered with the CQC as separate practices. However, in practice they operate as one service with one patient list. The evidence contained in this document relates to all three registered locations unless specified otherwise. The term “the practice” refers to all four locations unless specified otherwise.

Safe

Safety systems and processes

| Safeguarding | Y/N |
|--|--------------------------------|
| There was a lead member(s) of staff for safeguarding processes and procedures. | Yes |
| Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff. | Yes |
| Policies were in place covering adult and child safeguarding. | Yes Updated in June 2018 |
| Policies were updated and reviewed and accessible to all staff. | Yes |
| Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs). | Yes |
| Information about patients at risk was shared with other agencies in a timely way. | Yes |
| Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients. | Yes |
| Disclosure and Barring Service checks were undertaken where required. | Yes |
| Further information and explanation of any answers: | |
| The practice continued to ensure staff had received up to date training for safeguarding. As part of this inspection we reviewed the tool the practice had in place for monitoring all staff training. The practice had a clear set of mandatory training requirements for staff and they maintained a spreadsheet which | |

recorded staff training. This showed most staff had received all the mandatory training appropriate for their role. We were told the few training gaps in the spreadsheet were caused staff who were on maternity leave or had recently started. We looked at three examples which confirmed this.

We were told all clinical staff and all new staff were DBS checked and we saw evidence which confirmed this. Longer serving non-clinical staff had a risk assessment instead and we saw evidence to confirm this. We were told non-clinical staff did not do chaperoning.

We saw evidence the practice held a group medical indemnity insurance policy with all clinicians named.

| Recruitment Systems | Y/N |
|---|-----|
| 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 and if relevant to role. | Yes |
| Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored. | Yes |
| Staff who require medical indemnity insurance had it in place | Yes |
| <p>Further information.</p> <p>The practice had recruited one member of staff since our last inspection. We looked the recruitment record for this employee. We found all the appropriate records, such as photo ID, references, induction, except for the records associated with the staff members application and interview. We were told this was because staff records were usually held at the Pucklechurch location, but in this case the interview had been done at the Wick location where the new staff member was based and the records had not yet been sent back.</p> <p>The practice had a clear system for monitoring and recording staff vaccinations and registration of nurses and GPs, which they did on an annual basis.</p> <p>We saw evidence the practice had medical indemnity insurance, which named all clinicians.</p> <p>The practice maintained a spreadsheet which they used to monitor staff vaccinations, registration of nurses and GPs, which they reviewed on an annual basis.</p> | |

| Safety Records | Y/N |
|--|---|
| <p>There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test: We did not look at the last date as this was verified on our previous inspection.</p> | <p>Yes. We did not look at the last date as this was verified on our previous inspection.</p> |
| <p>There was a record of equipment calibration Date of last calibration: We did not look at the last date as this was verified on our previous inspection.</p> | <p>Yes. We did not look at the last date as this was verified on our previous inspection.</p> |
| <p>Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals</p> | <p>Yes</p> |
| <p>Fire procedure in place</p> | <p>Yes</p> |
| <p>Fire extinguisher checks</p> | <p>Yes</p> |
| <p>Fire drills and logs</p> | <p>Yes</p> |
| <p>Fire alarm checks</p> | <p>Yes</p> |
| <p>Fire training for staff</p> | <p>Yes</p> |
| <p>Fire marshals</p> | <p>Yes</p> |
| <p>Fire risk assessment Date of completion</p> | <p>Yes 18/01/2018</p> |
| <p>Actions were identified and completed.</p> | <p>All high priority actions completed. See below for further information.</p> |
| <p>Additional observations: We saw evidence the practice had commissioned an external consultant to carry out a fire risk assessment. The subsequent report made a number of recommendations which had been categorised as high priority, which should be done as soon as possible, and medium priority, which should be actioned within 3 months. We found;</p> | |

| | |
|---|--------------------------|
| <ul style="list-style-type: none"> • The practice had completed all the high priority actions recommended in the report. These actions included, installing emergency lighting at the Marshfield and Colerne locations, fitting new fire signage in all sites and removing the community library from the foyer at the Marshfield locations as it was a fires escape route. • There were a few medium priority actions that had not yet been completed. For example, the report suggested that many of the internal doors could be replaced as they were not up to the latest recommended standards. The practice had applied to the local clinical commissioning group for a grant to help pay for this work and were currently waiting a response. • A new system had been put in place to ensure the recommended checks were carried out and recorded. • Each location had premises folder which included an up to date fire log book which evidenced that evacuation drills and fire equipment tests had been carried out at the appropriate intervals. | |
| <p>Health and safety Premises/security risk assessment? Date of last assessment:</p> | <p>Yes July 2017</p> |
| <p>Health and safety risk assessment and actions Date of last assessment:</p> | <p>Yes See below</p> |
| <p>Additional comments:</p> <p>The practice had done a number of separate health and safety assessments since our last inspection covering areas such as fire and security and infection control, and we saw evidence the practice had taken appropriate action where this was required.</p> | |

| Infection control | Y/N |
|---|--|
| Risk assessment and policy in place Date of last infection control audit: The practice acted on any issues identified | Yes November 2017 (also monthly nurse led checks) Yes |
| The arrangements for managing waste and clinical specimens kept people safe? | Yes |

Risks to patients

| Question | Y/N |
|---|-----|
| There was an effective approach to managing staff absences and busy periods. | Yes |
| Comprehensive risk assessments were carried out for patients. | Yes |
| Risk management plans were developed in line with national guidance. | Yes |
| Staff knew how to respond to emergency situations. | Yes |
| 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. | Yes |
| In addition, there was a process in the practice for urgent clinician review of such patients. | Yes |
| The practice had equipment available to enable assessment of patients with presumed sepsis. | Yes |
| There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance. | Yes |

Information to deliver safe care and treatment

| Question | Y/N |
|---|-----|
| The practice had a documented approach to the management of test results and this was managed in a timely manner. | Yes |

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) | 1.03 | 0.92 | 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) | 16.4% | 11.7% | 8.9% | Variation (negative) |

| 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. | Yes |
| Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions). | Yes |
| Prescriptions (pads and computer prescription paper) were kept securely and monitored. | Yes |
| 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. | Yes |
| The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength). | Yes |
| There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer. | Yes |
| If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance. | Yes |
| Up to date local prescribing guidelines were in use. | Yes |
| Clinical staff were able to access a local microbiologist for advice. | Yes |
| For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance. | Yes |
| The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held. | Yes |
| The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases. | Yes |
| There was medical oxygen on site. | Yes |
| The practice had a defibrillator. | Yes |

| | |
|---|-----|
| Both were checked regularly and this was recorded. | Yes |
| Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use. | Yes |
| <p>Further information and explanation of any answers:</p> <p>Since the previous inspection in November 2017 the practice had stopped using handwritten prescription stationary. They informed us that they had subsequently removed and destroyed all stationary they had for this purpose. All prescriptions were now printed or sent electronically.</p> <p>We found;</p> <ul style="list-style-type: none"> • The practice had reviewed their security arrangements and had taken a number of steps to improve security • The practice had Introduced a new lockdown procedures for staff to follow when the surgery was closed. • Key safes had been installed at all four locations and were in use. • New duties had been agreed for the location managers which covered security and other risk management duties. • We saw that the vaccine fridges were routinely kept locked and the keys stored in the key safe. • The security issues had been discussed with staff to make them aware of the risks and how they could be minimised. • The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. The practice had signed up to DSQS which rewards practices for providing high quality care to their dispensing patients. There was a named GP responsible each dispensary. Staff involved in dispensing medicines had received appropriate training or were supervised while they completed their training. • Annual competency assessments were completed by the lead GP for the dispensary. The dispensary carried out regular medicines audits including one looking at dispensary staffing hours. • Medicines were stored securely with access restricted to authorised individuals in three of the four dispensaries. • Fridge temperature checks were completed daily at all locations to ensure medicines were kept at the appropriate temperature. Staff were aware of the process to follow if the temperatures went out of range. | |

- Repeat prescriptions could be ordered by patients online, in person and by fax. When medicines needed a review, a GP would need to authorise the medicine before a prescription could be issued.
- Prescriptions were signed before medicines were dispensed and handed out to patients. A bar code scanner was used to check the dispensing process in addition to a second check by a doctor and dispensary staff member. The dispensaries also offered patients weekly blister packs to support them to take their medicines.
- The standard operating procedures (SOPs are written instructions about how to safely dispense medicines) had been signed by dispensary staff and were reviewed annually.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored securely and access was restricted to appropriate individuals. Suitable arrangements were in place for the destruction of controlled drugs.
- Dispensing incidents and near-miss errors were recorded. Staff demonstrated how changes had been made to the dispensary following a review of these records to minimise the chance of similar error reoccurring.
- Emergency medicines were easily accessible to staff, held in a secure area and were checked regularly to make sure they were in date and safe to use. It was suggested that arrangements could be further improved by the use of tamper evident storage.
- Patient Group Directions (PGDs) were in place to allow nurses to administer medicines. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Authorised staff had been assessed as competent to use them and the directions were up to date to ensure patients were treated safely.
- We discussed the practice' prescribing of antibiotic, as the data available at the time of inspection showed the 16 % of the practice' antibiotic prescribing was for Co-Amoxiclav, Cephalosporins or Quinolones compared to the national average of 8.9%. The practice was aware of the data were taking steps to reduce this type of prescribing by automatically alerting GPs to the issue when they were in the process of deciding which was the most appropriate antibiotic to prescribe.

| Dispensing practices only | Y/N |
|--|-----|
| There was a GP responsible for providing effective leadership for the dispensary. | Yes |
| Access to the dispensary was restricted to authorised staff only. | Yes |
| The practice had clear Standard Operating Procedures for their dispensary staff to follow. | Yes |
| The practice had a clear system of monitoring compliance with Standard Operating Procedures. | Yes |
| Prescriptions were signed before medicines were dispensed and handed out to patients. There was a risk assessment or surgery policy for exceptions such as acute prescriptions. | Yes |
| If the dispensary provided medicines in weekly or monthly blister packs (Monitored Dosage Systems) there were systems to ensure appropriate and correct information on medicines were supplied with the pack. | Yes |
| Staff were aware of medicines that were not suitable for inclusion in such packs and had access to appropriate resources to identify these medicines. Where such medicines had been identified staff provided alternative options that kept patients safe. | Yes |
| The home delivery service, or remote collection points, had been risk assessed (including for safety, security, confidentiality and traceability). | Yes |
| Information was provided to patients in accessible formats e.g. large print labels, braille labels, information in variety of languages etc. | Yes |
| There was the facility for dispensers to speak confidentially to patients and protocols described process for referral to clinicians. | Yes |

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 | Yes |
| Staff understood how to report incidents both internally and externally | Yes |
| There was evidence of learning and dissemination of information | Yes (?) |

| Safety Alerts | Y/N |
|--|-----|
| There was a system for recording and acting on safety alerts | Yes |
| Staff understand how to deal with alerts | Yes |

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 comparable, 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 comparable 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 Band | Z-score threshold |
|---|----------------------------------|-------------------|
| 1 | Significant variation (positive) | $Z \leq -3$ |
| 2 | Variation (positive) | $-3 < Z \leq -2$ |
| 3 | Comparable to other practices | $-2 < Z < 2$ |
| 4 | Variation (negative) | $2 \leq Z < 3$ |
| 5 | Significant variation (negative) | $Z \geq 3$ |
| 6 | No data | Null |

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.

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](#)).

