

Care Quality Commission

Inspection Evidence Table

Phoenix Surgery (1-9308400225)

Inspection date: 7 September 2022

Date of data download: 06 September 2022

Overall rating: Requires Improvement

This was the first inspection of the practice since its registration with the Care Quality Commission on 31 July 2020. The practice is rated Requires Improvement because:

- Our clinical searches of the electronic patient records, identified some patients who had been bulk read-coded as having an appropriate review. However, on further investigation, it was found not all of these patients had received an appropriate assessment. Bulk-coding means multiple documents or records had been acted on at once, instead of being coded individually ensuring specific and person-centered approach.
- The monitoring of patients on high-risk medicines and some long-term conditions were not always in line with National Institute of Health and Care Excellence (NICE) recommendations.
- We could not be assured the leaders understood the challenges to the quality and sustainability of the service, due to issues we found.

Safe

Rating: Requires Improvement

We rated the practice as Requires Improvement for providing safe services because:

- Not all clinicians were trained to appropriate levels for their role in safeguarding in accordance with national guidance. A a bulk read-code had been added to the safeguarding register as the patients were having their reviews done, however, this was not the case upon reviewing the documentation.
- Recruitment checks were not always carried out in accordance with regulations.
- We found that not all people on high-risk medicines had had appropriate monitoring in the last 12 to 18 months.

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Yes
Partners and staff were trained to appropriate levels for their role.	Partial
There was active and appropriate engagement in local safeguarding processes.	Yes

Safeguarding	Y/N/Partial
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Partial
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
<p>Not all clinicians were trained to an appropriate level of safeguarding for both children and adults, in line with intercollegiate guidance. All registered health care staff should be trained to level three, for example, general practitioners and registered nurses. We found that two out of three GPs had not had their Level 3 training up to date. Furthermore, the GP safeguarding lead, was not up to date with their training. After the inspection the provider sent us a spreadsheet with updated safeguarding training for clinicians with appropriate levels achieved. However, there were no certificates submitted, so the competence could not be fully demonstrated.</p> <p>There was a system to identify vulnerable patients on record, however, at the time of the inspection this was not up to date. As part of our clinical remote searches, we reviewed safeguarding registers and found that a bulk read-code had been added, for both children and adults, as having had a safeguarding review. However, there were no further details in the patient's record of the review or what was discussed. At the time of the inspection on 7 September 2022, we saw evidence of written notes of the safeguarding reviews which had taken place on 2 September 2022. However, these reviews had not yet been added to the system at the time of the inspection, so we could not be assured the vulnerable patient's records were up to date.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence:	
<p>Not all staff had the full employment checks done. At the time of the inspection, the practice operated on dual systems for recruitment checks, both paper and electronic files. This created a barrier to having comprehensive recruitment checks, as documents were stored in different places. For example, for one of the receptionists who had worked at the practice since 2002, they did not have proof of identity or references in their file or electronic record. The provider sent some of the missing evidence post-inspection, however not all gaps we found at the time of the inspection were covered, and we could not be assured that full recruitment checks were obtained.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: General Risk Assessment 30/06/2022	Yes
There was a fire procedure.	Yes

Date of fire risk assessment: 30/06/2022 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: There was a General Risk Assessment document in place which was dated 30/06/2022. However, this was a list of hazards and control measures that were in place, and there was no measurement of risk. Post inspection we received a Premises and Security Risk Assessment and were assured that the provider took an action to assess and manage the risks. However, this was a short document, dated 22/03/2022 and one action recognised in it, had not been completed.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 20/06/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes
The arrangements for managing waste and clinical specimens kept people safe.	Yes

Risks to patients

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes

Information to deliver safe care and treatment

Staff had 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. ¹	Yes

There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
The practice processed pathology requests in a timely manner, however, because of the issues found in our clinical searches for people with long-term conditions and on high-risk medicines we could not be assured all test results were appropriately documented.	
The practice had adapted "Quality of Outcomes (QOF), long-term conditions (LTC) and Recall Procedure and Action Plans" for the management of people with long-term conditions and high-risk medication. However, our clinical search found that in some cases test results were not managed in a timely way and there wasn't an appropriate overview of test results. This is further explained in the Effective domain below.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	0.62	0.74	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	10.2%	9.8%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets	6.14	4.82	5.31	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) <small>(NHSBSA)</small>	146.2‰	122.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) <small>(NHSBSA)</small>	0.69	0.63	0.59	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) <small>(NHSBSA)</small>	8.0‰	5.8‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Partial
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines. ¹	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. ²	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N/A
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	N/A
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes

Medicines management	Y/N/Partial
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
Explanation of any answers and additional evidence, including from clinical searches.	
<p>Not all of the Patient Group Directions (PGD)s were managed according to guidance. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a doctor or nurse prescriber. Some of the PGD's had post-authorisation records added for staff who had joined the practice after the original authorisation had been made. Guidance for the authorising manager stated at the end of the PGD states that any unused lines should be scored through once authorised and a new sheet started for further approvals. Post inspection the provider submitted updated records, evidencing that this had been rectified.</p> <p>Our clinical searches identified that not all of the patients with long-term conditions and on high-risk medicines had appropriate monitoring in place. The details of the findings can be found below in Effective domain.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	2
Number of events that required action:	2
Explanation of any answers and additional evidence:	
<p>The practice had recorded two significant events in the last 12 months. However, the provider had consistently monitored all near misses and other issues arising calling them "causes of concern". The practice recorded 8 of them in the last 3 months. These were monitored, managed and escalated as appropriate, the practice manager had a system in place to review those monthly.</p>	

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

Event	Specific action taken
An incorrect label was attached to sample bottles, therefore not able to be tested at the laboratory.	<ul style="list-style-type: none"> • The patient was contacted and the incident explained and a repeat test booked. • A review of the incident was completed with the staff involved. • Information regarding the incident was added to the staff newsletter and learning was shared – for samples to be labeled and bagged before the next patient consultation. • Reviewed at the significant event meeting on the 2nd August.
There had been a delay in completing coroner's form due to GP going on annual leave.	<ul style="list-style-type: none"> • Review of GPs to use portal instead of paper copies • Discussed at clinical meeting and the need to use portal confirmed • Learning shared with staff

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence: We saw examples of actions taken on recent alerts, for example, regarding sodium valproate.</p>	

Effective

Rating: Requires Improvement

This was the first inspection of the practice since its registration with the Care Quality Commission on 31 July 2020. The practice is rated Requires Improvement because:

- Our clinical searches have identified some patients who had been bulk read-coded as having an appropriate review but on further investigation, it was found not all of these patients had received an appropriate assessment.
- The monitoring of patients on high-risk medicines and some long-term conditions was not always in line with National Institute of Health and Care Excellence (NICE) recommendations.
- Child immunisation and cervical screening were below national targets.
- There were some gaps in mandatory training for staff.

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing. ¹	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way. ²	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated. ³	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: Our clinical searches found not all of the patients with long-term conditions and on high-risk medicines had required monitoring as per guidance. See examples below in Effective care for the practice population.	

The search also found that for patients living with dementia and mental health issues and/or on the safeguarding register there was a bulk read-code added, which suggested patients had their care plans and/or reviews completed. However, when reviewing the documents it showed us these care plans/reviews had not been completed at the time of the inspection. For example, our clinical search found that 147 patients had been coded as hypertensive due to historic blood pressure recordings. These patients had received a read-code of hypertension added in bulk on 17 June 2022 and 15 July 2022. Whilst the appropriate code had been applied to patient records there was no subsequent evidence in the records of a review of care and treatment being undertaken with each patient or that this had been carried out in consultation with the patient.

Effective care for the practice population

Findings

The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.

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.

All patients with a learning disability were offered an annual health check.

End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

The practice demonstrated that they had a system to identify people who misused substances.

Patients with poor mental health, including dementia, were referred to appropriate services.

The practice had a social prescriber in place, who offered a range of services to the practice population. For example, the social prescriber liaised with carers and offered them health checks, provided financial advice as a response to the cost of living crisis, supported weight management and kept engaging with patients on the safeguarding register and those who might be isolated or lonely, offering support where appropriate.

Management of people with long term conditions

Findings

Patients with long term conditions and on high-risk medicines were not always reviewed to ensure their treatment was optimised in line with national guidance:

- Of the 80 patients prescribed Direct-Acting Oral Anticoagulants (DOAC – medicines which thin the blood), six of these patients did not have a record of their Creatinine Clearance (CrCl) blood test and their CrCl level was based on out-of-date monitoring. CrCl test provides information about how well kidneys are working. For patients on DOAC this is used to determine appropriate dose of medication.

- Of the 527 patients with asthma who had been prescribed two or more courses of rescue steroids, 16 patients had not had the required monitoring to help prevent further exacerbation of their condition. The patients should be reviewed annually.
- Of the 120 patients with hypothyroidism, 15 patients had not had the required thyroid function test (TFT) for 18 months to check their medicines were correct. These patients should have regular TFT test to assess the ability of the thyroid gland to produce and regulate thyroid hormone production.
- Of the 287 patients with diabetic retinopathy whose latest HbA1c (average blood glucose level) was >74mmol/l, 26 had not had the required monitoring in the last 12 months.
- A search identified six patients who had a potential missed diagnosis of diabetes. A bulk text message had gone out to patients to request them to attend the practice for a diabetes check, but the patients had not been informed they were diabetic. There was no evidence of further reviews booked for those patients at the time of the inspection.
- Patients with other long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services.
- Patients with asthma were offered an asthma management plan, however this was not always up-to-date.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	23	25	92.0%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	38	81.6%	Below 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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	31	38	81.6%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	31	38	81.6%	Below 90% minimum

(01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	32	39	82.1%	Below 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>

Any additional evidence or comments

The practice had not met the 90% minimum World Health Organisation (WHO) target for child immunisation for four out of five immunisations. However, we saw evidence the practice had a process in place for following up non-attendance of booked appointments and they were actively doing re-call to encourage the uptake. The practice had also worked in collaboration with South, Central and West Commissioning Support Unit (SWCCSU) to improve the uptake of immunisation, this included completing a data cleanse and additional training for administration staff to better understand the immunisation schedule.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	67.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	73.3%	67.4%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	60.1%	69.9%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	37.5%	62.3%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

Any additional evidence or comments

The practice did not meet the 80% England average for cervical cancer screening. We saw evidence of unverified data from the practice, which suggested that the practice's cervical screening is at 74.5% (72.5% for people aged 25-49 and 76.4% for people aged 50-64).

We saw evidence the practice encouraged uptake by inviting eligible patients, and displaying posters in the practice, reminding patients not to ignore their cervical screening appointments. Recently the practice ran the first Saturday clinic to give the patients more flexibility when booking appointments and there was a plan in place to carry on the Saturday clinics every first Saturday of a month.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Partial
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

Phoenix Surgery took part in West Swindon local and national initiatives for improving health and wellbeing. One of the initiatives recognised by the programme was introducing a social prescriber.

Any additional evidence or comments

The practice did not provide any examples of clinical audits at the time of the inspection. The practice had "QOF, LTC and Recall Procedure and Action Plans" in place, that recognised step-by-step guidance for all long-term conditions.

The action plans for asthma, atrial fibrillation, chronic kidney disease (CKD), COPD, diabetes, epilepsy and heart failure management stated the operation manager was responsible for ensuring the correct coding and recalls were applied before the patient contact was made. However, findings from our clinical searches discovered the issue of bulk read-coding the patients prior to them having a review of care plans submitted. This meant patients were put at risk of not receiving appropriate care in a timely way and at risk of harm due to incomplete care planning.

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.	Partial
The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: There were some gaps in mandatory training. For example, two out of three GPs were not up to date with their safeguarding, mental capacity act, equality and diversity and fire safety training. There was limited evidence to show us who was responsible for making sure that all staff had their training completed. The practice manager told us they can see on the system whose training was overdue, but we saw no evidence of this being monitored and actioned when training was due.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. ¹	Yes

Caring

Rating: Good

Kindness, respect and compassion

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

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

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	70.7%	88.1%	84.7%	Tending towards 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 (01/01/2022 to 30/04/2022)	75.0%	87.9%	83.5%	No statistical variation
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 (01/01/2022 to 30/04/2022)	88.7%	95.5%	93.1%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	51.4%	79.0%	72.4%	Tending towards variation (negative)

Any additional evidence or comments

The practice was collecting patient feedback through comments cards available in the reception area and texts sent to patients after appointments. This data was collated each month and reviewed by the

practice manager to review trends. The results from August 2022 showed that patient's overall experience with the practice was 85% positive.

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

Involvement in decisions about care and treatment

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

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

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	77.9%	93.0%	89.9%	Tending towards variation (negative)

Any additional evidence or comments

From the practices' own feedback collated monthly, the response to the question about time spent with healthcare professional was 82% good.

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

Carers	Narrative
Percentage and number of carers identified.	1.3%, 61 carers.
How the practice supported carers (including young carers).	A social prescriber offered health checks and support. A link to Swindon Carers Centre was available on the website and posters informing of resources available for carers were in the practice.
How the practice supported recently bereaved patients.	A social prescriber offered calls and support. The practice sent out bereavement cards.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	8 am – 6 pm
Tuesday	8 am – 6 pm
Wednesday	7 am – 6 pm
Thursday	8 am – 6 pm
Friday	8 am – 6 pm
Appointments available:	
Monday	8 am – 1 pm and 2 pm – 6 pm
Tuesday	8 am – 1 pm and 2 pm – 6 pm
Wednesday	7 am – 1 pm and 2 pm – 6 pm
Thursday	8 am – 1 pm and 2 pm – 6 pm
Friday	8 am – 1 pm and 2 pm – 6 pm

Further information about how the practice is responding to the needs of their population

- 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 liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- Additional nurse appointments were available at 7 am on a Wednesday for school age children so that they did not need to miss school.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice had introduced a Saturday clinic, which took place on the first Saturday of a month.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Yes
Patients were able to make appointments in a way which met their needs.	Yes
There were systems in place to support patients who face communication barriers to access treatment.	Yes
Patients with most urgent needs had their care and treatment prioritised.	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Yes

National GP Patient Survey results

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

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 (01/01/2022 to 30/04/2022)	39.9%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	38.9%	62.7%	56.2%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	40.5%	60.5%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	66.3%	76.6%	71.9%	No statistical variation

Any additional evidence or comments

The results from the practices own survey in August 2022 regarding access by phone was described as easy by 70% of responders and helpfulness at reception was 97%.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	7
Number of complaints we examined.	7
Number of complaints we examined that were satisfactorily handled in a timely way.	7
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

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

Example(s) of learning from complaints.

Complaint	Specific action taken
Incorrect information given by a receptionist caused a delay in care and referral.	<ul style="list-style-type: none"> • Call listened to • Staff involved interviewed and notes reviewed • Additional training given to the receptionist • Disussed at reception meeting
A patient was unhappy with a consultation from the GP considering their had been a lack of review and incorrect test results.	<ul style="list-style-type: none"> • Call listened to • GP interviewed and notes reviewed by a GP partner • Learning shared with clinicians: ensure clinicians explain how test result from hospital are processed.

Well-led

Rating: Requires Improvement

This was the first inspection of the practice since its registration with the Care Quality Commission on 31 July 2020. The practice is rated Requires Improvement because:

- We could not be assured the leaders understood the challenges to the quality and sustainability of the service, due to gaps in systems and processes found.
- We could not be assured risk was assessed and managed appropriately.
- There was no active Patient Participation Group in place.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: The leaders did not always take action when required to address challenges. At this inspection, we found issues, which were not addressed at the time: gaps in mandatory training for staff, gaps in recruitment, inadequate management of some of the long-term conditions and high-risk medicines identified by our clinical search. The practice had the The Quality and Outcomes Framework (QOF) and long term conditions (LTC) protocol in place which identified actions to be taken and plan for each of the conditions. However, it did not mention any timescales for this to be achieved, therefore we could not be assured the practice had a sustainable plan to complete it.	

Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes

Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Partial
Staff had undertaken equality and diversity training.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Not all staff were aware of the Freedom to Speak Up guardian in the practice. The staff we spoke with did not know who the Freedom to Speak up Guardian was. However upon reviewing the practices whistleblowing policy, two members of staff were identified. This was fed back to the provider at the inspection.</p> <p>Upon reviewing staff's training we saw that two members of staff were not up to date with their equality and diversity training.</p>	

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

Source	Feedback
CQC Staff Questionnaire	<ul style="list-style-type: none"> We sent staff surveys to the practice prior to the inspection. We received 11 staff surveys back. Staff told us the practice was a good place to work and everyone in the team was supportive. During inspection staff we spoke with were complimentary about the practice, the management and support they received.

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.	Yes

Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>The practice did not always appropriately manage risks. We found that the health and safety risk assessment was not comprehensive and did not consider all risks and their levels. This was discussed with the practice manager at the time of the inspection and post-inspection, additional documentation was provided, which had more detail. However some further developments needed and actions remained incomplete.</p> <p>The practice did not always manage risk to patients appropriately. The practice had developed QOF, LTC and Recall Procedure and Action Plans for long-term conditions and high-risk medicines, however, our clinical search had found that some of the patients had not been appropriately monitored at the time of the inspection. This indicated there had not been oversight of systems and processes to ensure the monitoring and care and treatment of patients.</p>	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes

There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence: The practice did not have an active Patient Participation Group (PPG) at the time of the inspection. We saw evidence the practice had actively been trying to recruit new members to join the PPG and information was available to patients both in practice and on their website. PPGs are made up of volunteers interested in healthcare issues which meet to decide ways and means of making a positive contribution to the services and facilities offered by the surgery to patients.</p>	

Feedback from Patient Participation Group.

Feedback
As there was not an active PPG in place we were unable to obtain feedback.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence: The practice did not always monitor the outcomes of care and treatment, therefore we could not be assured that they sought continuous learning and improvement. However they have learnt from significant events and “causes of concerns”, and these have been shared with the team during team meetings, we could not be assured they have improved outcomes for patients in other fields. The practice did not provide any examples of clinical audits at the time of the inspection.</p>	

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique, we can be 95% confident that the practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.