

Care Quality Commission

Inspection Evidence Table

Moredon Medical Centre (1-7934412175)

Inspection date: 27 February 2020

Date of data download: 06 February 2020

Overall rating: Requires Improvement

We previously inspected Moredon Medical Centre on 13 and 14 August 2019, when the service was under different provider arrangements. At that inspection we found there were significant issues relating to patient safety, and leadership and governance. Following the inspection, we issued a Warning Notice which related to the provider's Moredon Medical Centre location.

The Great Western Hospitals NHS Foundation Trust became the new registered provider in November 2019. This inspection, undertaken 27 February 2020, was a follow-up comprehensive inspection, within our regulatory timescale, of the urgent conditions previously imposed. The Evidence Tables cover the activities under the registered provider, and the regulated activities provided from the location Moredon Medical Centre. At this inspection we identified new concerns regarding the provision of safe care and treatment, since the new provider took over the contract for the practice.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Requires Improvement

Following our previous inspection, undertaken in August 2019, Safe services (under the previous provider) were rated as Inadequate because:

- Systems and processes to keep patients safe were not clear.
- The practice did not have appropriate systems in place for the safe management of medicines.
- Lessons were not always learned, or improvements made when things went wrong.

Some improvements had been made since the new provider took over the contract in November 2019. However, some safety issues continued to require action and improvement;

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

Following this inspection, the provider submitted an action plan to address these issues. The action plan included timescales, lead areas for responsibility, and monitoring for effectiveness and sustainability.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y ¹
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Partial ²
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Partial ²
What we found at the August 2019 inspection:	
Staff were unsure about safeguarding processes, including the route to escalate concerns.	
What we found at this inspection:	
1. Safeguarding systems, processes and practices were developed, implemented and communicated to all staff. Staff we spoke with were aware of safeguarding processes, including how to escalate concerns, and knew who was the nominated safeguarding lead. We saw documentary evidence of regular safeguarding meetings, but these were not formally minuted. When we spoke to staff about this, they told us they would minute all future meetings. Concerns raised during meetings were added to patient's records.	
2. When we spoke with practice staff, they told us that multi-disciplinary meetings did not take place on a regular basis, and they recognised this needed to change. We saw documentary evidence that these meetings are scheduled to occur regularly (monthly).	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y

Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
What we found at the August 2019 inspection:	
<ul style="list-style-type: none"> • Staff recruitment files did not contain all required information, as per the practice recruitment policy and the regulations. • Three recruitment files for locum doctors were incomplete. • A salaried GP's file was blank apart from photo ID, a Basic Life Support certificate, and their GMC number. 	
What we found at this inspection:	
<ul style="list-style-type: none"> • We looked at several recruitment files of non-clinical staff. All files contained required information in accordance with the practice's recruitment policy. For instance, files contained a job description, proof of identification, evidence of satisfactory conduct in previous employment, contract of employment, induction training undertaken, Disclosure and Barring Service (DBS) checks, and evidence of appraisals. • We looked at several recruitment files for salaried GPs and locum doctors. All files contained required information in accordance with the practice's recruitment policy. 	

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: 21 April 2019	Y
There was a record of equipment calibration. Date of last calibration: 11 September 2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 30 August 2019	Y
There was a log of fire drills. Date of last drill: 21 February 2020	Y
There was a record of fire alarm checks. Date of last check: 30 October 2019	Y
There was a record of fire training for staff. Date of last training: Various. All staff up-to-date with training requirements.	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 19 February 2020	Y

Actions from fire risk assessment were identified and completed.	Partial ¹
<p>What we found at the August 2019 inspection:</p> <p>A fire risk assessment had been carried out which identified actions that were either completed or scheduled to be completed, to address improvements needed to maintain fire safety. However, some scheduled actions had not been completed or undertaken. For example, the weekly walkaround of the premises to monitor for fire hazards and ensure fire escape routes were accessible had not been undertaken since February 2019.</p> <p>What we found at this inspection:</p> <p>All actions from the previous fire risk assessment had been completed.</p> <p>1. The fire risk assessment dated 19 February 2020 was conducted a week before our inspection, and listed improvements needed to maintain fire safety. These included testing and maintenance of the emergency lighting system, and conducting fire drills. Staff we spoke with told us the most urgent points had been addressed, and we saw an action plan to address any outstanding points within the next two weeks.</p>	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 11 February 2020	Partial ¹
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11 February 2020	Y
<p>What we found at the August 2019 inspection:</p> <p>Some actions from the 2019 premises risk assessment had not been carried out. For example, the risk assessment stated that emergency lighting on the premises was 'insufficient and unsatisfactory'. Staff told us the practice did not have an action plan for this, and some of the emergency lights had not been working since April 2019.</p> <p>What we found at this inspection:</p> <p>All 'essential' actions from the 2019 premises and Health and Safety risk assessments had been completed.</p> <p>1. We saw documentary evidence that required actions identified by the 2020 premises risk assessment were either completed, or scheduled for completion. Actions included obtaining a quotation for outside security lights, and updating the practice's lone working policy.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 13 January 2020	Y

The practice had acted on any issues identified in infection prevention and control audits.	Partial
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
What we found at the August 2019 inspection:	
<p>A Legionella risk assessment was undertaken on 18 June 2019 and six actions were identified to ensure water safety in the practice. Actions included the removal of limescale from water outlets to minimise the risk of bacteria build up and enable appropriate cleaning; and ensuring a log book to record this information was completed by an appropriately trained person. The action plan produced as a result of this risk assessment showed that these examples had been classified as medium risk with a timescale for completion of 18 July 2019. Staff told us that none of these actions had been completed, but they would be planned for completion in the two weeks following this inspection.</p>	
What we found at this inspection:	
<ul style="list-style-type: none"> • Actions from the Legionella risk assessment undertaken on 18 June 2019 had been completed. • The practice commissioned an external organisation to identify actions required to strengthen the water hygiene arrangements. A safety report, dated 20 February 2020, stated that whilst some actions were required, there was 'no undue concern' about water safety at the site. • We saw documentary evidence that some tasks, for example the purchase and fixing of a glove holder, were scheduled for completion. • The findings from the report were incorporated into the practice action plan and process improvement tool. Both documents detailed actions arising from the audit undertaken on 13 January 2020 that had either been achieved, or were in progress. Delayed items were risk assessed for impact. All urgent items had been addressed. • We saw documentary evidence that infection prevention and control risks had been added to the practice risk register. 	

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial ¹
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	N ²
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the	Partial ¹

impact on safety.	
Explanation of any answers and additional evidence:	
<p>1. The provider had recognised staff capacity issues in November 2019 and had increased staff numbers to ensure the demands of the practice were more likely to be met. This included existing staff working extra hours. The provider also showed us evidence to confirm recruitment processes were in progress to increase clinical capacity in the practice, with the recruitment of pharmacists, nursing staff and health care assistants.</p> <p>2. At this inspection, we could not be assured that all patients would have appropriate risk assessments carried out for their medical needs. Under the previous provider, systems and processes to ensure people received the correct care and treatment had not always been followed and if care and treatment was provided this was not always accurately recorded on the practice system. At the time of inspection, the new provider was not able to assure us that, where relevant, every patient would have an appropriate risk assessment.</p>	

Information to deliver safe care and treatment

Staff did not always have 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.	N ³
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
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Partial ¹
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial ²
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N/A
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
What we found at the August 2019 inspection:	
<ul style="list-style-type: none"> • There was some clinical oversight of test results, but this was not always effective. For example, we saw evidence that alerts were placed on records, to remind clinicians to ensure blood tests were carried out. However, these had not been acted upon. • Information needed for ongoing care was not always available to share. Staff told us they were not fully aware of safeguarding processes and were unsure who to escalate concerns to. 	

We found that although there had been improvements in the processing of patient correspondence, there were still large numbers of tasks outstanding. For example, we found 2574 items of outstanding correspondence at Moredon Medical Centre. The practice had identified that between 4000 and 7000 pieces of correspondence had been filed in a short space of time (over one weekend) and a second review of correspondence records was being undertaken by clinicians from an external agency. We found:

- The correspondence backlog was being addressed, and delays to correspondence were being dealt with.
- Serious issues identified from correspondence had been appropriately actioned.
- Where required, further care and treatment and urgent referrals were being dealt with appropriately.

Practice leaders told us it was not clear when this backlog would be cleared. Leaders told us that due to a re-review and assessment of records, to date there had been no instances identified that the health needs of vulnerable patients were being missed or a there was a delay in treatment.

What we found at this inspection:

1. We found that the system to monitor delays in referrals needed developing, because patients with a diagnosis of cancer were not followed-up if they failed to attend their hospital appointment. When we spoke to staff about this, they told us they were currently introducing a process to track hospital referrals and planned to audit the process after six months. The process included placing an alert on the practice's electronic patient records system, to ensure a clinician contacts the patient after a scheduled appointment date. Following the inspection, the practice advised that they had implemented a Standard Operating Procedure (SOP) for ensuring referrals for two week wait appointments have been actioned, and patients' attendance at appointments in relation to the referral followed up in a timely manner
2. There was some clinical oversight of test results, but this was not always effective. For example, we saw evidence that alerts were placed on records, to remind clinicians to ensure blood tests were carried out. However, these had not been acted upon. We saw two examples where patients on high risk medicines did not have the required blood tests due to delays. When we spoke with staff about this, they told us they would organise blood tests and medicines reviews for these two patients. Following our inspection, staff told us these patients had received their blood test reviews and recalls where appropriate. We were also advised that the practice had implemented systems and processes to ensure all people prescribed high risk medications are appropriately reviewed and tested.

Staff also told us that the following measures put in place would increase patient safety:

- Receptionists were now receiving training in how to identify controlled drugs.
- All patients on high risk medicines have been identified to ensure secondary care monitoring is in place where appropriate.
- A repeat prescription protocol has been developed to ensure all repeat requests for high risk medicines were reviewed by a clinician.

Following this inspection, we saw an action plan that included timescales and monitoring information. The plan included appointing a pharmacy team to provide professional and clinical leadership to enhance all aspects of prescribing and medicines reviews.

The new provider had continued with efforts to process correspondence in a reasonable timeframe. Under the previous provider arrangements, there were around 680 unfiled documents at Moredon Medical Centre and another location, Abbey Meads Medical Centre (unfiled documents included patient records that are actioned but not saved in patients' records). We saw documentary evidence that this had been reduced to less than 300 unfiled documents across both practices. We looked at a selection of previously unfiled documents and saw that all had received appropriate clinical oversight.

There is currently a backlog of around 1000 unsummarised records at Moredon Medical Centre, dating back to 2018 (unsummarised records are paper records that have not been clinically summarised and added to a patient's electronic records). The absence of this information may increase the risk of clinicians not having the correct information about a patient at the time of consultation, review or assessment. The practice provided an action plan with timescales and a commitment of resources to address the backlog. The plan included offering existing staff overtime hours, additional staff recruitment and a review of existing staff skill mix.

3. We found records relating to patients with long-term conditions were not always up to date or recorded in line with guidelines. Where care and treatment had been provided to patients information had not always been recorded appropriately, to confirm what care or treatment had taken place.

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, there were shortfalls regarding medicines reviews.

Any data indicators in this domain relate to the previous provider, are provided here for context, and have not been used to form our judgement. We have included here any information which demonstrates whether the new provider has plans or is making improvements based on the old provider data.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.81	0.72	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	12.7%	9.7%	8.5%	Tending towards variation (negative)
Average daily quantity per item for	6.22	5.84	5.60	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)				
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.35	2.36	2.08	No statistical variation

Any additional evidence or comments

Data showed a tendency to overprescribe antibacterial medicines. When we spoke to staff about this, they told us they were aware of the issue and had put measures in place to actively reduce 'habit forming' medicines and other prescribing. These measures included teaching sessions for clinicians on antibiotic prescribing, and updating the practice's prescribing procedure.

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial ¹
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial ¹
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and	Y

Medicines management	Y/N/Partial
written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

What we found at the August 2019 inspection:

- We found shortfalls in processes for the monitoring of disease modifying medicines. Alerts were placed on records, to remind clinicians to ensure blood tests were carried out; however, these had not been acted upon.
- The practice had systems in place to identify that medicines stocks had expired and were replaced when needed. However, we found supplies of one medicine that had exceeded its expiry date and was still available for use. When we spoke with practice staff about this, they removed the out of date medicines stocks immediately.

What we found at this inspection:

All medicines stocks were in date.

1. Not all medicines reviews had been undertaken as required. For example, we found that two patients had received repeat medications without an appropriate blood test. Following the inspection, these patients received their required blood tests. We were also advised that systems and processes had been implemented to ensure all people prescribed high risk medications are appropriately reviewed and test.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, there were shortfalls regarding recording and acting on safety alerts.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y

Number of events recorded in last 12 months:	24
Number of events that required action:	24

What we found at the August 2019 inspection:

- Not all staff understood how to identify and raise concerns, safety incidents and near misses. Staff said that significant event reporting did not necessarily take place because they were unsure of the threshold, and that certain events had become 'normalised', even if they met the criteria of a significant event as described in the practice significant event policy. Some staff also reported that they had raised significant events and no action had been taken. Practice leaders told us they recognised the need to improve systems and processes surrounding significant events and would commence a review of existing processes in the weeks following this inspection.

The provider had a significant event policy, but events were not always identified, recorded, investigated or discussed to ensure lessons learned were shared across the practice. We looked at a number of significant events requiring action. In June 2019 all significant events dating back to January 2019 had been re-opened and reviewed by practice staff, and clinical staff from an external agency. However, these were not always actioned or added to the significant event register to assist with ongoing monitoring to ensure they were actioned.

What we found at this inspection:

- The practice had developed a system for recording and acting on significant events that was shared with all staff. We saw examples of learning from significant events.
- Staff we spoke with understood how to raise concerns about, learn from and report safety incidents.

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

Event	Specific action taken
Staff were unsure about the level of information that should be given to the police, regarding a patient whose life might be at risk. The patient's record was opened, and the police then requested to see details about the patient's consultation history and medicines. The police request for this information was acted upon.	The incident was recorded, and discussed at a staff meeting. Staff reflected on the circumstances where an official warrant or other form of documentation should be presented to explain the need for access to a patient's record, and how this was balanced with a need for urgency. The practice policy was updated to reflect the staff consensus.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial ¹
Staff understood how to deal with alerts.	N ¹

Explanation of any answers and additional evidence:

During our last inspection we saw there was a system in place for circulating safety alerts which was managed from the Moredon Medical Centre Hub. Staff we spoke with told us that at an individual level,

all relevant alerts were actioned and we saw records which confirmed actions had been taken. However, there was no routine central monitoring to ensure that appropriate actions had been taken.

1. We checked an alert that was issued in 2018 and reissued annually for sodium valproate. The practice had not undertaken any checks against this alert in the last 12 months. Following this inspection, the provider told us they had implemented a system to manage safety alerts. We also asked the provider to undertake a retrospective review of all safety alerts in the last 18 months to ensure appropriate action is taken. They confirmed this would be completed in March 2020.

Following our inspection, we saw an action plan (with timescales and areas of staff responsibility) and spoke to staff regarding how the practice would address these issues. Staff told us they planned to recruit two prescribing pharmacists and a pharmacy technician to review and distribute alerts appropriately. Safety alerts would be included as a standing item at clinical meetings. We saw documentary evidence of a template developed to record actions taken, which would be cascaded to all clinicians.

Effective

Rating: Requires Improvement

Great Western Hospitals NHS Foundation Trust became the registered provider for Moredon Medical Centre in November 2019 and made significant and immediate improvements to address the previous provider's failings. These improvements have led to a delay in the review of outcome measures for patients with long-term conditions. Current data for long-term condition activity has been managed by both the previous and current provider. The current unverified outcomes data for this financial year showed significant poor performance. In the interim, the practice put in place the following measures:

- Three diabetic nurses organised recalls for patients with long-term conditions, and initiated insulin injections.
- When patients request medication, this was checked via the Prescription on Demand (POD) service.
- An electronic system that automatically monitors the blood tests of all patients who were prescribed disease-modifying anti-rheumatic medicines and other special medicines.
- Staff told us they were currently embedding the use of clinical system templates that enhance medicines reviews for patients with long-term conditions.
- A member of staff had been allocated to work through the list of outstanding recalls. Patients from the list would then be contacted and an appointment booked the following day or within the week. Patients would then be reviewed during their appointment and following a series of tests, would be booked to see a dedicated GP, with results filed and a follow-up appointment arranged as necessary.

We also saw a detailed action plan for clinicians and administrators to set recall dates. The plan included areas of staff responsibility and monitoring systems.

Effective services provided at this location by the previous provider were rated as Requires Improvement because:

- There was limited monitoring of the outcomes of care and treatment.
- The practice was unable to show that staff had the skills, knowledge and experience to carry out their roles.

At this inspection we found that the practice had worked hard to improve patient care. Following this inspection, the practice produced an action plan to summarise (and action where necessary) the backlog of correspondence.

Effective needs assessment, care and treatment

Patients' needs were not fully assessed, or care and treatment delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.

Y/N/Partial

The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N ¹
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial ¹
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

Explanation of any answers and additional evidence:

At the inspection in June 2019, we found a significant backlog of correspondence, tasks and test results. GPs reported there was no formal buddy system to ensure that test results and correspondence was dealt with when they were absent.

In February 2020, we found:

1. The practice's electronic patient records system had templates for conditions such as asthma, diabetes and end of life care, which clinicians could complete and produce a care plan from. There were also links to best practice guidance via the internet. However, we found templates were not always being used to accurately record the treatment patients received. The new provider told us that due to the enormity of the improvements needed when taking over from the previous provider, they had not been able to keep up to date with monitoring and effective record keeping.

Our GP specialist advisors looked at a selection of patient records and found some had appropriate care and treatment with accurate record keeping. However, systems designed to demonstrate care and treatment provided in line with recommended timescales showed poor performance results. Other records reviewed demonstrated that in some cases no records or appropriate coding had been added to the patient's record.

The plan to address the backlog included offering existing staff overtime hours, additional staff recruitment and a review of existing staff skills mix.

Prescribing	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) (01/10/2018 to 30/09/2019) <small>(NHSBSA)</small>	0.84	0.82	0.74	No statistical variation

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

Older people

Population group rating: Requires Improvement

Findings

The system to ensure older patients were followed up when discharged from hospital was not effective, due to the backlog in managing correspondence.

However, there were areas of good practice:

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The system to ensure people with long-term conditions were followed up when discharged from hospital was not effective, due to the backlog of correspondence.

However, there were areas of good practice:

- 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 usually 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.

Diabetes Indicators	Practice	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 (01/04/2018 to 31/03/2019) (QOF)	67.1%	76.4%	79.3%	Tending towards variation (negative)

Exception rate (number of exceptions).	3.9% (34)	14.7%	12.8%	N/A
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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	71.5%	75.6%	78.1%	No statistical variation
Exception rate (number of exceptions).	2.3% (20)	8.8%	9.4%	N/A

	Practice	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	63.2%	77.2%	81.3%	Significant Variation (negative)
Exception rate (number of exceptions).	11.0% (97)	13.9%	12.7%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	54.3%	73.7%	75.9%	Significant Variation (negative)
Exception rate (number of exceptions).	1.9% (16)	4.5%	7.4%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	62.7%	83.7%	89.6%	Significant Variation (negative)
Exception rate (number of exceptions).	4.1% (12)	9.1%	11.2%	N/A

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	76.8%	82.6%	83.0%	Tending towards variation (negative)
Exception rate (number of exceptions).	2.1% (38)	3.7%	4.0%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.9%	90.6%	91.1%	No statistical variation
Exception rate (number of exceptions).	2.0% (4)	4.3%	5.9%	N/A

Families, children and young people

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- Childhood immunisation uptake rates either met or exceeded World Health Organisation (WHO) targets.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice was a 'breastfeeding welcome' centre.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	148	155	95.5%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	165	175	94.3%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	165	175	94.3%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	163	175	93.1%	Met 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Working age people (including those recently retired and students) Population group rating: Requires Improvement

Findings
<p>The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement. For example, issues with managing correspondence at the practice impacted on timely referrals for patients accessing NHS health assessments and checks.</p> <p>However, there were areas of good practice:</p> <ul style="list-style-type: none"> • Patients could book or cancel appointments online and order repeat medicines without the need to attend the practice. • The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university.

Cancer Indicators	Practice	CCG	England	England
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		average	average	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). (01/07/2019 to 30/09/2019) (Public Health England)	72.5% (83%) ¹	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	74.0%	74.1%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	52.8%	54.9%	58.0%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2018 to 31/03/2019) (PHE)	37.5%	60.3%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	54.4%	53.4%	53.8%	No statistical variation

Any additional evidence or comments

1. We saw unvalidated QOF data from the period 1 April 2019 to 24 February 2020. This data showed that the practice exceeded the 80% national target for cancer screening.

People whose circumstances make them vulnerable Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- 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 medicines.
- 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.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	55.6%	85.4%	89.4%	Significant Variation (negative)
Exception rate (number of exceptions).	0.8% (1)	11.8%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	52.4%	86.2%	90.2%	Significant Variation (negative)
Exception rate (number of exceptions).	0.8% (1)	10.1%	10.1%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.1%	80.4%	83.6%	No statistical variation
Exception rate (number of exceptions).	11.3% (9)	6.4%	6.7%	N/A

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	461.6	534.3	539.2
Overall QOF score (as a percentage of maximum)	82.6%	95.6%	96.7%
Overall QOF exception reporting (all domains)	3.4%	6.2%	5.9%

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

Any additional evidence or comments

At the time of inspection, the practice had not carried out any clinical audits since the new provider had taken responsibility for the practice in November 2019. Staff told us that clinical audits were planned and, as part of quality improvement activity, the practice was introducing personal feedback to clinicians on clinical performance, use of templates and adequacy of coding. Staff also told us the newly appointed frailty nurse will review unplanned admissions, readmissions and discharges.

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician	Y

associates.	
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment, but this was not always done effectively.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2018 to 31/03/2019) (QOF)	Y
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 coordinated way when different teams, services or organisations were involved.	N ¹
Patients received consistent, coordinated, person-centred care when they moved between services.	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 answers and additional evidence:	
1. The practice was unable to fully demonstrate that all relevant information was available to be shared with other services when needed. A backlog of unreviewed hospital letters, and correspondence from other sources, meant information was not always accurate, valid, reliable and timely.	

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 need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Partial ¹
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	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
Explanation of any answers and additional evidence:	
1. Due to circumstances inherited from the previous provider, the new provider was not always able to prioritise and identify patients who needed additional support in a structured way.	

Patients had access to a greater range of services through the provider co-ordination of community, primary and secondary care.

Smoking 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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.7%	94.2%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (17)	0.6%	0.8%	N/A

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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.	Partial ¹
Policies for any online services offered were in line with national guidance.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There were processes and protocols in place for monitoring consent, but the practice did not have formally audit these. When we spoke to staff about this, they • There were processes and protocols in place for monitoring consent • All records we looked at showed consent sought appropriately. 	

Caring

Rating: Good

Caring services provided at this location by the previous provider were rated as Requires Improvement because:

- There were low patient satisfaction scores regarding the delivery of services

At this inspection we found that patient satisfaction scores had greatly improved.

Kindness, respect and compassion

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

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

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

Source	Feedback
Patient interviews	We spoke with several patients, all of whom told us that staff treated them with dignity, kindness and respect. Three patients told us that services had 'improved beyond measure' since the new provider arrangements, despite any issues inherited.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	75.5%	86.5%	88.9%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2019 to 31/03/2019)	74.7%	84.6%	87.4%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2019 to 31/03/2019)	90.3%	94.1%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	60.4%	75.0%	82.9%	Variation (negative)

Any additional evidence or comments

Patients we spoke with on the day of inspection told us they had noticed a positive change regarding the overall experience of making an appointment, with one describing a 'vast improvement' in terms of appointment availability. One patient told us that when they contacted the practice, there was a shorter wait time before they spoke to a call handler. Another patient reported that the practice call-back function (where patients opt to receive a call back from a member of staff, rather than wait on the phone for a call handler to become free) was working more efficiently.

We saw documentary evidence that the provider deployed more call handlers during periods of peak demand, to improve access and continuity. On the day of inspection, we collected data that showed during peak time (8am-9am), the practice received 42 calls. Forty-one calls were answered within 8 minutes, with one call abandoned.

The practice introduced an electronic patient feedback facility, but it is too early to assess its impact.

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

Involvement in decisions about care and treatment

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

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

Source	Feedback
Interviews with patients.	We spoke with several patients on the day of inspection, all of whom told us they had noticed a positive change regarding the overall experience of making an appointment. Two patients expressed 'relief' about the new provider arrangements, and their belief in the provider's commitment to high quality patient care. Patients also told us that the change of provider arrangements had 'positively' affected the attitude of the reception staff, who in their view were more relaxed and helpful.

National GP Survey results

Note: The questions in the 2019 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 changed in 2019.

All data indicators relating to the GP Patient Survey data in this domain relate to the previous provider and are provided here for context, and have not been used to form our judgement. The new provider has made improvements to how patients access the services since November 2019 and is continuing to make improvements by recruiting more clinicians in the next two months.

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 (01/01/2019 to 31/03/2019)	93.1%	92.3%	93.4%	No statistical variation

	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, pictorial, 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.	A total of 423 carers had been identified by the practice. This figure represented around 4% of the total practice population. The carers register was reviewed and updated regularly.
How the practice supported carers (including young 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 supported 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
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Requires Improvement

All data indicators relating to the GP Patient Survey in this domain relate to the previous provider, are provided here for context, and have not been used to form our judgement. The new provider has made improvements to how patients access the services since November 2019 and is continuing to make improvements by recruiting more clinicians in the next two months.

Responsive services provided at this location by the previous provider were rated as Inadequate because:

- Although improvements had been made, patients were unable to access services in a timely manner.
- There was a lack of continuity of care.

At this inspection we found that although services could be accessed in a more timely manner, and there was more continuity of care, the service needed to make further improvements.

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
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
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times

Day	Time
Opening times:	
Monday	7.30am-6.30pm
Tuesday	7.30am-6.30pm
Wednesday	7.30am-6.30pm
Thursday	7.30am-6.30pm
Friday	7.30am-6.30pm
Appointments available:	
Monday	7.30am-6.30pm
Tuesday	7.30am-6.30pm
Wednesday	7.30am-6.30pm
Thursday	7.30am-6.30pm
Friday	7.30am-6.30pm

National GP Survey results

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 (01/01/2019 to 31/03/2019)	89.0%	93.5%	94.5%	Tending towards variation (negative)

Any additional evidence or comments

We spoke with staff who told us they were aware of the low patient satisfaction scores under the previous provider arrangements and outlined a series of improvement measures. These included:

- Undertaking more patient surveys once Trust systems and processes were more embedded.
- GPs undertaking their own patient feedback, and auditing their findings.
- A recruitment drive for 10 additional telephone call handlers and administrators.
- Long-term locum contracts awarded on a rolling one-month basis, to encourage continuity of care.
- Recruitment of additional nursing staff, pharmacy technicians and pharmacists.
- Undertaking reviews of job matching and skills mix.

Older people

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- 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.

- Care and treatment for people with long-term conditions approaching the end of life was usually coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

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

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.

However, there were areas of good practice:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, It operated extended morning opening hours from Monday to Friday, 7.15am to 8am.
- The practice had adjusted the services it offered to ensure these were accessible. 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: Requires Improvement

Findings
<p>The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.</p> <p>However, there were areas of good practice:</p> <ul style="list-style-type: none"> • The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability. • People in vulnerable circumstances were easily able to register with the practice. • The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings
<p>The areas we found that required improvement affected all population groups, so we rated all population groups as requires improvement.</p> <p>However, there were areas of good practice:</p> <ul style="list-style-type: none"> • Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	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
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

What we found at the August 2019 inspection:

Since September 2018, CQC has received direct information from patients about access to appointments and their difficulties when contacting the practice by phone. Healthwatch Swindon reported several examples to us, where patients have not been able to access timely care and treatment and the impact on these patients. We have also received information from local parliamentary offices, local media and social media outlets, focused on the poor experience of patients trying to access appointments, calling the practice by phone and ordering repeat prescription delays.

- The provider was making efforts to improve access to appointments, by making more on the day appointments available, and enabling patients to access any of its locations. However, addressing this issue has yielded mixed results..

What we found at this inspection:

- The provider has a base (called the 'orbital') where various professionals including three GPs work to address urgent queries, visit requests, pathology results, and emergency visits. Staff at the orbital also follow-up ill patients previously seen by other clinicians and treat urgent walk-in patients.
- Patients we spoke with on the day of inspection reported that they felt involved in and consulted about the new provider's transformation plans.
- We had not received direct information from stakeholder organisations or patients, regarding access difficulties, since the new provider arrangements.
- Patients reported to us that they were able to access appointments in a more timely way, and experienced fewer waits when contacting the practice by phone. Data collected on the day of inspection and submitted by the practice showed that call wait times had reduced significantly.
- We saw evidence that more on-the-day appointments are available.

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 (01/01/2019 to 31/03/2019)	18.6%	N/A	68.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	35.5%	56.6%	67.4%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	38.5%	58.1%	64.7%	Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2019 to 31/03/2019)	58.4%	65.9%	73.6%	Tending towards variation (negative)

Any additional evidence or comments

The practice was aware of the lower percentages in the National GP Survey results. When we spoke with practice leaders, they told us they were focussed on ensuring stability and making improvements for patients and staff. We saw documentary and other evidence of the following:

- An increase in on-the day appointments and support within the Hub so that telephone call waits had reduced significantly. Twelve months ago, the longest wait time was over 75 minutes, this is now down to around 10-14 minutes.
- The introduction of a 'call-back' feature allowed patients to be called back when a call handler was available so they do not need to spend time waiting in a queue.
- Patients could book appointments in advance and the number of GPs had increased which has allowed an increase in appointment availability. In addition, we were advised about plans to establish additional nurse led clinics for asthma, COPD and diabetes, with additional capacity sourced to strengthen these pathways from April.

Source	Feedback
Patient Reviews	The practice has received 14 social media reviews since the new provider arrangements. Reviews are mixed, with patients praising the standard of clinical care received, but stating they are unable to access appointments in a timely manner.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received since the new provider arrangements.	6
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

What we found at the August 2019 inspection:

- The practice Standard Operating Procedures contained information about how to escalate a complaint if patients were not satisfied with the internal outcome. However, none of the practice responses to patient complaints included this information.
- Complaints had not been shared with all relevant staff since 1 April 2019, but all had been investigated, acknowledged and responded to.
- There were gaps in data gathering and learning. For instance, there was no evidence of learning and no record of how complaints were received by the practice (for example, as a phone call, in

person, or by letter correspondence).

What we found at this inspection:

- Practice responses to patient complaints included information concerning escalation, if patients were not satisfied with the outcome. We saw documentary evidence of complaints shared with all relevant staff, investigated, acknowledged and responded to.

Example(s) of learning from complaints.

Complaint	Specific action taken
A patient starting cancer treatment was concerned about the availability of appointments at the practice, and the level of clinical support they might receive, given their 'negative' experiences under the previous provider arrangements.	The patient was contacted and advised that continuity of care was a priority, reflected by (among other measures) the awarding of long-term locum contracts. The patient told staff they were satisfied with the practice's response.

Well-led

Rating: Requires Improvement

Well-led services provided at this location by the previous provider were rated as Inadequate because:

- Leaders could not show that they had the capacity and skills to deliver high quality, sustainable care.
- While the practice had a clear vision, that vision was not supported by a credible strategy.
- The practice culture and structure did not effectively support high quality sustainable care.
- There was limited support from the provider Better Health Partnership to the local team at Moredon Medical Centre.
- The overall governance arrangements needed strengthening in order to be effective and sustainable.
- The practice did not have clear and effective processes for managing risks, issues and performance.
- The practice did not always act on appropriate and accurate information.
- We saw limited evidence of systems and processes for learning, continuous improvement and innovation.

At this inspection we found:

- Improvements were required regarding governance systems, accurate and reliable data, the management of risks, patient and staff engagement.
- Before taking over the contract, the new provider had undertaken due diligence assessments to understand the significance of the issues identified from the previous provider. However, the issues identified were more significant when the new provider began working within the practice.
- The new provider was an NHS trust with a demonstrable history of improving services previously rated as inadequate, and being responsive when concerns were highlighted to them.
- Although the provider had a clear plan to make improvements, at the time of inspection, some areas lacked comprehensive detail to ensure the areas of lower performance would be improved in a timely way.
- The provider's plans to make improvements at Moredon Medical Centre included brief outlines of innovative work to combine community and primary health care services in the Swindon area.
- The provider recognised the significant improvement and transformation required. However, at the time of the inspection some of the changes and improvements had not been implemented as the new provider commenced the management of the service 12 weeks prior to this inspection.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y ¹
They had identified the actions necessary to address these challenges.	Partial ²
Staff reported that leaders were visible and approachable.	Y ³
There was a leadership development programme, including a succession plan.	Y

What we found at the August 2019 inspection:

- Staff told us the local practice leadership was now more inclusive, accessible and supportive. They told us that a more 'hands-on' management style had led to higher levels of staff satisfaction, lower levels of staff turnover and improved morale. Two staff members told us that they previously 'dreaded' seeing the leadership team during working hours, but now 'welcomed' their presence.
- There had been limited provider level leadership support from the provider Better Health Partnership at any of the five Swindon practices, including Morden Medical Centre. The CQC registered manager had left the organisation in March 2019 and the provider had not submitted an application to deregister them at the point of inspection. In addition, the two partners of the practice, registered with CQC, had not provided support to the local practice management team and were not present during this inspection.

What we found at this inspection:

1. The practice conducted a monthly audit now being done of workforce quality, to better manage the clinical correspondence received by GP practices, and reduce GP workload.

A comprehensive review of systems and processes led to increased understanding of risks and mitigation.

An external company had provided advice regarding workflow processes, to address the backlog of outstanding correspondence.

2. The provider had ensured there was adequate leadership and capacity to ensure the improvements needed were made. They were in the process of recruiting additional staff to promote capacity, in the proceeding two months after inspection.

Actions and improvement plans had been identified but not all had been implemented due to the significant improvements required. Further plans were being developed for when the provider had recruited additional staff, to ensure staffing levels were at an adequate level to allow improvements to be made. Following this inspection, we wrote to the provider to confirm our levels of concern around a number of areas in the safe and effective domain. The provider responded with a comprehensive outline of the additional actions needed, recognising the timescales for some improvements would extend to 12 months.

3. All staff we spoke with referred to a vast improvement in morale since the new provider arrangements. Staff said they supported with training and career development opportunities.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y

Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
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Progress against delivery of the strategy was monitored.	Y
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What we found at the August 2019 inspection:

Simplified call data showed both the number of calls made and calls abandoned, but this did not have information on call waiting times. Information from the hub call board was recorded at 10.40am, 11.45 am and 12.45pm on 13 August 2019. The information, which was a mix of what we saw on the day and data provided by the practice, showed:

- Once a patient had contacted the practice to make an appointment, and then requested a call back via the practice answer machine, the longest wait to receive this call back was 38 minutes. Outside of the times recorded, the longest wait for a call back on the day was 64 minutes. This data showed an improvement from data submitted in July 2019, when the longest wait for a call back was around 75 minutes.
- Patients waited no longer than eight minutes before speaking to a call handler at the practice. The longest wait on the day 16.09 minutes. This data showed an improvement from data submitted in July 2019, when the longest wait to speak to a call handler was around 40 minutes.
- No calls had been abandoned. Review of data supplied by the practice related to call handling was sampled and showed that abandoned calls were minimal. This data showed an improvement from data submitted in July 2019, when an average of 15 calls per day were abandoned.

What we found at this inspection:

- Staff told us the practice was currently providing a higher quality service for patients than was the case previously (based on verbal feedback received from patients at the reception desk, and on the phone), and that leaders valued their suggestions for positive changes.
- Clinical and non-clinical staff reported being less concerned that patients may be at risk, as the changes or subsequent improvements made were becoming more effective. For example, as this related to additional staffing resource and the development of safe processes and systems.
- An increase in same day appointments and support within the Hub has led to a reduction in telephone call waits. Twelve months ago, the longest wait time was over 75 minutes, this is now down to around 10-14 minutes.
- There is ongoing recruitment to additional posts to address the back-log in summarising and putting processes in place going forward.
- We had not received complaints about access and appointment delays since the new provider arrangements.

The provider had a clear vision and strategy which had been shared with staff and patients. Staff we spoke with were clear about the priorities and felt they had been included in the development. They were also committed to making the improvements to Moredon Medical Centre.

The current strategy was to continue with the transformation plan, implementing the changes and embedding good practice. The provider told us about the arrangements in place to monitor the changes and the regular reporting to the trust board.

Culture

The practice had a culture which drove high quality sustainable care but improvements were still required.

	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
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y

What we found at the August 2019 inspection:

- Some staff reported safety fears when the check-in screen malfunctioned, because this increased the numbers of people waiting to speak to them at the reception desk. When we spoke with staff, they told us the check-in screen had 'consistently malfunctioned' for the last three months, and that they had reported this, but no action had been taken.

What we found at this inspection:

- Staff we spoke with told us that levels of work satisfaction had improved since the new provider arrangements. They told us they now felt feel respected, valued and supported by practice leaders. Staff also told us that increased understanding of their work pressures positively affected how they interacted with patients. For example, staff told us that, previously, a 'top down, directive culture' had had a negative effect on their professionalism and manner, making them defensive and appearing to lack compassion with patients.
- Staff identified a more permanent practice manager presence, whole team half days (where clinical and other practice issues were discussed), access to a massage therapist and work identifying training requirements as the most prominent and positive changes.

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

Source	Feedback
Staff interviews	Staff we spoke with told us that levels of work satisfaction had improved since the new provider arrangements. They told us they now felt feel respected, valued and supported by practice leaders. Staff also told us that increased

	understanding of their work pressures positively affected how they interacted with patients.
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Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial1
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

What we found at the August 2019 inspection:

Governance arrangements were not always clear and effective, were out of date, or there was no monitoring of risk.

What we found at this inspection:

Governance structures and processes had been implemented across the practice. Although the implementation was recent and it was too early to assess the effectiveness at this inspection, we saw:

- Risk assessments for legionella were planned.
- Fire safety and premises risk assessments were undertaken, with actions either undertaken or planned.
- Information was comprehensively collected and reviewed appropriately, with action taken as a result.
- All staff were aware of safeguarding processes.
- Complaints had all been investigated, acknowledged and responded to.
- Recruitment files contained all required information as per practice policies.

However, we found shortfalls. For example:

- There was no evidence of quality improvement or an established programme, for example clinical audit activity.
- We could not be assured that all patients would have appropriate risk assessments carried out for their medical needs.
- An unsummarised records backlog created by the previous provider had not been resolved. There were approximately 800 patient records which had not been summarized for patients registering with Moredon Medical Centre, dating back to October 2018. The absence of this information may increase the risk of clinicians not having the correct information about a patient at the time of consultation, review or assessment.
- Systems designed to demonstrate care and treatment, provided in line with recommended timescales, showed poor performance results. Some records reviewed did not contain appropriate coding.

Managing risks, issues and performance

There were processes for managing risks, issues and performance, but it was too early to fully assess their effectiveness.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N ¹
There were processes to manage performance.	N ²
There was a systematic programme of clinical and internal audit.	N ³
There were effective arrangements for identifying, managing and mitigating risks.	N ⁴
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

What we found at the August inspection:

Risks, issues and poor performance were not always dealt with appropriately or quickly enough.

1. There was a failure to manage risks, issues, performance management; audit systems and processes. Risk or issue registers and action plans were not always completed, reviewed or updated. For example, actions from risk assessments for legionella and fire safety had not been completed within the timeframes specified on the practice's action plan.
2. Improvements were needed to ensure learning was effectively shared as a result of significant events and complaints. Although the practice had made some progress in dealing with the backlog of correspondence, there were continued shortfalls in audit systems and processes.

What we found at this inspection:

1. Systems to provide assurance were still in development or early stages of implementation and it was too early to assess the effectiveness at this inspection.
2. Managing performance of patient outcomes had been identified as requiring significant improvement. However, the provider had to prioritise the recruitment of staff in the first instance. Actions to address poor performance in relation to the outcomes of patients with long-term or mental health conditions were only recently being developed. Following inspection, the provider shared an outline of the plans to make improvements in this area over the next 12 months.
3. There was limited internal audit and quality improvement activity due to the prioritisation of more urgent actions from the transformation plan.
4. Risk to patients required improvement and this included the risks to those with long-term or mental health conditions.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making. However, systems to assure appropriate and accurate information had not yet been embedded.

	Y/N/Partial
Staff used data to adjust and improve performance.	Partial ¹
Performance information was used to hold staff and management to account.	Partial ¹
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial ¹
There were effective arrangements for identifying, managing and mitigating risks.	N ¹
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>What we found at the August inspection:</p> <p>Between our last inspection in April 2019, and this current inspection, the provider has increasingly used information to monitor and address performance issues and to make decisions. The correspondence backlog was being managed and appropriate action taken when needed. Call waiting times, accessing appointments, and problems with the Prescription Ordering Service (POD) have been addressed. Regular performance reports show the provider was steadily reducing waiting times for appointments and prescription requests. Complaints from patients, and from stakeholder organisations that represent patient's interests have reduced.</p> <p>What we found at this inspection:</p> <p>The new provider has continued with efforts to address the backlog of correspondence. However, information and data relating to patient outcomes was not always accurate or recorded appropriately. We found outcome measures were significantly lower than clinical commissioning groups and national averages.</p>	

Engagement with patients, the public, staff and external partners

The practice had taken steps to improve the involvement of 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
The practice had an active Patient Participation Group.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y

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 ¹
Learning was shared effectively and used to make improvements.	N ²
Explanation of any answers and additional evidence:	
<ol style="list-style-type: none"> 1. Continuous improvement was evident within the current and immediate transformation plan. The provider told us about new innovations they were considering once the immediate improvements had been made and in the longer term. This includes the joining together of primary, community and secondary care services across Swindon; identifying care navigator training for frontline staff and assessing an online triage system to support and meet patient demand for same day care and services. 2. Whilst learning and sharing was evident to ensure improvements, this was not always undertaken in a structured way. 	

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 practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: <https://www.cqc.org.uk/guidance-providers/gps/how-we->

[monitor-gp-practices](#)

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.