

# Care Quality Commission

## Inspection Evidence Table

### Shiregreen Medical Centre (1-544597866)

Inspection date: 23 July 2019

Date of data download: 15 July 2019

## Overall rating: Good

At the last inspection on 20 November 2018 the practice was rated requires improvement in safe and well led. This was because safety risk management processes and systems and processes to ensure good governance in accordance with the fundamental standards of care were not effective. At the inspection in July 2019 we found the provider had satisfactorily addressed these issues.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

## Safe

## Rating: Good

At the inspection on 20 November 2018 we rated the practice requires improvement for providing safe services because:

Governance arrangements did not ensure effective risk management. At this inspection, we found that the provider had satisfactorily addressed these issues.

### Safety systems and processes

**The practice had clear systems, practices and processes to keep people safe.**

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 25 July 2019	Y
There was a record of equipment calibration. Date of last calibration: 10 January 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 10 October 2018	Y
There was a log of fire drills. Date of last drill: 10 and 17 July 2019 at the main site and 10 July 2019 at the branch site.	Y
There was a record of fire alarm checks. Date of last check: 18 July 2018	Y

There was a record of fire training for staff. Date of last training: December 2018 and January 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 14 June 2018 for the main site and 18 June 2018 for the branch site.	Y
Actions from fire risk assessment were identified and completed.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection on 20 November 2018 we found fire alarm maintenance checks were completed weekly at the main site. However, checks had lapsed between June and October 2018 and were ad hoc at the branch site. There was no record of a fire drill at either site. We also observed that GP locum staff would sometimes use their own medical equipment. There was no system in place to monitor if this equipment had been calibrated.</p> <p>At the 23 July 2019 inspection we found the practice had reviewed its fire safety systems and processes. We observed records had been maintained to evidence weekly fire alarm testing and fire drills had been carried out and actions taken where required at both sites.</p> <p>A GP locum equipment pack had been introduced at both sites which all locums were asked to use. The practice had a record of the calibration of this equipment.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: May 2018. A date was scheduled for this to be completed 30 July 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: May 2018. A date was scheduled for this to be completed 30 July 2019	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection on 20 November 2018 we found that a legionella risk assessment had been completed in April 2017. Actions to mitigate the risks identified were being carried out and recorded at the main site. However, the checks at the branch site had lapsed between June to 26 September 2018 and were ad hoc in October.</p> <p>At the inspection on 23 July 2019 we found that the legionella checks at both sites were being completed monthly and actions were being taken to mitigate the risks identified. For example, the practice had arranged for a plumber to check the water systems following temperature checks.</p>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
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: July 2019	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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection on 20 November 2018 the practice had completed an infection, prevention and control (IPC) audit. However, the actions taken to mitigate any risks identified were not recorded on the audit sheet and it was not clear how this was being monitored. The infection control policy stated audits would be completed bi-monthly. However, there was only a record of annual audits.</p> <p>We observed the sharps bins at the branch site were not labelled as outlined in the Health Technical Memorandum 07-01-safe management of healthcare waste guidance.</p> <p>We were told that there were systems to check stock at both sites. However, we observed some consumables (syringes and needles) in the clinical rooms at the branch site were past their expiry date.</p> <p>At the inspection 23 July 2019 we reviewed an IPC audit the practice were working on. The audit form had been amended to clearly record what actions had been identified, who would address them and when this would be completed. We also observed actions identified on an audit the CCG had completed with the practice and these had been added to the monitoring log. We observed actions identified were being taken. The practice manager had introduced a monthly quality monitoring check which included review of the infection control audit. The infection control policy and been updated to reflect an annual audit and monthly checks. The practice nurse was the infection control lead. The practice had arranged for her to attend an enhanced training course to support her in this extended role.</p> <p>During the inspection in July 2019 we observed the sharps bins to be labelled as specified in guidance at both sites and consumables in clinical rooms to be within their expiry date. The practice had implemented systems for the practice nurse to check the sharps bins and stock control on a monthly basis. This was recorded on the monthly monitoring log and overseen by the practice manager as part of the quality monitoring check.</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) (01/04/2018 to 31/03/2019) (NHS Business Service Authority - NHSBSA)	1.18	0.89	0.88	Tending towards variation (negative)
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). (01/04/2018 to 31/03/2019) (NHSBSA)	6.8%	8.1%	8.7%	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 (01/10/2018 to 31/03/2019) (NHSBSA)	4.70	5.34	5.61	Tending towards variation (positive)
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/10/2018 to 31/03/2019) (NHSBSA)	2.51	1.94	2.07	No statistical variation

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
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.	Y
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

Medicines management	Y/N/Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection on 20 November 2018 we found that patient specific directions (PSDs) were not used. The provider could not demonstrate patients attending for immunisations, such as vitamin ones, had been authorised by a prescribing clinician before administering.</p> <p>Blank prescriptions were securely stored at the main site in a locked room. However, they were stored in a desk drawer at the branch site which was not locked.</p> <p>We observed blank prescriptions were logged into the practice by box number. However, there was no system to track the prescriptions within the practice at both sites as specified in NHS Counter Fraud Authority guidance.</p> <p>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. However, the practice did not have a formal process to check medicines for patients with poor mental health were being ordered by patients.</p> <p>The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines. However, we observed the adult defibrillator pads at the branch site had expired in October 2018. This was replaced immediately at the time.</p> <p>At the inspection in July 2019 we found the practice had implemented a new PSD protocol. Following patient commencement on a treatment regime by a GP an authorisation form would be completed and stored electronically in the patient record. Staff who required a PSD to be able to administer medicines were able to demonstrate the new process. This was being monitored by the GPs and a review date for 12 months had been set up to audit the system.</p> <p>We observed blank prescriptions to be stored securely in locked cabinets at both sites and a system to track them throughout the practice and the branch site had been implemented. Staff we spoke with were able to explain the new system. This was being monitored on the monthly quality monitoring checks by the practice manager.</p> <p>The practice had introduced a formal process to check medicines for patients with poor mental health were being ordered. The practice held a register of patients on high risk and anti-psychotic medications. The administration staff would run a search on the clinical system every three months to ensure the patients on this register were ordering their repeat medicines. If a patient had not ordered their medicines this would be brought to the attention of the GP who would take the appropriate action.</p> <p>We observed monthly checklists of stock control were being completed by the nurse and monitored monthly by the practice management team as part of the quality assurance checks. We observed all equipment, including defibrillator pads to be in date during this inspection. A system to check the emergency medicines including the oxygen and defibrillator were completed weekly and recorded on the monitoring log.</p> <p>The clinicians were aware that their antibiotic prescribing data was slightly above the CCG and national average and were reviewing the reasons for this at the time of the inspection.</p>	

## Well-led

### Rating: Good

At the last inspection on 20 November 2018 systems and processes to ensure good governance in accordance with the fundamental standards of care were not effective. At this inspection, we found the provider had satisfactorily addressed these issues.

#### Leadership capacity and capability

#### There was compassionate, inclusive and effective leadership at all levels

	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
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection on 20 November 2018 we found that there had been significant changes to the leadership of the practice with the recent retirement of two long standing GP partners. Succession planning had resulted in GPs increasing their sessions and recruitment of an Advanced Nurse Practitioner (ANP). We were told there was still a six session deficit of GP hours which was currently being filled by regular locum doctors. We were told a new partnership was in the process of being formed and plans for further recruitment considered. A practice operational structure had been developed which included a management structure with roles and responsibilities outlined. Some staff were undertaking additional training to diversify the workforce. The GP, registered manager and business manager were aware that this was a time of considerable change in the practice and were supporting staff by sending out weekly newsletters to keep them updated. However, there was a lack of comprehensive oversight of some safety systems, identified risks and lack of actions to mitigate those risks.</p> <p>At the inspection in July 2019 we found the practice had successfully recruited two new salaried GPs as part of their succession planning so there was no longer a deficit in GP hours. We saw evidence the process to apply to change the provider registration with the Commission had commenced. The practice had implemented a monthly quality monitoring review of safety systems to ensure oversight that systems were operating as intended. These were recorded and actions to mitigate risks identified were completed and recorded.</p> <p>We noted the practice had also managed to gain some patient interest in setting up a new patient group. The first meeting was scheduled for 10 September 2019.</p>	

## Governance arrangements

**There were clear 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.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection on 20 November 2018 we found that the provider had some managerial oversight of monitoring safety systems: For example, stock control of treatment room consumables and emergency equipment checks. However, these were not operating as intended as we observed out of date consumables in the treatment room at the branch site. Also, the checks of the emergency medicines were not adequate as the defibrillator pads had expired at the branch site and the oxygen cylinder monitoring checks at the main site were not being recorded. We observed systems to monitor and track blank prescriptions was not effective and staff administering medicines did not have a patient specific directive authorising these.</p> <p>At the inspection in July 2019 we were told that the management team had reviewed the systems in place and developed monitoring logs and systems to check and oversee that these were being completed. We observed a monthly quality monitoring review was being completed by the management team of safety systems, including tracking and security of blank prescriptions and infection, prevention and control audits. A record of actions to mitigate risks identified had been completed and recorded. We saw a system for authorising patient specific directives by a clinician had been implemented and staff using them were able to explain how it worked on the clinical system.</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.	Y
There were processes to manage performance.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Explanation of any answers and additional evidence:	
<p>At the last inspection on 20 November 2018 we observed there were gaps in risk management systems relating to legionella, fire safety and equipment used by locum staff. We also found staff were overdue their appraisal.</p> <p>At the inspection on 23 July 2019 we observed that systems to manage risks had been reviewed. Actions had been taken to identify, manage and mitigate risks as identified on the risk assessments and monthly quality monitoring logs were completed by the management team to confirm these systems were operating as intended. For example, legionella control measures were being completed and recorded at both sites and risks identified on these were being actioned. Fire safety systems had been reviewed and fire drills carried out as specified on their fire risk assessment. The infection, prevention and control policy had been reviewed and audits had been completed and actions taken recorded. Regular monthly checks of consumables and emergency equipment were being completed by the nurse and overseen by the management team as part of the quality assurance checks.</p> <p>We observed staff had all had their appraisal which had been arranged at the time of the last inspection.</p>	



## 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)	$\leq -3$
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.
- 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.

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>

### 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.