

Care Quality Commission

Inspection Evidence Table

Littletown Family Medical Practice (1-542588138)

Inspection date: 3 July 2019

Date of data download: 02 July 2019

Safe

Safety systems and processes

The practice had some systems, practices and processes to keep people safe and safeguarded from abuse, but the process was not yet embedded.

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Explanation of any answers and additional evidence: At our previous inspection we saw that although the practice requested DBS checks for all clinicians, they were issued to the clinicians' home address so the practice did not always hold evidence of their result. At this inspection we saw that evidence of a DBS check was held in personnel files. The practice was in the process of setting up a system to monitor training. The spreadsheet that would be used was not fully populated but the practice manager told us all mandatory training had been completed. We looked at the training records of a salaried GP. We saw that safeguarding training had been completed; safeguarding adults training was completed on 30/06/2019 and safeguarding children training at the appropriate level was completed on 02/07/2019.	

Recruitment systems	Y/N/Partial
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Partial
Explanation of any answers and additional evidence: At our previous inspection we saw there was no system to ensure the registration of clinical staff, and the medical indemnity insurance for clinical staff, was up to date. At this inspection we saw that the professional registration and medical indemnity insurance had been checked for all clinicians. The practice manager told us they were in the process of setting up a system to check this every three months and record the results on a spreadsheet. We saw that this was not yet in place but the practice manager told us it would start in July 2019. At our previous inspection we saw the recruitment policy stated an unconditional offer of employment was made following the receipt of satisfactory references and medical information. At the time the	

practice manager told us this was incorrect and the policy needed to be updated. At this inspection we saw the new recruitment policy dated March 2019. This policy also stated that references were requested and medical reports were requested if required. It stated that following this the process was to confirm to the candidate that the job offer was firm and unconditional. This was the same as the previous policy that had been said to be incorrect. We asked about the process for requesting a Disclosure and Barring Service (DBS) check, and how this could impact on a job offer. The practice manager told us they usually started staff without a DBS check "because they were desperate". They said they told staff verbally that if the DBS, when returned, was not satisfactory, their contract may be terminated. This was not mentioned in the recruitment policy.

Safety systems and records	Y/N/Partial
There was a log of fire drills. Date of last drill: 15/05/2019	Yes
There was a record of fire training for staff. Date of last training: Various dates in the previous 12 months.	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: 09/05/2019	Yes
Actions from fire risk assessment were identified and completed.	No
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that the most recent fire risk assessment was completed in 2010. A new fire risk assessment had been carried out by an external company on 09/05/2019. This highlighted that items stored in the loft space were a fire risk and items should be reorganised or removed. The fire risk assessment document showed this was given a risk rating of 'high', and it stated this needed attention within one month. The practice manager told us this had not been actioned as it was rated as a medium risk and not urgent.</p> <p>The fire risk assessment stated that emergency lighting should be checked monthly to ensure full operation. The practice manager told us their relative had attended the practice and showed them how to do this, but they had not yet started the checks or amended their proformas so checks could be recorded. The practice manager amended the proforma during the inspection and told us monthly checks would commence.</p> <p>At the previous inspection we found there was one fire warden and no protocol to follow if the fire warden was not in work. We saw evidence that all staff had received fire warden training on 09/05/2019. A deputy fire warden was nominated but all other staff were able to stand in if necessary.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 18/04/2019	Yes
The practice had acted on any issues identified in infection prevention and control audits.	No
The arrangements for managing waste and clinical specimens kept people safe.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we found that not all staff had completed training in infection prevention and control, and formal hand washing training was not carried out. At this inspection we saw the hand washing technique of staff had been assessed in January 2019. We saw evidence that the majority of staff had completed training in infection prevention and control. We asked for evidence that the three salaried GPs had completed this training and found that two of the three had not completed the training.</p> <p>At the previous inspection we found that the practice had carried out their first infection control audit on 30/01/2019. Some improvements were required but there was no plan in place regarding how and when the improvements would take place.</p> <p>At this inspection we saw that a further infection control audit had been carried out on 18/04/2019. An action plan had been put in place. Most of the actions were still outstanding. For example, it was noted that wall mounted soap and hand gel dispensers would be purchased, and the practice manager confirmed they had not done this yet. It was noted that a disinfection policy was required. We saw that one had been purchased but this was from Harrogate and District NHS Foundation Trust and the services highlighted were located in East Yorkshire, not Greater Manchester. The practice manager told us it was being reviewed and would be personalised to the practice. It was also noted that mop heads would be discarded after use. The practice manager told us they were not discarded but they were washed and re-ordered frequently. They said in the future they would make sure they were changed frequently and this would be recorded.</p> <p>At the previous inspection we found that sharps bins were not attached to the walls, and one had been in use since 19/05/2017. We checked four sharps bins and the oldest one had been in use less than two months. The sharps bins had been wall mounted by hooking them onto self-adhesive plastic hooks. In one room these were located approximately 5'10" above the ground, and in another they were located next to a desk and not within easy reach. The sliding doors on three of the boxes were open, so there was a risk of injury should they be knocked off the hook. The practice manager told us the sharps bins were removed from the hooks during clinics, and they had been placed high up to avoid them being knocked off.</p>	

Medicines management	Y/N/Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we saw that the temperature of fridges used to store vaccinations were not being correctly monitored. At this inspection we saw a protocol was in place and an effective checking process was followed twice a day. We saw that this was up to date.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a wholly effective system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
There was a system for recording and acting on significant events.	Partial
There was evidence of learning and dissemination of information.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the previous inspection we saw that the system to manage significant events was not effective. At this inspection we saw the system had been reviewed and various forms were being used. We saw examples of significant events being recorded, discussed and learning documented. Significant events had review dates although the dates had not yet been reached.</p> <p>We looked at the practice meeting minutes from 06/03/2019. These stated that six significant events had been discussed. However, we did not see details of all these in the significant event file. We saw an incident form regarding an incident on 14/02/2019. This was noted that it was discussed in the practice meeting on 06/03/2019. There was no record in the meeting minutes of it being discussed.</p> <p>We asked the practice manager about this. They told us they only recorded significant events in meeting minutes and they had classed this as an incident. They said that it was difficult for them to chair meetings and take minutes but in the future staff would take the minutes which would make recording easier.</p> <p>It was difficult to track the significant events as the system was confusing. The practice manager agreed the system needed to be simplified so that significant events could be monitored properly.</p>	

Effective

Effective staffing

The practice was unable to demonstrate that all staff had the skills, knowledge and experience to carry out their roles.

	Y/N/Partial
The learning and development needs of staff were assessed.	Partial
The practice had a programme of learning and development.	Partial
Staff had protected time for learning and development.	Yes
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
Explanation of any answers and additional evidence: <p>At the previous inspection there was no evidence of a system to ensure training was kept updated and there had been an intense period of training in the two weeks prior to our inspection.</p> <p>The practice manager told us that training was “work in progress”. We saw that they had put a training spreadsheet in place to monitor training, but this had not yet been fully completed. They told us that all mandatory training for staff had been completed. However, when we asked for evidence that salaried GPs had completed training in infection prevention and control they told us that two of the three salaried GPs had not completed this training. We saw that one of the salaried GPs had completed some mandatory training on the day prior to our inspection, and the practice manager told us this was despite several reminders to them.</p> <p>We asked how they would ensure all staff completed the training required of them in the future. The practice manager told us that they would be having separate weekly meetings with administrative staff, the registered manager and with clinicians. They said they would inform them of any training requirements during these meetings and monitor this. Staff had protected learning time so they were able to complete training.</p> <p>At the previous inspection we saw little evidence of staff having appraisals, and the practice manager had never had an appraisal, having been at the practice since 2007. At this inspection the practice manager told us that they had not completed an appraisal for two of the six administrative staff or for the healthcare assistant. They said they intended to complete these on the Friday prior to our inspection but they were required to complete an urgent task. They told us they were putting a system in place to record appraisal dates on the training log so they could be monitored. This had not yet commenced. We looked at a selection of staff files and found that where an appraisal had been completed there was input from the appraiser and staff member, and objectives were set.</p>	

Responsive

Listening and learning from concerns and complaints

Complaints were responded to and a new system of dealing with complaints was in place.

	Y/N/Partial
Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence: At the previous inspection we found that not all complaints were satisfactorily handled. At this inspection we saw that a new complaint control sheet had been put in place to record aspects of complaint handling. One complaint that was received 25/02/2019 was recorded as being resolved within 10 days. However, the final response letter to the complainant was issued 03/04/2019 with an apology for the late response. We saw that complaints were discussed in practice meetings and learning points were recorded. However, this was a new system so it was not possible to determine its effectiveness. We saw that in one instance the complainant was asked for their consent to discuss the complaint with the person the complaint was regarding. No response had been received and to date the complaint had not been investigated.	

Well-led

Leadership capacity and capability

Leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	No
They had identified the actions necessary to address these challenges.	No
Explanation of any answers and additional evidence: Although there were plans to make the improvements identified as required at our previous inspection most of these plans had not been fully developed and put in place.	

Culture

The practice culture did not fully support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
Explanation of any answers and additional evidence: The practice had started to complete staff appraisals but at the time of the inspection these had not been completed for all staff. A system to monitor appraisals was planned but was not yet in place. This meant that the competence of staff was not fully assessed.	

Governance arrangements

The overall governance arrangements needed to be improved.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Explanation of any answers and additional evidence: The practice had reviewed some of their governance structures and systems following our previous inspection. However, we found further improvements were required. During the inspection we checked the sharps bins in two clinical rooms. We found the NHS smartcard of a clinical staff member left on a computer in one of the rooms. The staff member was on annual leave at the time of the inspection. The practice website did not include the CQC inspection rating in a prominent place. We saw that under a tab labelled 'Care Quality Commission the practice had included a link to the latest inspection report. The practice webpage did not include the rating or the date the inspection report was published. The practice had displayed a black and white photocopy of the front page of their inspection report in	

their reception area. The practice manager told us they were unaware they could access CQC posters and on-line widgets so the correct information required under Regulation 20 (A) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Requirement as to display of performance assessments). This information had been included in a letter to the practice when their previous report was published. During the inspection the practice manager accessed the CQC posters and on-line widgets and correctly recorded the information.

On a window next to the front door of the practice, clearly visible, was a laminated colour copy of the practice's inspection rating from a CQC inspection carried out in March 2015. This indicated that all areas were rated as 'good'. We removed this notice during the inspection.

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	No
There were processes to manage performance.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
<p>Explanation of any answers and additional evidence:</p> <p>An external company had carried out a fire risk assessment on 09/05/2019. Issues identified in the fire risk assessment had not been actioned. This included items stored in the loft space, which were a fire risk, not being reorganised or removed. The fire risk assessment document showed this was given a risk rating of 'high', and it stated this needed attention within one month. The practice manager told us this had not been actioned as it was rated as a medium risk and not urgent.</p> <p>An infection control audit had been carried out 18/04/2019. An action plan was in place but the practice manager told us the majority of actions had not yet been completed. The action plan did not contain dates where improvements should be made by.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Performance information was used to hold staff and management to account.	No
Our inspection indicated that information was accurate, valid, reliable and timely.	No
There were effective arrangements for identifying, managing and mitigating risks.	No
<p>Explanation of any answers and additional evidence:</p> <p>Not all the information we saw during the inspection was correct or complete.</p> <p>The practice manager was in the process of putting a system in place to manage and monitor staff training, the professional registration of clinical staff, medical indemnity insurance, and staff appraisals. The practice manager told us this was "work in progress" and full information was not yet included. They told us that although the system was not complete all staff had completed mandatory training. We saw that two of the three salaried GPs had not completed training in infection control, and one completed their safeguarding children training the day before the inspection.</p> <p>Appraisals had not been completed for all staff.</p> <p>Although a recent fire risk assessment had identified an issue as high risk and to be actioned within a month, the practice manager had not recognised this and told us it was medium risk and not urgent.</p>	

We saw complaint information stating a complaint had been resolved within 10 days. The complaint had been made 25/02/2019 and a response made 03/04/2019.

Engagement with patients, the public, staff and external partners

The practice involved the public to sustain high quality and sustainable care.

	Y/N/Partial
The practice had an active Patient Participation Group (PPG)	Yes
Explanation of any answers and additional evidence:	
<p>The practice had re-launched their PPG following our previous inspection. We saw that two meetings were held in May 2019 and further meetings were planned and though the next date was not yet scheduled. The practice manager told us they communicated with the PPG by email in-between meetings.</p>	

Continuous improvement and innovation

There was little evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	No
Learning was shared effectively and used to make improvements.	No
Explanation of any answers and additional evidence:	
<p>Although we saw a new system for dealing with complaints and significant events was in place, this was not fully embedded.</p> <p>A warning notice had been issued to the practice following our previous inspection. This inspection found that although the practice had started to put some new processes in place, sufficient progress had not been made.</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)	≤ -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.
- 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.