

Care Quality Commission

Inspection Evidence Table

Moredon Medical Centre (RN3X2)

Inspection date: **23 February 2021**

Date of data download: 01 February 2021

Overall rating: Requires improvement

We previously inspected Moredon Medical Centre on 27 February 2020 to follow up on areas of concern identified at a previous inspection when the practice was registered under a previous provider.

We carried out a follow up comprehensive inspection on 23 February 2021 to follow up on these concerns. At this inspection we identified new concerns regarding the provision of safe and well led services. The evidence table sets out our findings from this inspection.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Requires improvement

We previously rated the practice as requires improvement for providing safe services because:

- There was a backlog of approximately 1000 unsummarised records.
- The staffing capacity was still at reduced levels which meant delays in improving the provision of services.
- Medicines were not always managed safely. High risk medicines reviews were not always effective.
- There was limited management of safety alerts to ensure appropriate actions were taken to mitigate risk.
- Hospital referrals were not always monitored.

At this inspection we saw that the practice had:

- Addressed areas of concerns noted at our previous inspection in February 2020.
- Patient records had been risk assessed to ensure care and treatment was prioritised where required.

However, we rated the practice as requires improvement for providing safe services because:

- Fire safety processes were not embedded.
- Systems to ensure actions taken to mitigate risk were recorded and communicated by the provider to relevant members of staff were not consistently effective.
- Coding on patient records was not always appropriate to ensure safe care and treatment.
- Information contained in patient records was not always appropriate to ensure patients received care and treatment which met their needs.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Yes
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
There were policies covering adult and child safeguarding which were accessible to all staff.	Yes
Policies took account of patients accessing any online services.	Yes
Policies and procedures were monitored, reviewed and updated.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
Staff who acted as chaperones were trained for their role.	Partial
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
At our inspection in February 2020 we found:	
<ul style="list-style-type: none"> • Safeguarding meetings were not formally minuted. • Multi-disciplinary meetings did not take place on a regular basis. 	
At this inspection we found:	
Regular safeguarding and multi-disciplinary meetings took place and formal minutes were available to show what actions had been taken to safeguard patients. However, not all staff had completed safeguarding training appropriate to their role. We identified two non-clinical members of staff who had not completed the necessary training.	
The practice's chaperone processes were not embedded and did not give effective guidance to staff. Staff we spoke with confirmed this. The policy did not detail what staff should be trained in chaperoning or how frequently they should be trained. Instead, it stated that it was the responsibility of the managers to ensure training required was attended and kept up to date, but this training was not made available to staff by the provider. The practice said that a nurse lead would provide informal training to new nurses on chaperone procedures, but it was unclear if this was extended to any additional clinical staff. Feedback from an advanced clinical practitioner (ACP) was that they had acted as a chaperone but had not received training. We found that the informal training provided by the nurse lead had not been extended to non-clinical staff who also acted as chaperones. Some reception staff had a record of chaperone training however, this had been completed under the previous provider. There was also no process in place to ensure that only those members of staff who had received training were asked to chaperone and instead was reliant on staff declining the request. Following inspection, the practice confirmed that they had a localised standard operating procedure (SOP) for chaperoning but	

Safeguarding	Y/N/Partial
acknowledged that work needed to be done to improve staff understanding. They advised they would be updating the SOP and would look to embed this in practice.	

Recruitment systems	Y/N/Partial
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 if relevant to role.	Yes
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Yes

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: February 2021	Yes
There was a record of equipment calibration. Date of last calibration: February 2021	Yes
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Yes
There was a fire procedure.	Partial
There was a record of fire extinguisher checks. Date of last check: January 2021	Yes
There was a log of fire drills. Date of last drill: 26 February 2020	Yes
There was a record of fire alarm checks. Date of last check: February 2021	Partial
There was a record of fire training for staff. Date of last training: Various dates	Yes
There were fire marshals.	Yes
A fire risk assessment had been completed. Date of completion: October 2020	Partial
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence: Practice fire safety procedures were not embedded. For example: <ul style="list-style-type: none"> • Fire alarm checks were not done consistently. Records showed that the fire alarms had not been checked during several weeks in November and December 2020, and January 2021. • The practice had completed a 'fire risk assessment checklist'. This document was not site specific as it reviewed fire risk for Moredon Medical Centre and three other practice locations managed 	

by the provider. The risk assessment did not accurately identify all potential risk. For example, it did not identify that fire alarm tests were inconsistent and that fire drills had not been completed. The risk assessment checklist asked if the department had taken part in a fire drill in the last 12 months, this was ticked as 'yes' and identified that a further fire drill was due in February 2021. At the time of our inspection, this had not been conducted therefore it was unclear which site included on the checklist this related to.

- There was no indication on the fire risk assessment checklist if actions identified had been completed. For example, it was identified that further fire marshals were required, however there was no target completion date for this, and our inspection indicated that additional fire marshals had not been identified.
- The practice had a fire procedure, but it did not contain all necessary information. For example, it did not identify specific locations where fire extinguishers or firefighting equipment such as fire blankets should be situated on the premises.
- There were two trained fire marshals who covered Moredon Medical Centre and three additional practice sites managed by the provider. Therefore, it was not clear how this worked in practice, as the fire marshals were only able to be at one site at a time. The policy stated that in the absence of a fire marshal, this duty would be undertaken by a nominated person. However it did not detail who the nominated person was, how they would be identified or where this information could be found.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: February 2020	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Various dates	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The practice had completed appropriate premises and security risk assessments. However, a responsible person was not always identified to ensure works were carried out and completed.</p> <p>For example:</p> <ul style="list-style-type: none"> • The security risk assessment identified that additional lone working training should be explored and that CCTV was under review as was the use of covert alarms. There was no documented evidence to determine the outcome from these actions and no responsible person or target date for completion identified. • Items identified on the practice's crime reduction survey included that security alarms should be tested monthly; that a staff signing in and out process was needed; and that there should be lighting in the rear car park. The practice could not demonstrate that they had taken action to minimise these risks or provide information on when the improvements would be made by. The practice said that the risk assessments were due to be reviewed in February 2021 but due to unforeseen circumstances, this had not been done. They advised that a review would be completed by the end of March 2021. • Systems to ensure actions taken to mitigate risk relating to Legionella were recorded and communicated at practice level were not effective. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.) We saw that the practice had a Legionella risk assessment and conducted monthly water temperature checks. When water temperatures were recorded as out of range, we were told that this should be raised with the provider's estates department for them to investigate. However, the practice was unable to show that this was done consistently. Feedback from staff included that they did not get feedback from estates to confirm 	

appropriate actions had been taken to mitigate risk. We saw evidence that the provider held water management meetings every two months where the practice was discussed, however no representative from the practice attended.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Yes
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Yes
Date of last infection prevention and control audit:	
The practice had acted on any issues identified in infection prevention and control audits.	Yes
There was a system to notify Public Health England of suspected notifiable diseases.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: Clinical waste was appropriately stored so that members of the public could not gain access. However, staff told us that the clinical waste bins were too small for their requirements, which meant that they were unable to be closed properly. The practice had raised this on several occasions through the appropriate channels but at the time of inspection, no progress had been made to get larger clinical waste bins. We identified most staff were up to date with their infection prevention and control, however we identified two non-clinical members of staff who had not completed the necessary training.	

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
Comprehensive risk assessments were carried out for patients.	Yes
Risk management plans for patients were developed in line with national guidance.	Yes
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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
There was a process in the practice for urgent clinical review of such patients.	Yes

When there were changes to services or staff the practice assessed and monitored the impact on safety.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in February 2020 we could not be assured that all patients had appropriate risk assessments carried out for their medical needs to address shortfalls identified from a previous provider.</p> <p>At this inspection we found that patients records had been risk assessed using a red, amber, green system. This was to ensure that care and treatment was prioritised effectively for patients who required more immediate intervention.</p>	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referral letters contained specific information to allow appropriate and timely referrals.	Yes
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection in February 2020 we found:</p> <ul style="list-style-type: none"> The practice needed to develop a system to monitor delays in referrals. For example, patients diagnosed for cancer were not always followed up if they failed to attend hospital for an appointment. Following inspection, the practice told us that they had implemented a standard operating procedure (SOP) to ensure referrals for two week wait appointments were actioned, and patients' attendance at appointments in relation to these referrals were followed up in a timely manner Clinical oversight of test results was not always effective. For example, there was evidence that clinicians had not acted on alerts placed on patient records to ensure blood tests were carried out, such as patients on high risk medicines. There was a backlog of approximately 1000 new patient records which had not been summarised. 	

- Records relating to patients with long-term conditions were not always up to date or recorded in line with guidelines.

At this inspection we found:

- The practice had appropriate systems in place to monitor delays in referrals. This process had identified four patients who had not attended their appointments. As a result, the practice contacted them and encouraged them to attend. This system also identified and facilitated follow up if a patient had failed to receive an appointment.
- There were appropriate systems in place for the clinical oversight of test results.
- We reviewed records of patients with long-term conditions and identified that generally information was up to date and recorded appropriately. However, we also identified shortfalls in appropriate coding.
- The practice sent us evidence that they had reduced the backlog of new patient notes waiting to be summarised which was inherited from a previous provider. Following our last inspection, the practice had introduced a standard operating procedure to give guidance to staff on summarising and they had trained additional staff to summarise patient records.
- From March 2020 to February 2021 they reduced the number of records needing to be summarised from 800 to 150. The remaining 150 patient notes in February 2021 also included new patients joining the practice from October 2020.
- Following these improvements, the practice ran a report in September 2020 to identify if there were further historic patient records that had not been identified in the original backlog from previous providers. From this report they identified a further 851 records dating back 20 years which had not yet been summarised. The practice had added these records to their action plan and were in the process of working through these with the completion date set for May 2021. This gave assurance that there were systems and processes in place to identify and manage the summarising of patient records appropriately.

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) (01/10/2019 to 30/09/2020) (NHS Business Service Authority - NHSBSA)	1.02	0.76	0.82	No statistical variation
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). (01/10/2019 to 30/09/2020) (NHSBSA)	11.6%	9.9%	8.8%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and	5.99	4.88	5.34	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2020 to 30/09/2020) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2020 to 30/09/2020) (NHSBSA)	192.1‰	121.1‰	124.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2019 to 30/09/2020) (NHSBSA)	0.87	0.74	0.68	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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
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.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of 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 appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	N/A

Medicines management	Y/N/Partial
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
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 our inspection in February 2020 we found that not all patient medicines reviews had been conducted as required.</p> <p>At this inspection we found:</p> <ul style="list-style-type: none"> • The practice had implemented a new system to ensure patient medicine reviews were conducted as required. • A pharmacy team conducted structured medicine reviews for patients which included patients taking multiple medicines. Patients had been risk assessed to ensure those who required more immediate intervention were reviewed first. • Our inspection indicated that patients received appropriate monitoring and intervention, however coding on patient records was not always accurate to reflect this. For example, we conducted remote searches, prior to inspection, on patients prescribed high risk medicines. Our searches indicated that not all patients on blood thinning medicines had received the necessary monitoring. We raised this with the practice who advised that a number of the patients identified had received the monitoring, however the appropriate code had not been applied to the record. They recognised that coding was an area for improvement. Work was undertaken by the practice to address this between when we conducted the searches and our inspection visit. The practice was able to demonstrate that most patients had received the necessary monitoring, however some patients invited in for a blood test had been unwilling to attend the practice during the Covid-19 pandemic. • The practice had introduced multi-disciplinary team meetings for patients prescribed high dose opioid medicines. (Opioid medicines are used to treat moderate to severe pain.) 68 patients were identified and a GP with a specialist interest in addiction, led in the review of these patients to reduce, and if possible, eventually stop these medicines. 	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	80
Number of events that required action:	80

Explanation of any answers and additional evidence:
 Significant events were reported and investigated effectively. Incidents were discussed at a weekly incident meeting to ensure actions were taken. Learning was shared with clinical staff through team meetings and emails sent to staff. However, there was no process to ensure incident learning sent to staff by email had been read and implemented. For example, feedback from some non-clinical staff included that they didn't get feedback regarding significant events. Our inspection also indicated that not all staff groups had a team meeting to ensure information was shared effectively.

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

Explanation of any answers and additional evidence:
 At our inspection in February 2020 we found that the practice did not have an effective system for acting on safety alerts.
 At this inspection we saw that the practice had a system for acting on recent alerts. However, searches we conducted prior to inspection identified that not all historic alerts continued to be monitored. For example, one of the searches we conducted reviewed patients prescribed a medicine combination previously raised on a medicine alert. 22 patients were identified and we reviewed the records of five of these patients. Out of the five, there was one patient who remained on this medicine combination. We raised this with the practice and on inspection they advised that they had reviewed the patient. They told us that patient was not having any side effects and that they had been informed of the risks associated with this medicine combination. Therefore, a decision had been made for them to remain on the medicines. The practice advised that they would review all 22 patients we had identified to determine if further interventions were required. The practice confirmed that their systems enabled them to review safety alerts issued in the previous 18 months to ensure safe prescribing practices were maintained.

Effective

Rating: Good

We previously rated the practice as requires improvement for providing effective services because there was a delay in the review of outcome measures for patients with long-term conditions. Previous data from the Quality Outcomes Framework (QOF) indicated poor performance for the monitoring of patient outcomes. Improvements had been made when we previously inspected but it was too early to determine the impact.

At this inspection we rated the practice as good for providing effective services because:

- The practice had made improvements in the monitoring of patient outcomes. The Covid-19 pandemic had affected progress, but unverified data provided by the practice demonstrated improvements.

We identified the following areas for improvement:

- Coding on patient records was not always consistent.
- Processes to ensure staff completed and remained up to date with training were not fully effective.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
Explanation of any answers and additional evidence:	
At our inspection in February 2020 we found:	
<ul style="list-style-type: none"> Care and treatment received by patients was not always accurately recorded. For example, we found some instances where appropriate coding had not been added to patient records and treatment was not always delivered in the recommended time scales. Templates used to effectively record care and treatment for a patient's condition were not always used appropriately to accurately record the treatment patients received. 	
At this inspection we found:	
<ul style="list-style-type: none"> While improvements had been made, we found that coding was not always consistently applied. For example, we reviewed records of patients diagnosed with dementia or other mental health conditions. We identified that while these patients received care in line with guidance, this was not always coded appropriately in their record. The practice was aware that coding was still an area for development and had identified actions to assist continued improvement. We reviewed records of patients with a possible missed diabetes diagnosis. Our searches indicated that there were 17 patients which fell into this category. We raised this with the practice who reviewed all patients identified and on inspection they confirmed that patients had not been coded appropriately. The practice identified that 15 out of the 17 patients were receiving appropriate care and one patient was in remission. The practice did advise that one patient had not received the necessary monitoring and they were in the process of contacting them to bring them in for review. Clinical templates, specific to each long-term condition were being consistently used to ensure accurate information was available at all times. The practice had implemented a plan to ensure the monitoring and management of patients with long term conditions continued to improve. The action plan identified seven areas for improvement; four of these had been completed; two would remain under regular review; and one 	

action which focused on improving the sustainability and implementation of QOF, would be completed by April 2022.

- The practice ran regular reports to monitor progress against targets. This showed that between July 2020 and January 2021 there was a reduction in the number of patients with long term conditions whose monitoring had not been carried out at the recommended intervals.
- The practice had risk assessed patients with long term conditions to identify patients in higher risk groups in order to prioritise their care and ensure they were reviewed first. For example, patients diagnosed with diabetes who had high blood sugar levels were prioritised for review. Results of this intervention showed blood sugar levels for these patients had improved with some levels now in normal limits.

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs. All patients discharged with a diagnosis of Covid-19 received a welfare call from a clinician to ensure their support needs were met.
- A virtual multi-disciplinary ward had been set up to support complex patients in the community in collaboration with the local hospital's community services. Weekly virtual ward rounds were held and we saw that one patient had received hourly monitoring, without which, admission to hospital would have been unavoidable.
- Links with local elderly care consultants had been established, which provided immediate clinical support for clinicians at the practice. This ensured patients gained the care they needed without the necessity for referral or admission.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, would normally be offered to patients over 75 years of age, however these had been suspended temporarily due to the Covid-19 pandemic.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- All care home residents had received their first Covid-19 vaccination.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured 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. For example, the practice was working closely with the local hospital diabetic specialist teams, to discuss complex patients and gain advice on their management without the need for referral.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice was also in the process of training advanced care practitioners (ACPs) to carry out long term condition reviews to further increase capacity.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions. The practice worked closely with local hospital specialists to discuss complex patients and gain advice on their management without the need for referral.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	50.2%	75.3%	76.6%	Significant Variation (negative)
PCA* rate (number of PCAs).	3.4% (30)	10.8%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	45.9%	86.2%	89.4%	Significant Variation (negative)
PCA rate (number of PCAs).	2.0% (6)	12.9%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	65.8%	80.3%	82.0%	Significant Variation (negative)
PCA rate (number of PCAs).	3.3% (10)	5.6%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	49.9%	66.1%	66.9%	Variation (negative)
PCA rate (number of PCAs).	5.2% (43.0)	17.2%	15.3%	N/A

The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	58.4%	71.4%	72.4%	Variation (negative)
PCA rate (number of PCAs).	4.3% (61.0)	7.4%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.6%	92.6%	91.8%	No statistical variation
PCA rate (number of PCAs).	0.0% (0)	4.5%	4.9%	N/A

Any additional evidence or comments

The current provider did not take over the running of the practice until November 2019 therefore the data provided above also relates to the monitoring of patients under a previous provider.

On this inspection we reviewed unverified data for the period 1 April 2020 to 01 February 2021. During this period, the Covid-19 pandemic had severely impacted the number of patients who could be seen face to face to carry out certain aspects of monitoring, for example, blood pressure readings. We were also told that significant numbers of patients were reluctant to attend the practice during this time due to fear of infection. In addition to this, for some indicators the data cannot be directly compared as the indicators changed in April 2020. The practice had prioritised high risk patients for review.

Unverified data provided by the practice showed:

- The percentage of patients with COPD (chronic obstructive pulmonary disease) who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale was 57%.
- The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg was 57%.
- The percentage of patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, who are currently treated with anti-coagulation drug therapy was 86%.

At the time of inspection, no personal care adjustments (PCA) had been applied.

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for all five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. Records were maintained and monitored for children who had not attended to be immunised. One to one conversations were held with the parent or guardian of the child to encourage attendance and a referral to the health visitor and safeguarding were made when appropriate.
- The practice had implemented a standard operating procedure (SOP) on how to deal with those who had not attended a clinic or had attended A&E. Guidance included that this would be raised with the safeguarding team and a clinician who would assess if there were previous concerns. If there were, this would then be escalated further for discussion and appropriate actions taken.

- The practice held monthly safeguarding multi-disciplinary meetings where they would discuss cases and share information. We saw evidence where this process had resulted in a good outcome for a patient and her newborn child.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	163	174	93.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	161	171	94.2%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	162	171	94.7%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	161	171	94.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	176	193	91.2%	Met 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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- Appointments were available from 7.30am to accommodate those patients who were working.

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 30/06/2020) (Public Health England)	71.3%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) (PHE)	70.4%	74.4%	70.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	52.8%	61.1%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) (QoF)	11.1%	89.3%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) (PHE)	51.7%	56.7%	54.2%	No statistical variation

Any additional evidence or comments

The current provider did not take over the running of the practice until November 2019 therefore some of the data provided above also relates to the monitoring of patients under a previous provider.

We reviewed unverified data of the current provider for the period 1 April 2020 to 1 February 2021. During this period, the Covid-19 pandemic had impacted on the number of patients who could be seen face to face to carry out cervical screening. The unverified data showed:

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) was 72%.

The practice had identified actions in order to improve uptake, however the Covid-19 pandemic had impacted on this. For example, additional staff were going to be trained to undertake cervical screening,

but the course had been cancelled twice during the pandemic. Additional actions to improve uptake included:

- Women who failed to attend for screening, received a telephone call to encourage attendance.
- Early morning and late evening appointments were available.

We also discussed the low percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. This had already been identified by the practice as a coding error and actions had been identified to address this.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check. The learning disabilities nurse from the local hospital offered regular drop-in sessions for these patients to provide support.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- Two mental health nurses had recently been recruited to provide daily clinics for these patients.
- The practice worked collaboratively with the local Trust and developed an action plan and a mental health pathway to improve the care for these patients.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	4.6%	78.8%	85.4%	Significant Variation (negative)
PCA rate (number of PCAs).	2.7% (3)	20.3%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	11.1%	81.5%	81.4%	Significant Variation (negative)
PCA rate (number of PCAs).	10.0% (6)	8.9%	8.0%	N/A

Any additional evidence or comments

The current provider did not take over the running of the practice until November 2019 therefore some of the data provided above also relates to the monitoring of patients under a previous provider.

We reviewed unverified data of the current provider for the period 1 April 2020 to 1 February 2021. During this period, the Covid-19 pandemic had impacted on the number of patients who could be seen face to face.

Unverified data provided by the practice showed that improvements had been made. For example:

- The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 67%.

Monitoring care and treatment

The practice had a programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	331.79	Not Available	533.9
Overall QOF score (as a percentage of maximum)	59.4%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	3.3%	Not Available	5.9%

Y/N/Partial

Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Yes
Quality improvement activity was targeted at the areas where there were concerns.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

Any additional evidence or comments

At our inspection in February 2020 we found that the practice had not conducted any clinical audits.

At this inspection we found:

- The practice had registered to take part in the 2021 National Core Diabetes Audit which enables practices to benchmark themselves against other practices. However due to the Covid-19 pandemic, this year's audit had been cancelled.
- Monthly coding audits were undertaken to ensure continued improvement and that the correct coding supported improved clinical care.
- An audit was carried out to determine whether patients with a diagnosis of severe mental health were given the appropriate quality of care to address their physical as well as their mental health needs. Six criteria were used to benchmark the standards of care being achieved. These included blood pressure, weight and smoking status. The initial results demonstrated that only 23% of patients had had all six criteria assessed. Actions for improvement included that from September 2020 patients were sent a letter during the month of their birth, inviting them to the surgery to attend a physical health check. We saw that the second cycle of this audit would be carried out in August 2021.
- Clinical guardian audits were carried out quarterly (clinical guardian is a toolkit which audits a percentage of every clinician's work). Clinicians were given individual feedback and overall learning was fed back to all clinicians. The November 2020 learning report highlighted minimum standards for prescribing, safety netting and the need to document specific red flags.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Partial
The learning and development needs of staff were assessed.	Yes
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes

There was an induction programme for new staff.	Yes
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>Processes to ensure staff completed and remained up to date with training were not fully embedded. For example, we identified five non-clinical members of staff who had not completed or were up to date with their training. Gaps were identified for equality diversity and human rights, fire safety, safeguarding and infection prevention and control. Following inspection, the provider confirmed that they had a training compliance target of 80-100% as set out in their training policy and that their current compliance was above their 80% target.</p>	

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Yes
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	N/A
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in February 2020 we found that the practice was unable to demonstrate that all relevant information was available to be shared with other services when needed. A backlog of unreviewed correspondence meant information was not always accurate, valid, reliable and timely.</p> <p>At this inspection we found that all correspondence was dealt with in a timely way to ensure appropriate information was available.</p>	

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
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The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in February 2020 the practice was unable to give assurance that patients who needed additional support would be identified and prioritised.</p> <p>At this inspection we found that the practice had risk assessed patients to ensure that care and treatment was prioritised in an effective manner.</p>	

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
The practice monitored the process for seeking consent appropriately.	No
Policies for any online services offered were in line with national guidance.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in February 2020 we found that the practice did not have a process to formally monitor whether consent had been obtained and recorded appropriately.</p> <p>At this inspection we reviewed patient records and identified that where appropriate, consent had been recorded, but the practice had not implemented a process to formally monitor whether consent had been obtained and recorded appropriately.</p>	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes

Source	Feedback
Care home whose residents were registered with the practice	Feedback from the care home included that the advanced care practitioner (ACP) supported patients and that they had developed an understanding and positive relationship with residents who were registered at the practice.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	76.5%	90.5%	88.5%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	77.0%	90.0%	87.0%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	82.3%	96.7%	95.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	48.8%	84.7%	81.8%	Significant Variation (negative)

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	No

Any additional evidence

While the practice had not conducted patient surveys since our last inspection, they were due to hold a public virtual meeting with patients in March 2021 with the intention for this to become a routine engagement. Patients were told of the event using social media and would be encouraged to submit questions prior to the meeting to ensure all questions could be answered.

The practice was in the process of bringing patients together to create a patient participation group.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

Source	Feedback
Interviews with patients.	<p>Due to the Covid-19 pandemic we conducted remote patient interviews for this inspection. We spoke with three patients registered at Moredon Medical Centre. Feedback included that they felt supported, listened to, and that the clinician explained their care and treatment. We received mixed feedback regarding reception staff with patients advising that while reception staff could be helpful, they could also be quite abrupt.</p> <p>On inspection we saw that when the practice received complaints regarding reception staff attitude, the call was listened to and feedback given to the member of staff involved. They would then be asked to reflect on the call for their own learning.</p>
NHS choices website	<p>At the time of inspection there had been four reviews from patients for 2021.</p> <p>Two reviews gave five out of five stars. Comments included that staff were supportive, friendly and helpful and that they had been well looked after by all staff.</p> <p>Two reviews gave one out of five stars. Comments included that the telephone system was not fit for purpose and that one of the patients was unable to access a routine appointment.</p>

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	82.1%	94.7%	93.0%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 199 carers which represented 1.62% of the patient population.
How the practice supported carers (including young carers).	<ul style="list-style-type: none"> The Reception manager had regular contact with the health liaison officer at Swindon Carers. Patients identified as carers could be referred to this service. The provider hosted a carer drop-in at the one of their additional locations which patients from Moredon Medical Centre could attend. The drop-ins were run by Swindon Carers. However due to the Covid-19 pandemic, these had moved to virtual meetings. The practice advised that once it was safe to do so, face to face drop ins would resume. The website contained information on how to register as a carer as well as other signposting information for support available.
How the practice supported recently bereaved patients.	The practice made welfare calls to recently bereaved patients.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Yes
Consultation and treatment room doors were closed during consultations.	Yes
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Good

We previously rated the practice as requires improvement for providing responsive services because improvements were needed for patients to access services in a timely manner and to ensure continuity of care.

At this inspection we rated the practice as good for providing responsive services because improvements had been identified and implemented to ensure patients could access services in a timely manner.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes
Explanation of any answers and additional evidence: The practice had set up a two-weekly welfare call to a patient experiencing a deterioration in their mental health. The practice had identified that this patient had exhibited challenging behavior towards staff and had experienced a deterioration in their condition. The practice set up a consultation with the patient and agreed that that they would receive a welfare call from a GP to enable support and reduce anxiety. The practice also recognised that this intervention could be increased if the measures in place were not effective.	

Practice Opening Times

Day	Time
Opening times:	
Monday	7.30am to 8.00pm
Tuesday	7.30am to 8.00pm
Wednesday	7.30am to 8.00pm
Thursday	7.30am to 8.00pm
Friday	7.30am to 8.00pm
Appointments available:	
Monday	7.30am to 8.00pm
Tuesday	7.30am to 8.00pm

Wednesday	7.30am to 8.00pm
Thursday	7.30am to 8.00pm
Friday	7.30am to 8.00pm

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues. A home visiting service for all housebound patients was offered. An advanced care practitioner (ACP) and frailty ACP were responsible for patients with enhanced needs. This included any acute medical problems as well as annual reviews.
- Patients were referred as appropriate to the local Live Well hub. The hub offered support to those isolating during Covid-19 lockdowns.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available from 7.30am to 8pm Monday to Friday for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

- To improve communication with all age groups the practice engaged with social media, these sites were updated regularly with information including specific health information for young people.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- During the Covid-19 pandemic, telephone consultations became the default for GP and ACP consultations. These were available Monday to Friday 8.30am to 6.30pm.
- The practice was open until 8pm on a Monday and Friday. Pre-bookable appointments were also available to all patients at additional locations within the area.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice offered appointments early in the morning or later in the day as required.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Yes
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Yes
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Yes
Explanation of any answers and additional evidence: The practice employed advanced care practitioners (ACPs) to assess and undertake urgent on-the-day care. This included: <ul style="list-style-type: none"> • Triaging requests for on the day appointments and home visits. • Supporting the call handlers and the bypass telephone line used by care homes and other urgent care services. • Conducting home visits within their competencies or with the support of a GP. 	

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2020 to 31/03/2020)	17.1%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	33.3%	68.8%	65.5%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	49.6%	67.2%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	62.5%	76.1%	72.7%	No statistical variation

Any additional evidence or comments

<p>The practice was aware of areas which needed improvement in the national GP patient survey.</p> <ul style="list-style-type: none"> • They were aware of the difficulty patients faced in accessing the telephone system and following our last inspection, had implemented changes to improve this. The practice had employed more call handlers and were working closing with the phone providers to identify problems and improvements. Improvements already implemented included reducing the number of phone lines coming into the practice from 50 to 20. This meant patients were not faced with a message of being in a long call queue which had previously encouraged high call abandonment rates. • The practice had also identified an action plan with six actions with target completion dates. We saw that two of these had already been completed and one was on track for completion. Future

improvements included call navigation options for patients and training additional administration staff to take calls during peak times or as required.

At the time of inspection, the practice had seen an improvement in the average call wait times when compared with call volume. For example;

- November 2020:
Average call wait time – approx. 12 minutes
Average call volume – approx. 550 daily calls
- December 2020:
Average call wait time – approx. 7 minutes
Average call volume – approx. 525
- January 2021:
Average call wait time – approx. 12 minutes
Average call volume – approx. 475
- February 2021 (at the time of inspection):
Average call wait time – approx. 10 minutes
Average call volume – approx. 525

The practice had a data administrator who was responsible for collating the daily call data. The data administrator shared the information with the practice clinical and quality leads as well as with the operational team who oversaw the call hub. When call volumes fluctuated above expected levels it impacted on call abandonment rates and average wait times. However, the practice advised that the fluctuations often coincided with national factors. For example, in November, the practice saw an increase in call volume. This related to patients calling the practice for advice after receiving unexpected shielding letters from NHS England and Improvement. In response to unexpected increases in call volume, the practice had recruited ‘bank’ call handling staff. At the time of inspection, these staff had just finished their induction.

The practice also advised that each time they received a complaint regarding the phone system, they ensured the patient received a response and that they detailed the actions being taken to improve access.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	55
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	3

Y/N/Partial

Information about how to complain was readily available.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence:	
<p>The practice's complaints process ensured complaints were handled in a timely way and actions taken were documented. However, feedback from staff included that they did not always get feedback regarding complaints.</p> <p>Systems were not fully embedded to ensure all verbal complaints were recorded to ensure themes could be identified. The provider's complaints handling department (PALS) recorded all written and verbal complaints to ensure they could conduct analysis on themes and trends. However, we identified that some verbal complaints which had been raised at the practice and resolved in 24 hours, were not always submitted to PALS in line with the practice's standard operating procedure. This meant that the analysis conducted would not contain all relevant data.</p> <p>The practice told us that they wanted to encourage further improvements through the complaints process. This would involve inviting patients whose complaints had been resolved, into the practice to discuss the events and the impact it had on them. This process was currently on hold due to the Covid-19 pandemic.</p>	

Well-led

Rating: Requires improvement

We previously rated the practice as requires improvement for providing well led services because:

- Improvements were required regarding governance systems, accurate and reliable data being available to inform patient care, the management of risks, and patient and staff engagement.
- The provider's action plan for improvement did not always contain enough detail to show how the areas of lower performance would be improved in a timely way.
- Not all areas identified for improvement by the provider had been implemented.

At this inspection we found that the practice had introduced platforms to engage with staff, and patient engagement opportunities had been organised to take place in 2021.

However, we have rated the practice as requires improvement for providing well led services because:

- Assurance systems had been implemented but they were not fully effective. For example, fire safety, risk assessments, staff training and staff acting as chaperones.
- Systems and processes did not ensure that patients records were consistently accurate and kept up to date.

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.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes

There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence:	
At our inspection in February 2020 we found that the practice had not implemented all actions on their improvements plans due to the significant improvements required.	
At this inspection we found:	
<ul style="list-style-type: none"> The practice had made significant developments and continued to learn and improve the service. They were aware of the areas where there were shortfalls and were putting measures in place to address them but were also aware that initially some areas required prioritisation. For example, they had prioritised ensuring patients received the necessary health reviews to ensure safety. However, the practice was aware that the absence of a practice operational lead had led to inconsistent processes. They had advertised for this role, but the candidates had not met the required criteria, therefore the practice were due to re-advertise the role. 	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Yes
There was a realistic strategy to achieve their priorities.	Yes
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Yes

The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence: Feedback from staff included that they had seen an improvement in practice culture over the last nine months and that everyone was working towards the same goal of improving the patient experience. The provider, Great Western Hospitals NHS Foundation Trust, maintained oversight of processes at location level. However, feedback from staff included that the provider did not have a clear understanding about the requirements of primary care which had resulted in a disconnect with organisational policies and procedures.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Remote staff questionnaires	Feedback included: <ul style="list-style-type: none"> • Everyone was welcoming and helpful • The team including the clinical leads and senior staff were friendly and approachable • Staff supported each other • Improvements recognised over the last 18 months • Views were listened to and acted on however some staff also commented that they did not feel this was always the case.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management, but these were not always effective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: At our inspection in February 2020 we found: <ul style="list-style-type: none"> • There was no evidence of quality improvement or an established programme, for example clinical audit activity. • We could not be assured that all patients would have appropriate risk assessments carried out for their medical needs. • An unsummarised records backlog created by the previous provider had not been resolved. • Systems designed to demonstrate care and treatment, provided in line with recommended timescales, showed poor performance results. Some records reviewed did not contain appropriate coding. At this inspection we found: <ul style="list-style-type: none"> • The practice had a programme of quality improvement. • The practice had implemented a system to risk assess patients' needs to ensure care was prioritised where needed. 	

- The practice had implemented effective systems to summarise patient records in a timely way.
- The practice demonstrated processes had been implemented to monitor patient outcomes more effectively.

We also found:

- Processes to ensure coding was consistently applied were not fully effective. However, the practice recognised that coding was still an area for improvement and before inspection, had organised for an external company to attend the practice and give training to staff.
- Systems introduced by the provider to review and implement new policies at practice level did not ensure this was done in a timely way. We were told that it could take, on average, three months to implement a new policy due to the provider's review process. A policy would be reviewed and amended at practice level, it would then be passed to the relevant department at the provider who would conduct their assurance processes and make any required amendments. Feedback we received included that the provider could 'hold up' the process. When completed, the policy would be fed back to the practice who would communicate the change to staff. Out of 79 policies requiring review, 85% had been completed, 14% were in progress and 1% showed as 'no progress'.
- Feedback we received from staff included that practice policies made it difficult for staff to access relevant information. Staff said that policies contained information relevant to the provider and staff working in different clinical settings, but this made the policies extensive and it was difficult to navigate to the information they needed.
- Policies were not always easily accessible to staff. We identified that policies were kept in a number of places which made access to guidance difficult. We asked two separate members of staff to access different policies on their system. We asked them to access the Hypertension SOP and the whistleblowing policy. Both were unable to locate the policies at the time requested.

Managing risks, issues and performance

The practice did not always 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.	Partial
There were processes to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
Explanation of any answers and additional evidence: At our inspection in February 2020 we found: <ul style="list-style-type: none"> • The practice had recently implemented assurance systems, but it was too early to assess their effectiveness. • Managing performance of patient outcomes of patient outcomes required improvement. • There was limited internal audit and quality improvement activity. 	

- Systems to identify risk to patients required improvement.

At this inspection we found:

- Improvements had been made to practice oversight of patient outcomes. The practice had a quality and outcomes framework (QOF) data administrator who collected information and fed back to the practice's clinical and quality leads. Improvements had been made and patient risk assessments ensured that care and treatment had been prioritised where appropriate.
- The practice had a programme of clinical audit.
- The practice had implemented a system to identify risks to patients.

We also identified that assurance systems had been implemented but these were not always effective. For example;

- Systems to ensure staff had completed mandatory training required by the practice were not fully implemented. For example, safeguarding and infection prevention and control.
- Systems to identify and act on risk such as fire, Legionella and security were not effective, and risks were not always mitigated and accurately recorded.
- The practice did not have appropriate oversight of their chaperone processes and could not be assured that staff acting as chaperones had received relevant training to do so. Feedback from staff also indicated that the practice chaperone policy was not embedded.
- There was not always effective communication between the practice and the provider. For example, the practice did not always receive feedback regarding actions taken in response to risk.

Following inspection, the practice sent us evidence that they held incident and risk review panels where they would discuss concerns relating to incidents, safeguarding, safety alerts and emerging risks. However, there was no evidence to demonstrate that the risks identified on inspection relating to fire, Legionella and security had been discussed during these meetings.

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 adjust and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Yes

Explanation of any answers and additional evidence:

At our inspection in February 2020 we found that information and data relating to patients was not always accurate or recorded appropriately.

At this inspection we found that systems to ensure appropriate coding was applied to patient records required further improvement to ensure accurate records were maintained.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice told us that they did not currently have a patient participation group and progress in setting the group up had been hindered by the Covid-19 pandemic. However, they advised that they had a list of patients interested in participating and had some preliminary future dates to begin the engagement.</p> <p>Feedback from staff included that the majority felt listened to and that when suggestions were made the practice implemented them. For example;</p> <ul style="list-style-type: none"> • It was previously necessary for children requiring a blood test to attend the hospital. However, a health care assistant (HCA) working for the practice had previously been trained in paediatric phlebotomy and suggested that they could take the blood tests rather than patients transferring between services. The practice took this on board and implemented the change in process. At the time of inspection, the HCA was conducting all paediatric blood tests. • However, some feedback from non-clinical members of staff included that while they felt supported and could raise concerns, their views were not acted on. • Communication with all staff groups was not consistent and did not ensure all staff received and understood necessary information. While we saw evidence that regular clinical meetings were being held, team meetings for non-clinical members of staff had not taken place for the two months prior to inspection. It was also unclear when these would be reinstated. We were told that information was disseminated to staff using emails however this process did not ensure staff read and understood information relevant to their role. Conversations with staff on inspection also indicated that they did not always read the information sent to them in this format. The practice had recently introduced a site and reception manager who, at the time of inspection, had been in post for 3 weeks. They told us that they intended to reintroduce reception team meetings. <p>Positive feedback had been received from a care home whose residents were registered at the practice regarding the continued service and support they receive from the advanced care practitioners.</p>	

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our inspection in February 2020 we found that while learning and sharing was evident to ensure improvements, this was not always done in a structured way.</p>	

At this inspection we saw evidence of learning and sharing of information, but it was not always effective. The practice was aware that there were areas which required additional focus and that the operational teams would benefit from a consistent management structure. The provider had recently appointed a deputy divisional director who was due to start their role in March 2021 and they were also due to re-advertise for the role of an operational manager at practice level. The implementation of these roles would offer greater oversight of the operational teams to ensure processes were consistent.

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. 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 women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women 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.
- **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.

- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.