

# Care Quality Commission

## Inspection Evidence Table

### Moredon Medical Centre (1-553733346)

Inspection date: 07 March 2019

Date of data download: 07 November 2018

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

## Safe

### Safety systems and processes

The practice had 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.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y <sup>1</sup>
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.	Y <sup>2</sup>
Disclosure and Barring Service (DBS) checks were undertaken where required	Y <sup>3</sup>
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
<b>Explanation of any previous answers</b>	
On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found there had been no internal clinical meetings to discuss safeguarding risks, vulnerable patients and other safeguarding issues since June 2018; and there was no safeguarding lead at the time of the inspection.	

### What we found on this inspection

1. The practice had recruited a specialist safeguarding nurse who was responsible for all safeguarding activities for the practice. At the time of the inspection in November 2018, the nurse had not commenced their employment at Moredon Medical Centre. We saw documentary evidence of appropriate safeguarding systems which were communicated to staff.
2. We spoke with staff and saw documentary evidence of a risk register of specific patients.
3. We saw documentary evidence that all staff had a recent and relevant DBS check, where required.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y <sup>1</sup>
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y <sup>1</sup>
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who required medical indemnity insurance had it in place.	Y <sup>1</sup>

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found that staff records did not include all information relevant to their employment. There were gaps in relevant information in five recruitment files we reviewed. In addition, current and existing staff records were not on the new system. The practice could not provide evidence that all staff had received up to date vaccinations.

### What we found on this inspection

1. We saw documentary evidence that all staff, both new and existing, had their own personnel file and that the records included all information relevant to their employment. Previous gaps relating to, for example, employment history, up to date vaccinations or medical indemnity insurance had been rectified.

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: 28.08.18 <sup>1</sup>	Y <sup>1</sup>
There was a record of equipment calibration. Date of last calibration: 28/08/18	Y
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals.	Y
Fire procedure in place.	Y
There was a record of in date fire extinguisher checks. Date of last check: 05.08.18	Y
There was a log of fire drills.	Y

Date of last drill: 05.03.19		
There was a record of fire alarm checks. Date of last check: 02.11.18	Y	
There was a record of fire training for staff. Date of last training: Various dates in February 2019	Y	
There were fire marshals in place.	Y <sup>2</sup>	
A fire risk assessment had been completed. Date of completion: 17.02.19 <sup>3</sup>	Y <sup>3</sup>	
Actions from fire risk assessment were identified and completed.	Y	
<p><b>Explanation of any previous answers</b></p> <p>On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found that:</p> <ul style="list-style-type: none"> <li>• The monitoring of fire safety systems was not effective or well managed.</li> <li>• Fire safety training for staff could not be verified as having been completed.</li> <li>• The last fire risk assessment was dated 1 April 2015 and had not been updated. There was no formally recorded evidence that the actions recommended in the risk assessment from 2015 had been completed.</li> <li>• There was no documented fire safety procedure in use within the practice.</li> </ul> <p><b>What we found on this inspection</b></p> <ol style="list-style-type: none"> <li>1. We saw documentary evidence that portable fire equipment was checked and passed as safe in August 2018. The evidence predated our inspection in November 2018, but was not presented to us on the day of that inspection.</li> <li>2. The practice fire safety policy included a list of fire marshals. We saw documentary evidence that staff had signed a form to indicate they had reviewed and understood the fire procedure.</li> <li>3. All identified actions resulting from the fire risk assessment were either completed, or scheduled to be completed. For example, 'keep locked' signage was added to electrical cupboards, and an emergency evacuation procedure for staff and patients was scheduled for the end of March 2019.</li> </ol>		
<p><b>Health and safety</b></p> <p>Premises/security risk assessment carried out. Date of last assessment: 04.03.2019</p>		Y
<p>Health and safety risk assessment and actions Date of last assessment: 04.03.2019</p>		Y
<p><b>Explanation of any previous answers</b></p> <p>On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, 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. We were informed that weekly premises and health and safety checks were undertaken, but there were no formal records of these assessments.</p> <p><b>What we found on this inspection</b></p> <p>Health and safety, and premises risk assessments had been carried out. Identified actions, such as removing trip hazards, had been completed.</p>		

## 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	Y
Staff had received effective training on infection control	Y
Date of last infection control audit: 22.01.19	Y
The provider had acted on any issues identified in infection control audits.	Y <sup>1</sup>
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p><b>Explanation of any previous answers</b></p> <p>On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, 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 (IPC), up-to-date staff training records for IPC 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.</p> <p><b>What we found on this inspection</b></p> <p>1. All identified actions resulting from the latest infection control audit were either completed, or scheduled to be completed. For example, sharps disposal information was posted in every clinical room.</p>	

## 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
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.	Y
<p><b>Explanation of any previous answers</b></p> <p>On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, practice staff told us staffing levels were being continually reviewed, and that identified staff shortages were being addressed. However, some staff we spoke with told us their concerns relating to low staffing levels and its impact on the quality of patient care, and that it had not been considered or acted upon by senior colleagues. We did not see documentary or other evidence of identified staff shortages.</p> <p><b>What we found on this inspection</b></p> <p>Opinions were mixed, with some staff claiming that identified shortages had not been addressed, and others claiming staff shortages had been addressed. We did not see documentary or other evidence of identified staff shortages, or of its impact on the quality of patient care.</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.	Y <sup>1</sup>
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y <sup>1</sup>
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 needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

<p><b>Explanation of any previous answers</b></p> <p>On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we saw no evidence of delays to urgent referrals. However, we saw evidence that the average time for routine referral letters to be processed had increased from September 2018. On the day of inspection routine referral letters were being processed with a five week delay.</p> <p><b>What we found on this inspection</b></p> <p>1. We spoke with staff, who told us they were working additional hours to address the backlog of routine letter referrals. We saw evidence that routine referral letters were now being processed with an average two to three week delay. We also saw documentary evidence that referrals delays were a</p>	
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regular item for discussion at clinical team meetings.

## 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.	Y <sup>1</sup>
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).	Y <sup>2</sup>
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

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found:

- The practice had not ensured the proper and safe management of blank prescriptions. Prescription pads were stored in different locations around the practice, with no central record of their storage. We also found unfilled prescriptions for Controlled Drugs among routine prescriptions in an unsecured room.
- There was no practice system or process to audit prescribing patterns or to assess prescribing impact, safety and quality.

### What we found on this inspection

1. There was a system for logging prescriptions and ensuring they were kept securely. We saw documentary evidence of a policy for the safe management of prescription forms. Staff signed to acknowledge they had read and understood the policy. We also saw an audit (dated 18 February 2019, and due to be re-audited on 20 May 2019) that identified all prescription pads were now stored safely and securely. A log tracking prescription was completed by staff every morning and evening. We spoke with staff, and saw documentary evidence that they had received additional training in the safe storage of prescription pads.
2. The practice had recruited a pharmacist and we saw documentary evidence that they conducted prescribing audits as part of their role.

## 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.	Y <sup>1</sup>
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.	Y <sup>1</sup>
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y <sup>1</sup>
Number of events recorded in last <b>three</b> months.	16
Number of events that required action	16

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found there was no current process for learning from significant events, to ensure quality improvement or enhance patient care. No significant events had been reported or recorded after September 2018.

### What we found on this inspection

1. We saw documentary evidence of staff learning from and sharing information on significant events. Significant event causes were reviewed quarterly at staff meetings, and shared in monthly half-day team meetings. Staff members unable to attend these meetings had information cascaded to them through written reports and verbal feedback.

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

Event	Specific action taken
A patient's referral for an appointment at the local hospital was delayed, because the referral was classified as a routine (rather) than urgent appointment.	The incident was discussed at a staff meeting. Following the incident, all tasks were checked twice daily, to ensure correct classification. A two-week wait referral guide was emailed to all relevant staff.

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

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

### Effective needs assessment, care and treatment

	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

Findings
<ul style="list-style-type: none"> <li>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.</li> <li>The practice carried out structured medication reviews for older patients.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>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.</li> <li>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.</li> </ul>

## People with long-term conditions

### Findings

- 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.

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%	9.8%	
Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on	76.7%	76.7%	80.1%	Comparable with other

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)				practices
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	17.7% (153)	19.1%	13.5%	

<b>Other long term conditions</b>				
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	2.7% (22)	5.3%	7.7%	
<b>Indicator</b>	<b>Practice</b>	<b>CCG average</b>	<b>England average</b>	<b>England comparison</b>
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
<b>QOF Exceptions</b>	<b>Practice Exception rate (number of exceptions)</b>	<b>CCG Exception rate</b>	<b>England Exception rate</b>	
	4.7% (13)	11.2%	11.5%	

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.

## Families, children and young people

### Findings

- 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)

### 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. SUCCESS (Swindon Urgent Care Centre and Expedited Surgery Scheme). One of the SUCCESS clinics was based in the same building as the practice location. 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

## 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.
- The practice offered an annual health check to patients with a learning disability.

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

### 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.
- 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, and that they had struggled to recruit suitably qualified staff.

During our focused inspection on 7 March 2019, the practice staff told us they had recently recruited more clinical staff. When we looked at more recent data, we noted a small improvement in the data (now 80%), and the practice were confident results would continue to improve in future.

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 previous 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 a 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.	Y
The learning and development needs of staff were assessed	Y
The provider had a programme of learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
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.	Y
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

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018:

- The practice was unable to provide evidence of training undertaken (such as infection control) for staff employed before June 2018, because the records were on a system the practice no longer had access to.
- Several non-clinical staff indicated they had not received an appraisal or attended a personal development meeting in the last year.

### What we found on this inspection

We spoke to staff and saw documentary evidence that:

- All staff had undertaken training relevant to their role (for example safeguarding, the mental capacity act, and information governance) in the past three months.
- All staff had accessed personal and professional development as per practice policy. This included receiving an appraisal or attending a personal development meeting in the last year.

## 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) (QOF)	94.5%	94.6%	95.1%	Comparable with other practices
<b>QOF Exceptions</b>	Practice Exception rate (number of exceptions)	CCG Exception rate	England Exception rate	
	0.3% (10)	0.8%	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

## Well-led

At our previous inspection on 9 and 11 November 2018, we were not assured the provider had appropriately addressed several issues referenced elsewhere in the Evidence Tables. These concerned clinical auditing, auditing of prescribing, staff training, safeguarding, premises and health and safety risk assessments, recruitment checks, infection prevention and control, gaining access to the electronic system, or developing adequate evidence and systems.

### What we found at this inspection

The provider submitted an action plan and made significant improvements to systems and processes.

### Leadership capacity and capability

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	Y

### 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.	Y
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.	Y <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y <sup>1</sup>
Progress against delivery of the strategy was monitored.	Y <sup>1</sup>

#### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found that although the practice had a clear vision to deliver quality sustainable care, the supporting strategy did not fully engage staff and patients.

#### What we found on this inspection

1. Patients we spoke with claimed the changes were being more clearly communicated through a series of engagement meetings and newsletters. As a result, patients told us they now felt more consulted about changes to the practice structure. Staff we spoke to on the day of inspection told us they were fully aware of the practice strategy.

## 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.	Y <sup>1</sup>
There was a strong emphasis on the safety and well-being of staff.	Y <sup>1</sup>
The practice's speaking up policies were in line with the NHSI National Raising Issues Policy.	Y <sup>1</sup>

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, some staff we spoke with 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.

### What we found on this inspection

1. All staff we spoke to claimed that one-to-one meetings, regular staff meetings and personal and career development plans helped to ease their fears.

## Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found that the governance arrangements were not always effective, were out of date or there was no monitoring of risk.

### What we found on this inspection.

- Significant event reviews were being undertaken to identify where improvements were required and learning was disseminated to staff.
- There was a schedule of regular clinical team meetings to discuss safeguarding issues and patients who were vulnerable. The practice had a safeguarding lead to ensure safeguarding systems and processes were effective.

- The practice had undertaken a number of prescribing audits and internal prescribing reviews, and we saw a schedule of clinical audits to ensure regular opportunities for quality improvement.
- All recruitment files existed and included up to date information relevant to staff roles.
- Staff had received all training relevant to their role. This included fire safety training, training in infection control, the mental capacity act or information governance.
- Complaints information was 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.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found several areas of concern relating to managing risks, issues and performance.

### What we found on this inspection.

- We saw documentary evidence and spoke to non-clinical staff to confirm they had received feedback to manage performance. For example, all non-clinical staff had received recent appraisals, agreed personal development plans or had one-to-one meetings.
- We saw documentary evidence of an up-to-date infection prevention and control audit
- The practice had a clinical lead for infection control.
- Up-to-date health and safety risk assessments and fire safety assessments had been undertaken.
- Prescription pads were stored safely and securely.

## 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.	Y
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.	Y <sup>1</sup>
Staff views were reflected in the planning and delivery of services.	Y <sup>2</sup>
The provider worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, patients raised concerns around access arrangements and the prescription ordering service.

### What we found on this inspection.

1. 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. We examined call centre data on the day of inspection and for the two-week period prior to the day of inspection. The data indicated that patients waiting times had been reduced to between 15 and 25 minutes, from a previous high of 90 minutes. This represented a significant improvement on call waiting times. 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.
2. Staff told us their concerns about the challenges and needs of the population were being listened to and addressed. For example, through speaking to managers informally, and through formal meetings. Clinical staff we spoke to told us their views were reflected in the planning and delivery of services.

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement	Y
Learning was shared effectively and used to make improvements.	Y

### Explanation of any previous answers

On our previous inspection of Moredon Medical Centre on 9 and 12 November 2018, we found there was no current process for learning from significant events, complaints and audits, as a way to improve patient care.

### What we found on this inspection.

We spoke with staff and saw documentary evidence of a regular reviews of programme to drive quality improvement activity. This included the causes of significant events, learning disseminated to staff, and a scheduled annual review of significant events.



## 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](#)).