

Care Quality Commission

Inspection Evidence Table

Moredon Medical Centre (1-553733346)

Inspection date: 09 November 2018

Date of data download: 07 November 2018

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

Safe

Rating: Inadequate

At our previous inspection on 4 August 2015, we rated the practice as good for providing safe services. At this inspection we found several new concerns and rated the practice as inadequate for providing safe services.

Safety systems and processes

The practice did not always have clear and effective 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.	N
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
Systems were in place to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required	Partial
Staff who acted as chaperones were trained for their role.	Y
The provider had regular discussions with health visitors, school nurses, community midwives, social workers etc. to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

We saw documentary evidence of appropriate safeguarding referrals and safeguarding cases that were managed appropriately. However, this was not given sufficient priority at all times.

- There had been no internal clinical meetings to discuss safeguarding risks, vulnerable patients and other safeguarding issues since June 2018;
- There was no safeguarding lead at the time of the inspection.

The practice had recently (in the last two months) recruited a specialist safeguarding nurse who would be responsible for all safeguarding activities for the practice. At the time of the inspection the newly recruited nurse had not commenced their employment at Moredon Medical Centre.

The practice could not provide evidence or assurance that all staff had a recent and relevant DBS check, where required. We found gaps in relevant DBS information in five recruitment files. Three of the five files did not contain a DBS check, or a risk assessment outlining the reasons why one had not been not undertaken.

Practice staff told us there was a risk register of specific patients, but they were unable to provide this, as the information was recorded on an old IT system they no longer had access to.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	No
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Partial
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	No
Staff who required medical indemnity insurance had it in place.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>There was a recruitment check process for all staff, however these were not operated effectively. At the time of the inspection we found staff records did not include all information relevant to their employment and, since current and existing staff were not on the new system, the practice could not confirm their registration was up to date. We found a recruitment file did not exist for one GP, and the practice could not confirm their medical indemnity insurance was in place. Our additional checks identified the GP was registered with the professional body.</p> <p>Additionally, there were gaps in relevant information in the five recruitment files we reviewed. None of the five staff files we looked at contained information about full employment history, evidence of previous satisfactory employment conduct, medical indemnity insurance or an induction checklist. Only one file contained evidence of verified qualifications and only two files contained a signed employment contract. When we spoke to the General Manager about this, they told us they recognised the lack of appropriate data in the staff files, which had been inherited from the previous practice management. However, no further action had been taken to address the identified shortfall.</p> <p>Practice staff told us they had a new processes in place for ensuring all clinical staff remained on the appropriate professional register and staff were appropriately vaccinated. However, at the time of inspection, current and existing staff records were not on the new system. We asked the General Manager</p>	

to provide evidence that all staff had received up to date vaccinations. We saw up to date vaccination records for all staff except for one staff member, where evidence of the Hepatitis B vaccine was not provided.

The General Manager was unable to provide evidence that staff had the required medical indemnity insurance in place, because the information was recorded on an old IT system they no longer had access to.

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:	N
There was a record of equipment calibration. Date of last calibration:	Y 28/08/18
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals.	Y
Fire procedure in place.	N
There was a record of in date fire extinguisher checks. Date of last check:	Partial August 2016
There was a log of fire drills. Date of last drill:	N
There was a record of fire alarm checks. Date of last check:	Y 02/11/2018
There was a record of fire training for staff. Date of last training:	N
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion:	Partial 01/04/2015
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

The monitoring of fire safety systems was not always effective or well managed. The practice told us that staff had completed on-line fire safety training. However, the previous management team had left without providing access to the full electronic fire training records. We saw fire training certificates in only two of the individual staff files. When we spoke to (seven out of 13) staff, they told us they had completed fire training, but were unable to confirm when they last undertook the training and were unsure of the dates and content. Six other members of staff told us they had not received any fire safety training.

The last fire risk assessment was dated 1 April 2015 and had not been updated when the building layout had been changed to allow the SUCCESS (Swindon Urgent Care Centre and Expedited Surgery Scheme) Clinic, which was a different service, to move into the building. Additionally, there was no formally recorded evidence that the actions recommended in the risk assessment had been completed.

There was no documented fire safety procedure in use within the practice. We asked for evidence of partnership working with the clinic in relation to fire safety and evacuation. The General Manager had not made arrangements to ensure appropriate and effective fire safety or evacuation procedures with other users of the building. There were no recent fire drills recorded and fire extinguishers had not been serviced since August 2015. On the day of inspection all fire exits were clear and some of the staff we spoke with understood their role in fire evacuation.

Health and safety Premises/security risk assessment carried out. Date of last assessment:	N
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Health and safety risk assessment and actions Date of last assessment:	N
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Explanation of any answers and additional evidence:
At the time of the inspection, we did not identify any visible health and safety related risks. However, systems and processes to assess and manage health and safety or premises risks were not effective or well managed. We asked the General Manager for evidence of health and safety risk assessments. They told us that weekly premises and health and safety checks were undertaken, but there were no formal records of these assessments.

Infection control

Systems to ensure appropriate standards of cleanliness and hygiene were not being met.

	Y/N/Partial
Infection risk assessment and policy in place	N
Staff had received effective training on infection control	N
Date of last infection control audit:	N See comments*
The provider had acted on any issues identified in infection control audits.	N See comments*
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:
During the inspection we observed the practice to be visibly clean and tidy and we noted an up to date cleaning rota. However, practice systems were not effectively assessing the risk in relation to the prevention, detection and control of the spread of infection.
*The practice was unable to provide evidence of the latest infection prevention and control audit, up-to-date staff training records for infection prevention and control and when the practice last had an infection control lead. This was due to the relevant electronic records being stored on a system which the existing practice staff no longer had access to.

Risks to patients

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

Question	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
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.	Y
There was a process in the practice for urgent clinician review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the provider assessed and monitored the impact on safety.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Practice staff told us staffing levels were being continually reviewed, and that identified staff shortages were being addressed. However, some staff we spoke to told us their concerns relating to low staffing levels and its impact on the quality of patient care, had not been considered or acted upon by senior colleagues. We did not see documentary or other evidence of identified staff shortages.</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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Partial
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The provider demonstrated that when patients use multiple services, all the information	Y

needed for their ongoing care was shared appropriately and in line with relevant protocols.	
<p>Explanation of any answers and additional evidence:</p> <p>There was a system to process referral letters and to monitor delays. We saw no evidence of delays to urgent referrals, but we saw evidence that the average time for routine referral letters to be processed had increased over the last two months. On the day of inspection routine referral letters were being processed with a five week delay.</p>	

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	0.96	0.85	0.95	Comparable with other practices
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). (01/07/2017 to 30/06/2018) (NHSBSA)	12.2%	9.9%	8.7%	Comparable with other practices

Medicines management	Y/N/Partial
The provider had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	N
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	N
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
Patients were appropriately informed when unlicensed or off-label medicines were prescribed.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y

The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y
Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y
Patients' health was monitored in relation to the use of medicines and followed up on appropriately.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We found prescription pads stored in different locations around the practice and no central record of their storage. We found unfilled prescriptions for Controlled Drugs among routine prescriptions in an unsecured room. When we raised this with practice staff, they told us they would ensure the room would be secured during the inspection. We later visited the room and saw that it was secured with lock and key.</p> <p>There was an annual audit of prescribing levels undertaken with the clinical commissioning group (CCG) prescribing advisor. However, there was no practice system or process to audit prescribing patterns or to assess prescribing impact, safety and quality. When we spoke to staff, they told us the practice had recently recruited a pharmacist who would conduct prescribing audits as part of their role. The pharmacist had commenced their employment with the practice, in October 2018, and at the time of inspection had not conducted any audits.</p>	

Track record on safety and lessons learned and improvements made

The practice did not always learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	N
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	N
Number of events recorded in last 12 months.	See comments
Number of events that required action	See comments
<p>Explanation of any answers and additional evidence:</p> <p>Staff were encouraged to raise any areas of concern relating to safety. However, there was no current process for learning from significant events, to ensure quality improvement or enhance patient care. For example, there were no regular reviews of the causes of significant events, annual reviews, or evidence of learning being disseminated to staff.</p>	

The general manager could not confirm whether significant events from the previous 12 months had been recorded or that there was evidence of learning and dissemination of information on the practice system. This was due to the relevant electronic records being stored on a system which the existing practice staff no longer had access to. Additionally, no significant events had been reported or recorded after September 2018.

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

Event	Specific action taken
None recorded since September 2018. Records from the previous 12-18 months as stored on an inaccessible system.	None recorded. Not available due to existing staff not having access to the practice electronic records.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understand how to deal with alerts.	Y
Explanation of any answers and additional evidence: All incoming alerts were disseminated to the appropriate person for action. We saw documentary evidence that all relevant alerts had been actioned.	

Effective

Rating: requires improvement

Please note: QOF data relates to 2016/17 unless otherwise indicated

Effective needs assessment, care and treatment

The practice continues to be rated good for providing effective services

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients' treatment was regularly reviewed and updated.	Y
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Y

Effective needs assessment, care and treatment

Prescribing				
Indicator	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	0.94	0.92	0.83	Comparable with other practices

Older people

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication. The practice carried out structured medication reviews for older patients. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. The practice followed up on older patients discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs. Patients could access a community navigator, employed by Swindon Borough Council. The community navigator supported patients to become more independent and use community services to prevent isolation and mental health problems. Patients were alerted to the navigator through their GP.

Findings	
<ul style="list-style-type: none"> Patients with long-term conditions had 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. Staff who were responsible for reviews of patients with long-term conditions had received specific training. Clinical staff opportunistically offered reviews if patients had failed to attend previous appointments. GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. The practice was able to demonstrate how they identified patients with commonly undiagnosed conditions. For example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. Patients could attend clinics for multiple conditions. For example, patients could attend one clinic for both diabetes and asthma. The practice followed up on patients with long-term conditions discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs. The practice was below local and national averages for diabetes and asthma indicators, and had high exception reporting for diabetes indicators. When we spoke to the practice about this data, they stated they were unclear about the reasons, but cited a range of factors. These included poor compliance on behalf of patients, and the lack of a GP lead for diabetes care. 	

Diabetes Indicators				
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.9%	78.2%	78.8%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	18.2% (157)	19.0%	13.2%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	80.3%	75.4%	77.7%	Comparable with other practices

QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	8.7%	(75)	12.2%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	76.7%	76.7%	80.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	17.7%	(153)	19.1%	

Other long term conditions				
Indicator	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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.5%	76.8%	76.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.7%	(22)	5.3%	
Indicator	Practice	CCG average	England average	England comparison
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 (01/04/2017 to 31/03/2018) (QOF)	82.8%	90.0%	89.7%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.7%	(13)	11.2%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	80.8%	83.4%	82.6%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.5% (46)	4.5%	4.2%	
Indicator	Practice	CCG average	England average	England comparison
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 (01/04/2017 to 31/03/2018) (QOF)	81.8%	89.0%	90.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	2.5% (5)	4.4%	6.7%	

Any additional evidence or comments

The practice was slightly below local and national averages for its percentage of patients with COPD, who had had a review undertaken by a healthcare professional, which included an assessment of breathlessness. The general manager told us this was due to a temporary staff shortage relating to the time period when the data was collected. We looked at more recent ongoing data which did not show a substantial improvement. The practice was aware of this, and told us they had now employed a COPD nurse, who had recently started work at the practice, to improve figures.

Findings
<ul style="list-style-type: none"> Childhood immunisation rates exceeded the World Health Organisation (WHO) target uptake of 95% or above. 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. The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary. The practice is a 'breastfeeding welcome' centre.

Child Immunisation				
Indicator	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017) <small>(NHS England)</small>	145	149	97.3%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) <small>(NHS England)</small>	152	160	95.0%	Met 95% WHO based target (significant variation positive)
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) (01/04/2016 to 31/03/2017) <small>(NHS England)</small>	152	160	95.0%	Met 95% WHO based target (significant variation positive)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) <small>(NHS England)</small>	153	160	95.6%	Met 95% WHO based target (significant variation positive)

Working age people (including those recently retired and students)

**Population group rating:
Requires Improvement**

Findings

- 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 triaged to determine if they had an acute health concern could be offered faster appointments at local SUCCESS centres. One of the SUCCESS clinics was based in the same building as the practice location, and was operated by a company named Medvivo, on behalf of NHS Swindon CCG. We did not inspect this service during this inspection.

The practice screening and diagnosis data for patients with cancer compared with local and national averages, but was below the 80% coverage target for the national screening programme. The practice was aware of this, and had taken action to improve screening rates. Measures taken by the practice included ensuring patients were offered appointments at different times throughout the week, including late appointments, and ensuring a female sample-taker was available.

Cancer Indicators				
Indicator	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) (01/04/2016 to 31/03/2017) (Public Health England)	72.2%	71.9%	72.1%	Comparable with other practices
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	69.9%	74.7%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (PHE)	53.0%	54.9%	54.6%	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. (PHE)	66.7%	70.9%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	37.0%	39.9%	51.6%	Comparable with other practices

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 they had a system to identify people who misused substances.

**People experiencing poor mental health
(including people with dementia)**

Population group rating: Requires Improvement

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.
- Patients were referred appropriately (or could self-refer) to a range of treatments. These included a group counselling service, and an individual talking therapy service.
- There was a system for following up patients who failed to attend for administration of long term medication.
- The practice offered an annual health check to patients with a learning disability.
- 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.
- The practice followed up on patients discharged from hospital. It ensured their care plans and prescriptions were updated to reflect any extra or changed needs.
- Practice figures were low compared to local and national averages, for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses, with a record of alcohol consumption. When we spoke to the practice about this, they told us a recording error explained the relatively low figure. However, when we looked at more recent data, we noted no improvement.

Mental Health Indicators				
Indicator	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 (01/04/2017 to 31/03/2018) (QOF)	89.9%	92.3%	89.5%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	1.7% (2)	12.8%	12.7%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	70.8%	89.7%	90.0%	Variation (negative)
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.8% (1)	9.2%	10.5%	
Indicator	Practice	CCG average	England average	England comparison
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	89.9%	82.4%	83.0%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	4.8% (4)	7.5%	6.6%	

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

Question	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
Explanation of any answers and additional evidence: We found two (two cycle) clinical audits, completed to assess, monitor and improve service quality, in the past 12 months. There was no planned programme for further clinical improvement activity beyond the two audits conducted.	

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	545	545	537.5
Overall QOF exception reporting	11%	12%	10%

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

Improvement activity
An audit identified patients who had undergone a splenectomy (a surgical operation involving removal of a spleen), ensuring their vaccination schedule was per current best guidance. Following the audit, any new patients or those with a recent splenectomy, were automatically identified and referred to the practice nurse responsible, for appropriate follow-up and ongoing care.

Effective staffing

The provider was unable to fully 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.	N See comments
The learning and development needs of staff were assessed	Partial
The provider had a programme of learning and development.	Partial
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Partial
Staff had access to appraisals, one to one, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice was unable to provide evidence of fire safety training, training in infection control, the mental capacity act or information governance for staff employed before June 2018. Six members of staff told us they had not received any fire safety training. Other staff could not confirm whether they had undertaken training in safeguarding, the mental capacity act, and information governance. The general manager advised that records demonstrating staff training completion were held on an electronic system the practice no longer had access to.</p> <p>All clinical staff we spoke to had accessed personal and professional development as per practice policy. However, we spoke to several non-clinical staff who indicated they had not received an appraisal or attended a personal development meeting in the last year. When we spoke to the general manager about this, they told us they were aware of this issue, and that it was due to management and organisational changes. They also told us they were seeking to arrange appraisals and personal development meetings in the near future.</p>	

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QoF)	Y

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

	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.	Y
Care was delivered and reviewed in a co-ordinated way when different teams, services or organisations were involved.	Y
The practice had regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may be in need of 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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	94.5%	94.6%	95.1%	Comparable with other practices
QOF Exceptions	Practice Exception rate (number of exceptions) 0.3% (10)	CCG Exception rate 0.8%	England Exception rate 0.8%	

Consent to care and treatment

The practice was able to demonstrate that it 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.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y

Caring

Rating: Requires Improvement

Kindness, respect and compassion

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

CQC comments cards	
Total comments cards received	1
Number of CQC comments received which were positive about the service	0
Number of comments cards received which were mixed about the service	0
Number of CQC comments received which were negative about the service	1

Examples of feedback received

Source	Feedback
Patient interviews, NHS Choices website	<p>We spoke to 17 patients on the day of inspection. They told us they were either 'unhappy' or 'extremely unhappy' with what they perceived to be long delays when trying to contact the practice by phone, and what they perceived to be a long wait for routine appointments. All patients claimed staff were kind, helpful and caring and they were treated with dignity and respect.</p> <p>All 17 patients also claimed they had not been consulted on plans to merge five practices and create a central telephone hub at Moredon Medical Centre.</p> <p>These findings were supported by feedback on the NHS Choices website. All respondents complained about difficulties in booking in appointment and delays in contacting the practice by phone. The practice had not responded to any of the three comments on the NHS Choices website posted since September 2018.</p>

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12013	247	113	45.7%	0.94%

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 (01/01/2018 to 31/03/2018)	82.0%	87.8%	89.0%	Comparable with other practices
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 (01/01/2018 to 31/03/2018)	78.7%	85.6%	87.4%	Comparable with other practices
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 (01/01/2018 to 31/03/2018)	91.7%	94.9%	95.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	69.1%	80.9%	83.8%	Comparable with other practices

Any additional evidence or comments

The results from the National GP Patient survey predate changes to the practice structure and a new partnership arrangement, which took effect from June 2018. The practice attempted to address patient concerns about delays to appointments.

However, on the day of inspection we found patients were frequently not able to access appointments in a timely way and experienced unacceptable waits to see a GP or nurse and accessing the practice by telephone.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	We spoke to 17 patients. All felt fully involved in decisions about their care and treatment.

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 (01/01/2018 to 31/03/2018)	89.2%	92.7%	93.5%	Comparable with other practices

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

Carers	Narrative
Percentage and number of carers identified	457 carers were identified by the practice computer system. This figure represented around 4% of the total practice population. The carers register was reviewed and updated regularly.
How the practice supports carers	An alert was placed on a carer's record. Information about carer support services was provided opportunistically during consultations and carers were given details of the Swindon Navigator. The community navigator supported patients to become more independent and use community services to prevent isolation and mental health problems. Information about carer support services was available in the patient waiting area.
How the practice supports recently bereaved patients	Notification of patient deaths was recorded in the notes and a separate book. A patient's GP would contact bereaved relatives by phone to offer support and advice.

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.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Responsive

Rating: Inadequate

Responding to and meeting people's needs

The practice took account of peoples' needs and choices so that all population groups received personalised care that was responsive to their needs.

	Y/N/Partial
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Requests for a home visit would be triaged by a GP and a visit made if necessary. Telephone triage was available each day with emergency appointments available. • Online repeat prescription request and appointment booking were available. • For patients whose first language was not English the practice accessed interpreters and used Language Line. However, we noted that the interpreting service was not advertised within the practice premises. 	

Practice Opening Times	
Day	Time
Appointments available:	7.15am-6pm
Monday	7.15am-6.30pm
Tuesday	7.15am-6.30pm
Wednesday	7.15am-6.30pm
Thursday	7.15am-6.30pm
Friday	7.15am-6.30pm
Weekends	Closed

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
12013	247	113	45.7%	0.94%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	89.6%	93.4%	94.8%	Comparable with other practices

Older people

Population group rating: Inadequate

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. Home visits and urgent appointments for those with enhanced needs and complex medical issues were triaged, and offered where appropriate.

Population groups –

People with long-term conditions

Population group rating: Inadequate

Findings

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Clinicians would opportunistically review patients if necessary when they had failed to attend for reviews.
- The practice liaised regularly with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- A specialist diabetic nurse ran a monthly clinic at the practice.

Population groups – Families, children and young people

Population group rating: Inadequate

Findings

- 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.

Population groups – Working age people (including those recently retired and students)

Population group rating: Inadequate

Findings

- The practice had adjusted the services it offered to ensure these were accessible. It operated extended morning opening hours from Monday to Friday, 7.15am to 8am.
- Telephone GP consultations were available, which supported patients who were unable to attend the practice during normal working hours.

- The practice encouraged patients to register for online access to book appointments and request repeat prescriptions.
- The practice offered text and email reminders of appointment times.

People whose circumstances make them vulnerable

Population group rating: Inadequate

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice.
- Double appointments could be booked for patients with a learning disability or those needing an interpreter.

Population groups – People experiencing poor mental health (including people with dementia)

Population group rating: Inadequate

Findings

- 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

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 (01/01/2018 to 31/03/2018)	48.0%	71.1%	70.3%	Comparable with other practices
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	59.4%	65.1%	68.6%	Comparable with other practices
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	56.3%	62.5%	65.9%	Comparable with other practices
The percentage of respondents to the GP patient survey who were satisfied with the type	69.4%	71.2%	74.4%	Comparable with other

Indicator	Practice	CCG average	England average	England comparison
of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)				practices

Any additional evidence or comments
The National GP Survey results predate the new practice partnership arrangements, which came into force in June 2018. The practice was aware of the lower percentages. Staff told us the practice reviewed and attempted to address these lower percentages through creating a new phone system and a centralised system for booking appointments. Patient comments on the day of inspection and on the NHS Choices website did not support a view of positive changes. Patients reported that they were frequently not able to access appointments in a timely way and experienced unacceptable waits when accessing the practice by telephone.

Examples of feedback received from patients:

Source	Feedback
NHS Choices September-November 2018	Three patients expressed dissatisfaction with what they perceived to be long delays when trying to contact the practice by phone, a long wait for routine appointments, and problems with the prescription ordering service.

Listening and learning from concerns and complaints

There was no evidence to demonstrate that complaints and concerns were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	NA
Number of complaints we examined	NA
Number of complaints we examined that were satisfactorily handled in a timely way	NA
Number of complaints referred to the Parliamentary and Health Service Ombudsman	NA
Any additional evidence or comments	
Staff told us they could not provide evidence of complaints submitted to the practice over the last year. This was due to the relevant electronic records being stored on a system which the existing practice staff no longer had access to. The practice was also unable to provide evidence of complaints between September 2018, and our inspection.	
We saw documentary evidence that the practice is responding to public concerns regarding phone and appointment delays, and issues with the prescription ordering service. Measures included:	
<ul style="list-style-type: none"> • Ongoing recruitment of 13 additional administrative staff for the telephone hub; • Ongoing recruitment of additional GPs; • Recent recruitment of a practice nurse. Due to start in December 2018 • Recent recruitment of a practice pharmacist. Commenced employment in October 2018; 	

- Continuous monitoring of call queue and wait times, to improve access to the phone hub;
- Creating a system-wide on-line access to daily and pre-bookable appointments.

We saw documentary evidence that the longest wait-time for patients to speak to a receptionist at the hub had decreased over a set time period. Data for 10 October 2018 and 19 October 2018 showed that when patients contacted the practice by phone, the time they were placed on hold decreased from 32.5 minutes to 20 minutes, before the phone was answered. This data is for routine calls.

Improvements were still underway at the time of inspection and it was too early to assess and measure the impact for patients.

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement	Partial

Any additional evidence or comments

The practice listened to patients regarding perceived problems with the new phone system and the prescription ordering service, during a series of information events. Challenges and issues were explained to patients. However, routine complaints, such as those that appeared on the NHS Choices website, were not always responded to and addressed.

Well-led

Rating: Inadequate

Leadership capacity and capability

At our previous inspection on 4 August 2015, we rated the practice as Good for well-led services. At this inspection we rated the practice as inadequate for providing well-led services because we identified concerns and breaches of regulations which put patients at risk. We were not assured that the provider had appropriately addressed several issues. These concerned clinical auditing, auditing of prescribing, staff training, safeguarding, premises and health and safety risk assessments, recruitment checks and infection prevention and control, gaining access to the electronic system, or developing adequate evidence and systems.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	N
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme in place, including a succession plan.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The delivery of high-quality care was not assured by the leadership, governance or culture at the practice. This was because:</p> <ul style="list-style-type: none"> • Governance arrangements and systems were ineffective. • Practice leaders had identified gaps in governance systems but had not always taken action to resolve or mitigate risks. A number of the governance systems and evidence of processes were recorded on an electronic system managed by the previous practice management. The new management team had not had access to the system since September 2018, and no further assurance had been undertaken to mitigate risks in relation to the gaps in governance systems. • We asked the provider for their practice information return prior to inspection to support our view and assessment of the quality of service. We also contacted the practice after the inspection for information around governance processes. To date, no additional information has been provided. • Patients told us on the day of inspection that they had not been fully consulted regarding the changes made to the telephone, appointment and prescription ordering systems in the practice. • Some staff told us their historic concerns about low staffing levels were ignored and that, in their view, perceived low staffing levels were affecting both the quality of patient care, and patient safety. We did not see documentary or other evidence of identified staff shortages. 	

Vision and strategy

The practice had a clear vision but it was not supported by a 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.	N
There was a realistic strategy in place to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <p>While the practice had a clear vision to deliver quality sustainable care, the supporting strategy did not fully engage staff and patients. Patients we spoke to claimed they were not made aware of or been consulted about changes to the practice structure until after these had occurred.</p> <p>Not all staff were aware of the practice strategy. Two staff we spoke to told us they did not understand the practice vision, values and strategy.</p>	

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	N
There was a strong emphasis on the safety and well-being of staff.	N
The practice's speaking up policies were in line with the NHSI National Raising Issues Policy.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Some staff we spoke to claimed they were reluctant to raise concerns, for fear of retribution. Some staff we spoke with claimed the practice did not value their safety and well-being.</p>	

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

Source	Feedback
Staff interviews	Some staff expressed feelings of 'extreme anxiety' and a 'lack of appreciation' for their work efforts.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial

There were governance structures and systems in place which were regularly reviewed.	N
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	N
<p>Explanation of any answers and additional evidence:</p> <p>The governance arrangements were not always effective, were out of date or there was no monitoring of risk.</p> <ul style="list-style-type: none"> • Significant event reviews were not being undertaken to identify where improvements were required and learning was not disseminated to staff. • There had been no clinical team meetings since June 2018, to discuss safeguarding issues and patients who were vulnerable. The practice did not currently have a safeguarding lead to ensure safeguarding systems and processes were effective. • The practice had undertaken two cycle audits but there was a limited system to ensure regular opportunities for quality improvement. For example, internal prescribing reviews were not undertaken. • We found a recruitment file did not exist for one GP, and there were gaps in employment and recruitment information in five staff files. This included employment and security checks. • The systems put in place for staff training were ineffective. There was no evidence staff had received fire safety training, training in infection control, the mental capacity act or information governance after June 2018, and some staff told us they had not received any fire safety training. • Staff were not able to confirm they had undertaken training in safeguarding, the mental capacity act, and information governance. • Complaints information was not being collectively reviewed to ensure learning across the practice. 	

Managing risks, issues and performance

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

	Y/N/Partial
There were processes in place to manage performance.	Partial
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	N
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	N
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The non clinical staff we spoke to had not received feedback to manage performance. For example, they had not received recent appraisals, agreed personal development plans or had one to one meetings. • There was limited assurance that systems and processes assessed risks to the health and safety of people who use the service. For example, there was no infection prevention and control audit, 	

and no clinical lead for infection control. Health and safety risk assessments and fire safety assessments had not been undertaken. We found prescription pads in different locations across the practice and no central record of their storage. During the inspection we found unfilled prescriptions for Controlled Drugs among routine prescriptions in an unsecured room.

- The last fire risk assessment was dated 1 April 2015 and had not been updated when the building layout had been changed, to allow the SUCCESS Clinic (which was a different service) to move into the building. There was no formally recorded evidence that the actions recommended in the risk assessment had been completed.

Appropriate and accurate information

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

	Y/N/Partial
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	<u>N</u>
Staff whose responsibilities include making statutory notifications understand what this entails.	Y

Engagement with patients, the public, staff and external partners

The practice did not always involve 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.	Partial
Staff views were reflected in the planning and delivery of services.	Partial
The provider worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients raised concerns around access arrangements and the prescription ordering service, since the new systems were put in place. We saw evidence the provider had been working to address these issues, for instance by deploying more staff to answer phones during times of peak demand.</p> <ul style="list-style-type: none"> • Some non-clinical staff we spoke to told us their views on the challenges and needs of the population were ignored. For example, staff told us they spoke to managers informally, and expressed concerns that perceived staff shortages would have a negative impact on patient care. Some clinical staff we spoke to told us their views were reflected in the planning and delivery of services. • There was a suggestions box in the waiting area and the practice produced a newsletter to keep patients informed of issues relating to the service and to allow them to give feedback. • The practice had displayed their CQC rating in the reception area and on their website. • Performance information was made available to the local clinical commissioning group (CCG) in relation to, medicines management, for example. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement	N
Learning was shared effectively and used to make improvements.	N
Explanation of any answers and additional evidence: There was no current process for learning from significant events, complaints and audits, as a way to improve patient care. For example, there were no regular reviews of the causes of significant events, no evidence of learning disseminated to staff, and no annual review of significant events. There was no programme to drive quality improvement activity.	

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 comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

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

The following language is used for showing variation:

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

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

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

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment. ([See NHS Choices for more details](#)).