

# Care Quality Commission

## Inspection Evidence Table

### Moredon Medical Centre (RN3X2)

Inspection date: Remote 9 May 2022, Onsite 10 May 2022

Date of data download: 04 May 2022

## Overall rating: Requires Improvement

We previously inspected Moredon Medical Centre on 23 February 2021 to follow up on areas of concern identified at the previous inspection on 20 February 2020. At the 23 February 2021 inspection we identified further concerns regarding the provision of safe and well-led services.

We carried out a focused inspection on 9 to 10 May 2022 to follow up on concerns identified in the 23 February 2021 inspection. At this inspection we identified some concerns had not been resolved and new areas of concern were identified regarding the provision of safe, responsive and well-led services.

## Safe

## Rating: Requires Improvement

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

- Fire safety processes were not embedded.
- Systems to ensure actions taken to mitigate risk were recorded and communicated at practice level were not consistently effective.
- Coding on patient records was not always appropriate to ensure safe care and treatment.
- Information contained in patient records was not always appropriate to ensure patients received care and treatment which met their needs.

At this inspection the practice remained requires improvement for providing safe services because:

- Staff were not always trained to appropriate levels for their role in safeguarding.
- We found assurance systems had been implemented but they were not fully effective. For example, Legionella and staff training.
- Information contained in patient records was not always appropriate to ensure patients received care and treatment which met their needs.
- Staff did not always have the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).
- Systems to record and act on safety alerts were effective. However, historically missed alerts had not been reviewed.
- The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period was not met.

## Safety systems and processes

**The practice did not always have 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
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Yes
Explanation of any answers and additional evidence:	
At our inspection in February 2021 we found: <ul style="list-style-type: none"> <li>• Training records demonstrated that not all staff had completed safeguarding training appropriate to their role.</li> <li>• Chaperone processes were not embedded and did not give effective guidance to staff.</li> </ul>	
At our inspection in May 2022 we found: <ul style="list-style-type: none"> <li>• Training records demonstrated that the majority of staff had completed safeguarding training appropriate to their role with the exception of staff who required safeguarding level three training. The organisation shared the practice mandatory training record for 10 May 2022, which showed only 38% of staff required to be trained to Safeguarding Adult Level 3 had completed their training. Mandatory training for individuals was determined from the training needs analysis for each role.</li> <li>• The Primary Care Network (PCN) had a full-time safeguarding lead who routinely attended case conferences, completed reviews and arranged regular staff training for safeguarding.</li> <li>• Staff told us the chaperone policy was embedded and only clinical staff were asked to chaperone patients.</li> </ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: October 2021	Yes

There was a fire procedure.	Yes
Date of fire risk assessment: October 2021 Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence:	
<b>Premises security Health and Safety</b>	
At the inspection in February 2021 we found:	
<ul style="list-style-type: none"> <li>The security risk assessment identified that additional lone working training should be explored and that close circuit television (CCTV) was under review.</li> </ul>	
At the inspection in May 2022 we found the area of concern had been addressed:	
<ul style="list-style-type: none"> <li>Premises risk assessments for Moredon Medical Centre were in place.</li> <li>We observed there was no internal security to prevent patients and visitors to access corridors or stairs within the building. However, the management team told us that they had recently submitted a request for CCTV to address this.</li> </ul>	
<b>Health and Safety</b>	
At the inspection in February 2021 we found:	
<ul style="list-style-type: none"> <li>The practice had completed appropriate premises and security risk assessments. However, a responsible person was not always identified to ensure works were carried out and completed.</li> <li>Systems to ensure actions taken to mitigate risk relating to Legionella were not communicated effectively at practice level. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings.)</li> </ul>	
At the inspection in May 2022 we found that not all areas of concern had been fully addressed:	
<ul style="list-style-type: none"> <li>Systems were in place to mitigate risk relating to Legionella. However, the local management team were unaware of actions being taken and were reliant on the Great Western Hospital (GWH) estates team to address them.</li> </ul>	
<b>Fire procedures</b>	
At the inspection in February 2021 we found:	
<ul style="list-style-type: none"> <li>Fire alarm checks were not consistently undertaken.</li> <li>The fire risk assessment checklist was not site specific.</li> <li>There was no indication on the fire risk assessment checklist if actions identified had been completed.</li> <li>It was unclear if there would always be a staff fire marshal on site as there were insufficient trained fire wardens working cross site.</li> </ul>	
At the inspection in May 2022 we found that the areas of concern had been addressed:	
<ul style="list-style-type: none"> <li>There had been routine fire drills, the most recent was undertaken in April 2022.</li> <li>Fire alarm checks were completed weekly.</li> <li>Fire risk assessments for Moredon Medical Centre were completed and site specific.</li> <li>Fire risk assessments with action plans were completed.</li> <li>There were 10 fire marshals routinely working on site.</li> <li>91% of staff had completed fire safety training.</li> </ul>	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met/not 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:	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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> <li>The provider had a dashboard, which showed the level of compliance against standards set. We found 96% of staff had completed Infection Prevention and Control training Level One and 92% of staff had completed Level Two.</li> </ul>	

## 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
Explanation of any answers and additional evidence:	
<p>At this inspection we found that systems were used to ensure the identification and management of risk:</p> <ul style="list-style-type: none"> <li>We observed the 'daily state of play' meeting where staff absence for each staff group was discussed and decisions were made regarding cover for any unplanned absence.</li> <li>All staff, both clinical and non-clinical, had received specific training to identify deterioration of a patient and possible sepsis. In May 2022, sepsis was a topic at a training event for Advanced Nurse Practitioners within the Primary Care Network (PCN).</li> <li>Management told us they had recruited into permanent GP positions and were less reliant on locum GPs. Locum GPs were booked early, and the service endeavored to use the same locums for continuity.</li> </ul>	

- The practice allocated a GP daily, to assess patients requesting a consultation via e-consult, the hub or reception and categorised their needs using a red, amber, green (RAG) rating system. Patients were then directed to the most relevant clinician, including advanced care practitioners (ACP) and clinical pharmacists as well as GPs.

## 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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
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.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>The practice assured us that there were systems and processes in place to identify and manage the summarising of patient records with a completion date to clear a backlog of May 2021.</li> </ul> <p>At the inspection in May 2022 we found some backlogs had not been fully addressed:</p> <ul style="list-style-type: none"> <li>We identified there were shortfalls in appropriate clinical coding, the management team informed us the service was two months behind with routine clinical coding. This remained a risk to patient safety.</li> <li>We identified there were still shortfalls in systems to summarise patient records on 10 May 2022, the PCN performance tracker summary showed the service had a backlog of 2,741 records waiting to be summarised.</li> <li>We identified nine patients with a possible missed diagnosis of diabetes. The blood test for diabetes (Hba1c) and coding to inform staff and patients of diabetes risks is required for patients with results greater than 48 mmol/mol. Five records were randomly reviewed during this inspection, we found two patients had not been coded as diabetic, one patient with two previous readings of Glycated hemoglobin test (Hba1c) 48 or greater in 2012 and who was registered with the practice in 2019 had no recent Hba1c test and was not coded with diabetes and had not been offered the appropriate support for managing this. The practice told us they were planning on training the broader administration team to cover the coding/summarising/scanning processes to upskill the team and build resilience into the process.</li> </ul>	

## Appropriate and safe use of medicines

### The practice did not always have systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHS Business Service Authority - NHSBSA)	1.08	0.69	0.76	Tending towards variation (negative)
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). (01/01/2021 to 31/12/2021) (NHSBSA)	9.9%	10.4%	9.2%	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 prescribed for uncomplicated urinary tract infection (01/07/2021 to 31/12/2021) (NHSBSA)	5.02	4.76	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	178.0‰	124.8‰	129.2‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2021 to 31/12/2021) (NHSBSA)	0.66	0.66	0.62	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2021 to 31/12/2021) (NHSBSA)	9.6‰	5.9‰	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

Medicines management	Y/N/Partial
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Yes
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Yes
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>• Our inspection indicated that patients received appropriate monitoring and intervention, however coding on patient records was not always accurate to reflect this.</li> </ul> <p>At the inspection in May 2022 we found that some areas of concern were still not fully addressed:</p> <ul style="list-style-type: none"> <li>• High risk medicines were not always monitored. We undertook a remote search of the practice's clinical patient records system which showed 1,336 patients were prescribed an ACE Inhibitor (a medicine used to lower blood pressure), of which 34 had not had the required monitoring. We reviewed five of these records and three were overdue (one had been seen in hospital and one had only required monitoring throughout pregnancy).</li> <li>• The immunisation patient group directive (PGD), which is used to ensure appropriate authorisations to administer medicines, was incorrectly completed and the authorising clinician had signed prior to some of the signatories being added making it invalid. The surgery corrected this during our inspection.</li> <li>• Patients received appropriate monitoring and intervention, however coding on patient records was not always accurate, for example, out of nine records where there was a possible missed diagnosis of diabetes, we sampled five records, two records had not been coded as diabetic. This</li> </ul>	



Medicines management	Y/N/Partial
meant that patients were at risk of not having correct monitoring and access to appropriate support services.	

## Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong. However, there were shortfalls identified regarding the management of safety alerts.

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:	94
Number of events that required action:	87
Explanation of any answers and additional evidence:	
<p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>Significant events were reported and investigated effectively. Incidents were discussed at a weekly incident meeting to ensure actions were taken. Learning was shared with clinical staff through team meetings and emails sent to staff. However, there was no process to ensure incident learning sent to staff by email had been read and implemented.</li> </ul> <p>At the inspection in May 2022 we found:</p> <ul style="list-style-type: none"> <li>The service had an embedded process for staff to report significant events via the Trust's intranet where it was reviewed within the Primary Care Network (PCN). Lead staff were assigned to attend the Great Western Hospital (GWH) divisional daily safety meeting. Learning was taken to the bi-weekly clinical meeting to share learning. For more serious incidents, a decision was made within 48 hours as to whether a full root cause analysis needed to be completed. The individual raising the incident received a copy of the report. Staff told us the outcome was shared locally via safety meetings and emails.</li> <li>Staff informed us that the service shared appropriate incidents with the national reporting learning system, where one incident was going to be discussed at the annual non-medical prescribing update to improve learning.</li> </ul>	

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

Event	Specific action taken
Cancer patient care delayed	An allocated GP now audited all cancer presentations, looking to ensure it was flagged as a two week wait and followed up.
Issue concerning remote triage of a patient with sepsis	PCN proactively developed sepsis screening tool telephone triage template for patients aged 12 and above (with the developers), to improve quality of care; They also utilised a sepsis leaflet.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>The practice did not always have an effective system to ensure medical safety alerts from Medicine and Healthcare Products Regulatory Agency (MHRA) or other bodies were being acted on appropriately.</li> </ul> <p>At the inspection in May 2022 we found some areas of concern had still not been addressed:</p> <ul style="list-style-type: none"> <li>The practice did not always have an effective system to ensure medicine safety alerts from the Medicine and Healthcare Products Regulatory Agency (MHRA) or other bodies were being acted on appropriately. The practice had systems and process which were embedded in practice for alerts since 2019. However, historic issues had not been reviewed. For example: We identified 11 patients who were prescribed omeprazole and clopidogrel concurrently. Omeprazole reduces the antiplatelet effect of clopidogrel, and concurrent use should be avoided. We looked at five clinical records of patients who had been prescribed both medicines and found four should not have been prescribed this concurrently. This was identified and responded to during the course of the inspection, however, we were not assured that other legacy alerts prior to 2019 had been identified as part of routine monitoring.</li> </ul>	

## Effective

## Rating: Requires Improvement

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 was rated as good in the inspection in February 2021.

At this inspection we rated the practice requires improvement for providing effective services because:

- Patients' needs, care and treatment was not always delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.
- Long-term conditions were not always followed up in an appropriate timescale or after changes in treatment, including those where any changes in treatment had occurred out of hours or whilst in hospital.

### • Effective needs assessment, care and treatment

**Patients' needs were not always assessed, and care and treatment was not 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.	Partial
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	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:	
At the inspection in February 2021 we found:	
<ul style="list-style-type: none"> <li>• Clinical coding was not always consistently applied.</li> </ul>	
At the inspection in May 2022 we found:	
<ul style="list-style-type: none"> <li>• Clinical coding was still not always consistently applied, we were informed by the management team that routine clinical coding backlog remained two months behind.</li> </ul>	

- Patients had not always received appropriate follow up care for their long-term conditions.
- The practice could not always demonstrate how they identified patients with commonly undiagnosed conditions.
- The practice had not always followed up patients with long-term conditions where any changes in treatment had occurred out of hours or whilst in hospital.

## Effective care for the practice population

### Findings

- The practice had created an 'essential information button' on the clinical patient records system which provided staff with emergency guidance. Information within the guidance included links to Standard Operating Procedures (SOPs), policies, useful resources, local pathways and protocols.
- The practice demonstrated a Learning Disability review had been completed by the Learning Disability (LD) Nurse employed by the PCN, which included the development of care plans for those patients. The practice had improved learning disability reviews from 4% to 67% and was aiming to improve further since they have employed a LD Nurse.
- Online learning for healthcare training was completed with reception and hub staff to cover major emergencies, so they were able to identify deteriorating patients, staff had supplemented their training by undertaking a mental health first aid course. Reception staff were given clear guidance (procedures) to identify which requests for care or treatment needed to be allocated to the daily duty list when there are no appointments available to support patients to get the care they needed.
- The practice pharmacy team had a high-risk recall system where patients were prioritised using a Red/Amber/Green (RAG) rating. Health Care Assistants (HCAs) had access to the nationally recognised tool to access Long term condition (LTC) initial review template to ensure all the appropriate tests required for each review / high risk medicine were completed.
- The practice had recently embedded a system where patients were invited for cervical smear tests via text messages, and they could book directly into an appointment from a link within the text message. We saw evidence which demonstrated this process had generated good initial up take by patients.

## Management of people with long term conditions

### Findings

- Patients with long-term conditions were not always offered a structured annual review to check their health and medicines needs were being met. For example:
  - We identified six patients who had been over prescribed Short-Acting Beta Agonists (SABA) Inhalers, we reviewed five of those patients and found all five had been over prescribed medicine.
  - We identified 91 patients with diabetic retinopathy with a Glycated hemoglobin test (HbA1c) over 74mmol/1, we reviewed five and found that one was overdue review and two had their medicines reviewed but had not been coded appropriately.
  - We identified that seven out of a total of 448 patients with hypothyroidism had not had thyroid function tests within the last 18 months, we reviewed five of those patients and

found that four of them were overdue appropriate monitoring. The practice started reviewing these patients whilst the inspection was ongoing.

- The practice did not always demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. This may place patients at risk. We identified nine patients who had a potential missed diagnosis of diabetes, we reviewed five of those patients, three patients who were pre-diabetic had not been coded as such and had therefore not been offered retinal screening or foot checks. The practice reviewed the patients at the time of the inspection and told us they were planning on completing further routine audits to capture patients incorrectly coded.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. The practice trained Advanced Care Practitioners (ACPs) to carry out long-term condition reviews.
- The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions. The practice worked closely with local hospital specialists to discuss complex patients and gain advice on their management without the need for referral.
- The practice did not always follow up patients with long term conditions where any changes in treatment had occurred out of hours or whilst in hospital.
  - GPs did not always follow up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma. Our searches of the practice's clinical records system showed 44 patients had received rescue steroids out of a total of 1,871 patients on the asthma register, we reviewed five of those patients and all five had not had a follow up review. The practice started reviewing these patients during our inspection.

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)	140	151	92.7%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	169	186	90.9%	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	169	186	90.9%	Met 90% minimum

Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	169	186	90.9%	Met 90% minimum
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)	153	162	94.4%	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>

### Any additional evidence or comments

The practice had exceeded the minimum percentage required for childhood immunisation uptake indicators.

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: 31/12/2021) (UK Health and Security Agency)	67.9%	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)	66.0%	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)	61.9%	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)	60.4%	62.3%	55.4%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> <li>The practice had identified actions in order to improve uptake for cervical cancer screening (CVS) and had recently embedded a system where patients were invited for smear tests via text. Patients could book directly into an appointment from a link within the text. This had increased patient up take of CVS.</li> </ul>



## Monitoring care and treatment

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

	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.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

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

Any additional evidence or comments
<p>The practice had completed the following:</p> <ul style="list-style-type: none"><li>• The PCN held weekly clinical training workshops, which all of the practice staff were enabled to join dependent on the relevance of the topic. Hospital and community specialists also attended those workshops to increase knowledge and provide support where needed. Training that had been provided included cardiovascular palpitations, radiology, neurological headaches, social prescribing and safeguarding.</li><li>• The staff had various development pathways accessible to them through the provider. For example, direct access for advice from some consultants, this has allowed them to look at patients more holistically.</li><li>• The practice staff received a daily dashboard report from the provider identifying any patients registered at the practice due to be discharged from hospital that day. This facilitated early intervention and planning for patients on return home from the community multidisciplinary team.</li><li>• The Primary Care Network (PCN) employed a full-time safeguarding lead, allowing a high level of attendance at case reviews as appropriate for patients within the practice.</li><li>• The PCN had a daily meeting to review any emerging issues, during which organisational leads shared the current staffing situation, raised any concerns, and discussed any new significant incidents. We observed one of those meetings which ensured that any daily issues were resolved, and communication was shared across all teams.</li><li>• The practice had taken part in a number of quality improvement initiatives including:<ul style="list-style-type: none"><li>○ NHSE programme around population health management, where segmented data is used to find highest deprivation patients.</li><li>○ Sepsis Quality Improvement activities</li><li>○ High frequency attender work to identify high users of secondary care</li><li>○ Vulnerability team multidisciplinary team meetings</li></ul></li></ul>

## Effective staffing

**The practice was able 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
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>All staff had an up to date appraisal</li> <li>Processes to ensure staff completed and remained up to date with training were not fully embedded.</li> </ul> <p>At the inspection in May 2022 we found the areas of concern had been addressed:</p> <ul style="list-style-type: none"> <li>Over 95% of staff had an up to date appraisal and others were scheduled to be completed within the year.</li> <li>93% of mandatory training allocated to staff was completed and up to date. However, not all staff had completed safeguarding training appropriate to their role.</li> </ul> <p>The Primary Care Network, of which the practice was part, had a number of non-medical prescribers. GPs provided one to one supervision (monthly) for non-medical prescribers enabling staff to discuss individual cases. An audit template was completed to document those meetings (including examinations) providing assurance of clinical competency and any training gaps. The practice accessed its prescribing data to provide assurance that staff prescribing was within current national guidelines. Staff were encouraged to attend a weekly teaching session run by the Clinical Lead GP.</p>	

## Coordinating care and treatment

### Staff worked 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-centered 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The Practice had segmented their demographic data and had identified patients who were experiencing deprivation, including patients who were not currently employed or were experiencing mental health issues, and invited them to attend a focus group; to see how they could be supported and how their unmet medical needs could be addressed. This had allowed the PCN to outreach to high risk population groups.</li> <li>The practice had identified patients who were frequent attenders and identified high use of secondary care, they discussed the individual patients at multidisciplinary team meetings. This ensured that the relevant healthcare professional could be put in place to support patients, for example a patient at risk of falls or deteriorating health due to frailty, would be referred to the frailty nursing service.</li> </ul>	

## 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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: The PCN were unsure of how many patients had consented to record sharing and currently had a drive working towards understanding this. They recorded consent for joint injection and smear tests and ran a weekly report to ensure informed consent had been obtained.	

## Responsive

## Rating: Not Rated

Moredon Medical Centre was rated good for the provision of caring services at our last inspection in February 2021. In accordance with Care Quality Commission's methodology, the rating from our previous inspection for this key question has been carried forward to contribute to the overall rating for the practice.

### Access to the service

#### People were/ were not 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.*

As such, we have looked specifically at this one aspect of responsive and included it in this report. This has not impacted the previous inspection rating for this domain.

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Partial
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	Partial
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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice took all patient calls from the call centre (Hub) which was located Moredon Medical Centre. The provider demonstrated they understood their call flow and manned the phones to meet demand. We reviewed the figures shared with us between January 2022 and May 2022. We found that on average 550 calls were offered per day with an average call abandonment rate of 12%. The average wait for calls to be answered was 6.34 minutes and the longest wait averages were 24.09 minutes.</li><li>• The PCN had taken as many as 211 online e-consult referrals in a day, however it had recently reduced the timeframe for e-consult referrals to be made to between 8.30 and 12.30, which had</li></ul>	

reduced the number to between 6 and 22 a day, we are unable to identify the individual figures for Moredon Medical Centre alone.

- The Care Quality Commission received 19 patient experience feedback enquires. Common themes highlighted included access problems. This included not being able to get an appointment and being required to ring back at 8am the following morning to be able to access a triage clinician. Patients who were unable to use a telephone or the online e-consult system did not have the opportunity to access triage appointments. However, patients who required an urgent appointment or showed red flag symptoms, would be prioritised to be seen and their request would be reviewed by a clinician.

## Well-led

## Rating: Requires Improvement

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

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

At this inspection we rated the practice requires improvement for providing well led services because:

- Systems and processes still did not ensure that patient records were consistently accurate and kept up to date.
- The practice did not always involve the public, staff and external partners to sustain high quality and sustainable care.
- The overall governance arrangements were not always effective.

### Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• The practice demonstrated an understanding of its short falls and the challenges it faced and had put strategies in place to resolve these issues. Some of the planned actions to address issues remained in their infancy and required more time to become embedded.</li></ul>	
The Great Western Hospital Trust managed this surgery and its branches along with another large surgery in Swindon. Together those primary care services form a Primary Care Network (PCN). The PCN fits into the Trusts structure, under the integrated care and community primary care director structure and is locally managed by a primary care clinical lead, deputy divisional director of community and primary care, and the primary care head of nursing. There is an operational lead who overarchingly manages the practices at a local level.	

## 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 behavior 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.	Yes
Staff had undertaken equality and diversity training.	Yes

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

Source	Feedback
CQC staff questionnaire	Feedback included: <ul style="list-style-type: none"> <li>• Moral had improved since the last inspection.</li> <li>• Staff liked working for the Primary Care Network (PCN) and across both all sites. The PCN contained two practices who were both part of the Great Western Hospital Trust (GWH)</li> <li>• Working as part of the wider GWH Trust allowed access to a range of support including wellbeing support and opportunities for development.</li> </ul>



## Governance arrangements

**The overall governance arrangements were not always effective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence:	
<p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>Processes to ensure coding was consistently applied were not fully effective.</li> <li>Systems to review and implement new policies did not ensure this was done in a timely way.</li> <li>Feedback we received from staff indicated it was hard to access relevant information included practice policies.</li> </ul> <p>At the inspection in May 2022 we found not all areas of concern had been addressed in full:</p> <ul style="list-style-type: none"> <li>The immunisation patient group directive (PGD), a legal document permitting specified clinicians to administer specified medicines, was incorrectly completed; the authorising clinician had signed prior to some of the signatories being added making it invalid. The surgery corrected this during the inspection.</li> <li>The practice did not always have an effective system to ensure medicine safety alerts from the Medicine and Healthcare Products Regulatory Agency (MHRA) or other bodies were being acted on appropriately. The practice had systems and process which were embedded in practice for alerts since 2019. However, historic issues had not been reviewed.</li> <li>Processes to ensure coding so patients were appropriately monitored was consistently applied but still not fully effective. Coding on the day of the inspection was still behind. The practice had received training from an external company around clinical coding and summarising and shared a plan, to train all administrative staff within a month, to support to catch up and when demand was high.</li> </ul>	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Yes
There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

Explanation of any answers and additional evidence:

At the inspection in February 2021 we found:

Assurance systems had been implemented but these were not always effective. For example;

- Systems to ensure staff had completed mandatory training required by the practice were not fully implemented. For example, safeguarding and infection prevention and control.
- Systems to identify and act on risk such as fire, Legionella and security were not effective, and risks were not always mitigated and accurately recorded.
- The practice did not have appropriate oversight of their chaperone processes and could not be assured that staff acting as chaperones had received relevant training to do so. Feedback from staff also indicated that the practice chaperone policy was not embedded.
- There was not always effective communication between the practice and the provider. For example, the practice did not always receive feedback regarding actions taken in response to risk. Following inspection, the practice sent us evidence that they held incident and risk review panels where they would discuss concerns relating to incidents, safeguarding, safety alerts and emerging risks. However, there was no evidence to demonstrate that the risks identified on inspection relating to fire, Legionella and security had been discussed during these meetings.

At the inspection in May 2022 we found:

Assurance systems had been implemented but these were still not always effective. For example;

- Systems to ensure staff had completed mandatory training required by the practice were not fully implemented. For example, the practice did not have assurance that safeguarding training had been completed as required.
- Systems to identify and act on risk such as, Legionella and security were not always effective. The provider, Great Western Hospitals NHS Foundation Trust, were responsible for and completed the work, however, local management did not always have oversight of the current situation.

### 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 did not always involve the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
<p>Explanation of any answers and additional evidence:</p> <p>At the inspection in February 2021 we found:</p> <ul style="list-style-type: none"> <li>The practice had no Patient Participation Group (PPG), they told us they were in the process of setting the group up, they advised that they had a list of patients interested in participating and had some preliminary future dates to begin the engagement.</li> </ul> <p>At the inspection in May 2022 we found:</p> <ul style="list-style-type: none"> <li>There was still no active Patient Participation Group (PPG) in the practice at the time of the inspection. This meant that the practice did not receive the feedback and support needed to ensure the patients voice was heard.</li> </ul>	

## Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>The practice was part of the local NHS Trust (the registered provider) and was integrated with the Community NHS Trust. The provider had been able to develop unique pathways and relationships which have supported training. For example, the practice worked closely with the tissue viability nurse specialist, who provided training as required for the practice nurses.</li> </ul>	

## Examples of continuous learning and improvement

- As a member of the Primary Care Network (PCN) staff were able to upskill and attend courses including a nurse preceptorship scheme and two pharmacy technicians were completing their Centre for Postgraduate Pharmacy Education (CPPE course).
- The PCN held weekly clinical training workshops, which all the practice staff were enabled to join dependent on the relevance of the topic. Hospital and community specialists also attended these

workshops to increase knowledge and provide support where needed. The practice specialists training included cardiovascular palpitations, radiology, neurological headaches, social prescribing and safeguarding.

- The staff had various development pathways accessible to them through the provider. For example, direct access for advice from some consultants, this has allowed them to look at patients more holistically.
- The practice staff received a daily dashboard report from the provider identifying any patients registered at the practice due to be discharged from hospital that day. This facilitated early intervention and planning for patients from the community multidisciplinary team.
- The Primary Care Network (PCN) employed a full-time safeguarding lead, allowing a high level of attendance at case reviews as appropriate for patients within the practice.
- The PCN had a daily meeting to review any emerging issues. All organisational leads shared the current staffing situation, raised any concerns and discussed any new significant incidents. We observed one of those meetings which ensured that any daily issues were resolved, and communication was shared across all teams.

#### 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)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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.