

Care Quality Commission

Inspection Evidence Table

Swanpool Medical Centre (1-1729331390)

Inspection date: 14 May 2021 to 21 May 2021

Date of data download: 12 May 2021

Overall rating: Requires Improvement

At our previous inspection in January 2020 we rated the practice as Inadequate overall due to a significant number of areas of non-compliance with the Health & Social Care Act (Regulated Activities) Regulations 2014. We identified issues related to the management of risks, inadequate governance processes, a lack of effective leadership and limited monitoring of patients' care and treatment.

At this inspection, we found the practice had made some improvements in areas of previous non-compliance and we have rated the practice as Requires Improvement overall.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe Rating: Requires improvement

At the previous inspection we rated the practice as inadequate for providing safe services as there were no clear processes in place to ensure patients were safe. This included inaccurate safeguarding registers and the management of patients on high risk medicines.

At this inspection we have rated the practice as requires improvement for providing safe services. We found some systems and processes had been strengthened to ensure patients were kept safe and protected from avoidable harm. Procedures had been implemented in the management of medicines, but there was a backlog in the actioning of administration tasks including acting on requests from clinicians.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y

Safeguarding	Y/N/Partial
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Safeguarding procedures had been strengthened to ensure safeguarding concerns were acted on. One of the GP partners had taken over the role of safeguarding lead and had implemented processes to ensure safeguarding registers were maintained. Staff meetings had been organised every two months and safeguarding was a standing item on the agenda. Meetings with the health visiting team were in place. On reviewing the minutes of the last meeting recently held, we cross referenced the information that had been discussed and found the information in the minutes corroborated with the details on the safeguarding register. Alerts were on each patient record where safeguarding concerns had been identified and family and other household members had been linked to the clinical record to ensure staff were aware who may be at risk of harm. Child and adult safeguarding policies were in place to support staff which included the contact details of relevant agencies. Following the previous inspection, a system had been implemented on a monthly basis to review all safeguarding concerns and information that had been shared through other agencies to ensure the practice safeguarding registers were up to date. Records showed that all staff were up to date with their safeguarding children and vulnerable adults training. We saw that staff were trained to the appropriate level for their roles. The practice had nominated chaperones who were DBS checked and had undertaken chaperone training. There was a Chaperone Policy in place to support these staff. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> We found recruitment systems had been reviewed and improved, with processes now in place to ensure the appropriate checks were carried out prior to employment and regular checks were made of the registration of clinical staff. 	

- We reviewed three staff files and found the relevant staff vaccinations and the appropriate checks had been completed.

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: April 2021	Y
There was a record of equipment calibration. Date of last calibration: April 2021	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: July 2020	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice was able to demonstrate that risk assessments had been completed. Action plans were in place for identified risks. For example, cardboard boxes once emptied were left outside of the cleaner's cupboard causing a potential fire risk. This was no longer the case. • All staff were up to date with fire safety training. A training matrix was in place to ensure all staff training was completed when due. Fire marshals had undertaken additional training for their role. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: January 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: January 2021	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We saw risk assessments in place in relation to health and safety and the premises. Issues identified through the risk assessment had been actioned. For example: needlestick injury posters were displayed to advise staff of the procedures to follow. • Health and safety was included in the new staff induction programme. • Training records showed health and safety training had been completed by all staff. 	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit:	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a nominated infection control lead in place. • An infection control audit had been completed in August 2020. The practice had achieved 99% in the audit. The practice had implemented stringent processes to ensure that during the COVID-19 pandemic both patients and staff were kept safe. • Evidence was provided to demonstrate that all staff had completed the relevant training in infection control appropriate to their roles. • Due to the COVID-19 pandemic stricter measures had been implemented to ensure both staff and patients were kept safe. This included cleaning of consultation rooms between patients, the wearing of protective personal equipment (PPE) and hand sanitizer situated throughout the building. 	

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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The provider told us that during the COVID-19 pandemic they had been able to manage staff absences effectively. • The induction process for new staff had been strengthened to ensure they had all the required information to be able to do their role effectively. Procedures including health and safety, infection control and fire safety were part of the induction process. • All staff had received the appropriate training in how to deal with an emergency. This included sepsis awareness training. A training matrix had been implemented which was monitored by the management team to ensure all staff were up to date with training relevant to their role. • Systems were in place to ensure emergency medicines and equipment was checked on a regular basis. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Partial
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	N
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Since the previous inspection we found improvements in the clinical coding of medical conditions. For example, on reviewing a random sample of records on the relevant register, we found the appropriate codes had been added to identify patients with diabetes. On reviewing a random sample of clinical records, we found the appropriate monitoring and reviews were in place.• Multi-disciplinary team meetings had been implemented and were held every six to eight weeks to share information and ensure patients received appropriate care and treatment.• On reviewing the clinical system, we found there was outstanding tasks to be completed. On further investigation we found there were 404 miscellaneous tasks awaiting action by administration staff dated from 8 March 2021 to 14 May 2021. On reviewing a random sample of 12 tasks we found seven were requests for patients to be contacted to organise an appointment with a GP, one was an appointment to be arranged with a nurse, four were requests for appointments to be organised for a medication review another was to send the blood results of a patient to a diabetic consultant for review.• On checking the number of pathology tasks, we found there were 158 pathology results that had been reviewed by a clinician but were awaiting further action by administration staff. On reviewing a random sample of five requests we found clinical staff had asked for patients to be contacted and an appointment arranged to speak with a clinician concerning abnormal results.• We saw a sample of patient referral letters and found these contained appropriate information.• There were systems in place for monitoring two week wait referrals so that they could be followed up.	

Appropriate and safe use of medicines

The practice had 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) (01/04/2020 to 31/03/2021) (NHS Business Service Authority - NHSBSA)	0.77	0.69	0.70	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). (01/04/2020 to 31/03/2021) (NHSBSA)	7.0%	6.9%	10.2%	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 (01/10/2020 to 31/03/2021) (NHSBSA)	4.77	5.13	5.37	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2020 to 31/03/2021) (NHSBSA)	136.1‰	131.9‰	126.9‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2020 to 31/03/2021) (NHSBSA)	0.70	0.70	0.66	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.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y

Medicines management	Y/N/Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and 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.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p data-bbox="57 999 810 1032">Explanation of any answers and additional evidence:</p> <ul data-bbox="105 1088 1513 1693" style="list-style-type: none"> • Since the previous inspection we found improvements in the management of clinical records. • We reviewed a sample of patients on high risk medicines and found the appropriate monitoring had taken place and patients were being monitored effectively. For example, we found six patients on mood stabilizing medicine and on reviewing each patient we found all had received the appropriate monitoring except for one patient, however the practice was aware of this and had taken steps to ensure the patient received regular reviews. • A clinical lead was now in place who carried out regular peer reviews of clinical consultations and prescribing practices. • There was clinical oversight for all requests to medicine changes and a clear process was in place to demonstrate what actions had been taken. • Emergency medicines and vaccines were appropriately stored and there were clear monitoring processes in place. • The practice had installed printer locks on all printers to ensure blank prescriptions could not be removed without staff presence. • Clinical staff told us that they routinely checked patient identification when undertaking remote consultations and prescribing. 	

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.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	15
Number of events that required action:	15
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Since the previous inspection the practice had reviewed the process they had for the recording and actioning of significant events and incidents and had implemented a more effective system to ensure all the appropriate information, actions and learning were shared to mitigate future risk. • Regular meetings with staff had been introduced to ensure any learning from incidents was shared with the team to mitigate future risk. • The practice told us they reported all incidents and significant events on an incident reporting system to share learning with the clinical commissioning group. Staff were aware of the reporting system and the actions that needed to be taken if they needed to report an incident. 	

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

Event	Specific action taken
Patient required ambulance on arrival at practice	<ul style="list-style-type: none"> • Patient was assessed by GP and a clinical decision was made to call the ambulance. • GP stayed with patient until ambulance arrived • Patient was transferred to hospital.
Patient referrals delayed	<ul style="list-style-type: none"> • Two patient referrals were delayed to the midwife. • Human error, referrals were done immediately • Learning was shared with staff.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had strengthened its processes for the receiving and actioning of safety alerts. The clinical pharmacist had the overall responsibility for disseminating the alerts to the relevant clinical staff and carrying out the searches on the clinical system if required. We reviewed two safety alerts that had been issued and found they had been acted on appropriately. For example: We reviewed patients who were on medicines that could cause fetal abnormalities in women of childbearing age. We found eight patients on these medicines. We reviewed a random sample of five records and found each clinical record clearly stated that the patient had been advised of the potential risks and the appropriate monitoring was in place. 	

Effective

Rating: Requires Improvement

At the previous inspection we rated the practice as inadequate for providing effective services as we found there was a lack of clinical oversight in the care and management of patients' health and wellbeing. This included ineffective processes for the monitoring of patients on high risk medicines, the management of patients with long term conditions and no evidence to demonstrate that clinical supervision was in place to monitor the appropriate prescribing of medicines.

At this inspection we have rated the practice as requires improvement for providing effective services. We found that the practice had implemented systems and processes to ensure care and treatment was delivered in line with evidence based guidance and supervision arrangements had been put in place, however screening targets were below national averages.

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.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Partial
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• Since the previous inspection the practice had implemented systems to ensure all clinical staff were kept up to date with best practice guidelines. We saw evidence of minutes of a clinical meeting that had recently been held.• During the inspection we carried out a remote review of a sample of patients' records and some found patients' care and treatment was in line with current guidance. However, clinical indicators of the Quality and Outcome Framework demonstrated a significant decrease in the management of patients with mental health conditions and dementia.• Systems had been strengthened to ensure clinical registers had been reviewed and updated and patients' had received the appropriate monitoring.	

Older people

Population group rating: Good

Findings

- Since the last inspection the practice had implemented processes to ensure the appropriate monitoring of older patients. We found regular medication reviews had been completed.
- 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.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires improvement

Findings

- Since the last inspection, the practice had reviewed patients with diabetes to ensure that they received the appropriate monitoring and follow up. On reviewing a sample of patients records we found that structured reviews were in place and medicine reviews had been completed. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Quality Outcome Framework (QOF) indicators highlighted a decrease in patients with COPD being reviewed. For example, the practice had achieved 62% for patients who had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in 2018/19 in comparison with 47.3% in 2019/20. Following the inspection, the practice provided unverified QOF data for 2020/2021 which showed 94.9% of patients had had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale.
- Patients with 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 for an acute exacerbation of asthma. The practice provided unverified QOF data for 2020/2021 showed 84.2% of patients' with asthma had received an asthma review in the preceding 12 months.
- On reviewing a random sample of five patients record who had been prescribed inhalers we found two patients had not received a formal review and two patients had not received the appropriate diagnosis before a prescription was issued.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) <small>(QOF)</small>	67.7%	75.4%	76.6%	No statistical variation
PCA* rate (number of PCAs).	1.2% (6)	6.6%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	47.3%	88.0%	89.4%	Significant Variation (negative)
PCA rate (number of PCAs).	1.8% (4)	8.5%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	80.1%	80.6%	82.0%	No statistical variation
PCA rate (number of PCAs).	2.6% (8)	3.9%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	58.7%	63.9%	66.9%	No statistical variation
PCA rate (number of PCAs).	2.4% (14)	11.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	61.6%	70.4%	72.4%	Tending towards variation (negative)
PCA rate (number of PCAs).	2.6% (28)	5.5%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) <small>(QOF)</small>	91.9%	91.9%	91.8%	No statistical variation

PCA rate (number of PCAs).	0.6% (1)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	57.9%	72.8%	75.9%	Variation (negative)
PCA rate (number of PCAs).	4.2% (25)	8.3%	10.4%	N/A

Families, children and young people

Population group rating: Good

Findings

- The practice had met the minimum 90% for all of the five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for four of five childhood immunisation uptake indicators.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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) (01/04/2019 to 31/03/2020) (NHS England)	131	136	96.3%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	140	153	91.5%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	139	153	90.8%	Met 90% minimum

The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	140	153	91.5%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	127	140	90.7%	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 nurse had implemented a system to follow up on patients who had failed to attend their immunization appointments. A form had been introduced by the nurse which detailed how many times a patient had not attended and how many times the practice had tried to contact them. This information was then passed to the health visiting team for further action.

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

- The practice's uptake for cervical screening was below the target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medicines without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/12/2020) <small>(Public Health England)</small>	61.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	64.7%	65.6%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) <small>(PHE)</small>	54%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>	50.0%	84.6%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	42.9%	48.0%	54.2%	No statistical variation

Any additional evidence or comments

Patients who failed to attend their cervical screening appointments were followed up by the practice nurse. Due to the Covid-19 pandemic, specific sites (amber site) had been set up to see patients to reduce the number of people entering GP practices. Swanpool Medical Centre was an amber site and face to face appointments were available when required.

People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- Same day appointments and longer appointments were offered when required.
- 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.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires improvement

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Quality Outcome Framework (QOF) indicators highlighted a significant decrease in agreed care plans for patients on the mental health and dementia care register. For example, the practice had achieved 90.3% for patients with schizophrenia, bipolar and other psychoses in 2018/19 in comparison with 12.5% in 2019/20. For patients diagnosed with dementia the practice had achieved 70.7% in 2018/19 in comparison to 21.6% in 2019/20. Following the inspection, the practice provided unverified QOF data for 2020/2021 which showed improvements in agreed care plans for people experiencing poor mental health and people with dementia. For example: 89.5% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan in the preceding 12 months and 80% of patients diagnosed with dementia had received a face to face review of their care plan in the preceding 12 months.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia awareness training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	12.5%	74.4%	85.4%	Significant Variation (negative)
PCA rate (number of PCAs).	0.0% (0)	15.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	21.6%	66.5%	81.4%	Significant Variation (negative)
PCA rate (number of PCAs).	5.1% (2)	9.8%	8.0%	N/A

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	422.7	Not Available	533.9
Overall QOF score (as a percentage of maximum)	75.6%	Not Available	95.5%
Overall QOF PCA reporting (all domains)	3.1%	Not Available	5.9%

Any additional evidence or comments

Unverified data provided by the practice showed an improvement in Quality Outcome Framework indicators for 2020/2021 with an achievement of 517.05 points out of 567.

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

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

The practice had completed an audit to evaluate patients with a previous diagnosis of gestational diabetes who had not had an annual diabetic test in past 12 months. The aim of the audit was to identify women who had a potential risk of undiagnosed diabetes following gestational diabetes in pregnancy. The first audit was carried out in December 2020, when a search of the clinical system was completed to identify patients within this category. The search found that in the previous 12 months, 45 patients had been diagnosed with gestational diabetes and 18 patients had not had the appropriate blood monitoring carried out. The practice contacted the 18 patients to complete the relevant blood tests. A second audit was completed in May 2021 which showed 55 patients had been diagnosed with gestational diabetes and 11 patients required appropriate blood monitoring.

An audit was carried out to review patients prescribed a specific antidepressant and the suitability of switching them to a safer medicine following recommended guidelines. A search of the clinical system was carried out in July 2020 which identified nine patients on this specific medicine. Each patients' record

was reviewed and where feasible patients' medicines were changed to a more suitable alternative. Patients were contacted to explain why the change had occurred. During the first cycle of the audit between July to December 2020, six patients had their medicine stopped or changed to another antidepressant. A second cycle was completed between January to March 2021 which showed the remaining three patients had had their medicine stopped or changed to another antidepressant.

Any additional evidence or comments

Since the previous inspection, the practice had been supported by the Royal College of General Practitioners (RCGP) to improve quality and implement new processes and procedures. During the inspection we found some improvements in both clinical and non-clinical areas and systems in place to ensure patients received appropriate care and treatment.

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.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y

Explanation of any answers and additional evidence:

- Since the previous inspection, a clinical lead had been appointed, who carried out regular reviews of consultations and medicine reviews of the clinical staff to ensure they were clear, appropriate and contained the relevant information. Clinical meetings were held regularly to discuss performance, clinical updates and highlight any training needs.
- A review of staff roles and competencies had been implemented to ensure staff had the appropriate knowledge and skills to carry out their duties.
- Staff induction had been reviewed and updated and all new staff received an induction tailored to their role.
- At this inspection we found staff training was monitored and that staff had completed training identified as mandatory by the provider. This included level three safeguarding training for clinical staff and chaperone training for those who undertook chaperoning duties. We also saw that staff had undertaken specific training for their roles and responsibilities such as immunisation training and sample taking for the cervical screening programme. A training matrix was now in place which was monitored by the management team to ensure all staff were up to date with their training needs.

- We were told that staff appraisals had taken place. We reviewed a sample of three staff records and found evidence to confirm this.

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.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Multi disciplinary team meetings were now in place to ensure patients received the appropriate care and treatment. 	

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.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had completed a review of their long term condition registers. For example, patients who had been diagnosed with diabetes had received the appropriate follow up and monitoring. • The practice had been involved in carers week. This included contacting all registered carers, ensuring alerts were on patients' records to advise staff, offering carers flexible appointments, health checks and flu jabs. • The practice had been allocated social prescribers through the Primary Care Network. We were told the practice referred patients who required advice and support. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	N
Explanation of any answers and additional evidence: <ul style="list-style-type: none">We carried out a search of the clinical system for patients who had a DNACPR in place. We found five patients who had been coded as having this decision, however we found no evidence to demonstrate why this code had been added to the patient record.	

Caring

Rating: Requires improvement

At the previous inspection we rated the practice as requires improvement for providing caring services because the practice were unable to demonstrate they had gathered patient feedback, reviewed national patient survey data or discussed with staff and patients actions to improve services.

At this inspection we found the practice had implemented processes to gather patient feedback and the outcome of surveys had been discussed with staff to improve patient satisfaction. However, results from the national patient survey continued to be below local and national averages. The practice continues to be rated as requires improvement for providing caring services.

Kindness, respect and compassion

Staff treated did not treat patients with kindness, respect and compassion.

Feedback from patients was negative about the way staff treated people.

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	72.1%	85.2%	88.5%	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 (01/01/2020 to 31/03/2020)	71.8%	83.4%	87.0%	Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	90.2%	93.2%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	75.5%	76.3%	81.8%	No statistical variation

Any additional evidence or comments

The practice had reviewed the results of the national GP patient survey and had discussed the outcomes of the survey with staff.

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

Any additional evidence

An inhouse survey had been carried out between August and September 2020. The questionnaire comprised of 18 questions taken from the GP national survey. A total of 396 patients completed the questionnaire. The results of the questionnaire showed 73% of patients felt the practice provided an excellent service with 22% saying it was good. Two patients had rated the service as poor for getting through on the telephone. Patients were encouraged to ring later in the day for test results and information on this was on display in the waiting room.

Involvement in decisions about care and treatment

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

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

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	80.6%	90.0%	93.0%	Variation (negative)

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

Carers	Narrative
Percentage and number of carers identified.	337 carers were registered at the practice, this represented 3.6% of the practice population.
How the practice supported carers (including young carers).	Health checks and flu jabs were offered to all carers. Alerts were added to patients records to identify carers, so staff were aware to offer flexible appointments.
How the practice supported recently bereaved patients.	Bereavement packs were available which contained a range of information to help families and appointments were available with the GPs if needed.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y

Responsive

Rating: Good

At the previous inspection we rated the practice as requires improvement as access to the practice was highlighted negatively through the national patient survey and through patient feedback, this impacted on all population groups. The practice was unable to demonstrate they had acted on patient feedback to improve the quality of services provided.

At this inspection we found the results of the GP national patient survey showed no significant variation to the national averages for access and the practice had implemented processes to gather patient feedback. The practice is now rated as good for providing responsive services.

Responding to and meeting people's needs

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

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

Practice Opening Times	
Day	Time
Opening times:	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
Appointments available:	
Monday	8.30am to 6pm
Tuesday	8.30am to 6pm
Wednesday	8.30am to 6pm
Thursday	8.30am to 6pm
Friday	8.30am to 6pm

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

People with long-term conditions

Population group rating: Good

Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Good

Findings

- Additional nurse appointments were available during the afternoon for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were available to all patients at additional locations within the area, as the practice was a member of a primary care network. Appointments were available Monday to Friday 6.30pm to 8pm and Saturday and Sunday 9am to 12pm. Due to the COVID-19 pandemic extended access appointments had been suspended.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support groups within the area and signposted their patients to these accordingly.

Access to the service

People were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
Patients were able to make appointments in a way which met their needs.	Partial
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
There were systems in place to support patients who face communication barriers to access treatment.	Y
Patients with urgent needs had their care prioritised.	Y
The practice had systems to ensure patients were directed to the most appropriate person to respond to their immediate needs.	Partial
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • Due to the COVID-19 pandemic, the type of appointments available had been changed. This included an increase in telephone consultations to limit face to face appointments. Patients after being triaged, who required a face to face appointment were offered a suitable date and time to attend the practice. • Minutes from a recent staff meeting in April 2021 highlighted the number of complaints that had been received concerning the telephone system and reception staff. The practice had contacted the telephone provider to check the phone system as patients are being provided with conflicting information of where they are in the telephone waiting queue. Plans are in place to trial options to improve telephone access. • Interpreter services were available for patients who did not have English as their first language. • The practice was aware of patients' dissatisfaction with access and getting through on the telephone. The practice continued to encourage patients to use the online system for booking appointments and to call for test results outside of peak times when the phone lines were busy. 	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to	51.5%	N/A	65.2%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
how easy it was to get through to someone at their GP practice on the phone (01/01/2020 to 31/03/2020)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	57.1%	58.2%	65.5%	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 (01/01/2020 to 31/03/2020)	55.9%	58.9%	63.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	60.6%	65.4%	72.7%	No statistical variation

Any additional evidence or comments

The practice had reviewed the results of the GP national patient survey and had implemented an action plan. Feedback from staff highlighted the difficulty for patients getting appointments. We were told when clinical staff were away from the practice their sessions were not always covered by another GP, causing further shortages in appointment availability.

Source	Feedback
NHS UK	Comments were generally negative about being able to get through on the telephone and the rudeness of staff. Patients highlighted the difficulties and the long waiting times when trying to call the practice.

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.	21
Number of complaints we examined.	4
Number of complaints we examined that were satisfactorily handled in a timely way.	4
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y

There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found the approach in the management of complaints had been strengthened. We saw evidence to demonstrate that a complaint review meeting had taken place with staff in September 2020. Learning from the complaint was shared with the team to improve patient satisfaction. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Explanation of why referral was being made not given to patient	<ul style="list-style-type: none"> Patient was distressed when appointment was received. Offered an appointment with the GP to discuss their concerns. Discussed in clinical meeting and learning shared with team. Clinical staff must ensure all patients that are being referred understand the reason for the referral and the patient is involved in the consultation.
Patient unhappy with difficulty in getting through to the practice	<ul style="list-style-type: none"> Patient was contacted to discuss difficulties they had been experiencing. Explanation was provided concerning the difficulties the practice had been experiencing with telephone lines, this was currently being investigated. A face to face appointment with a GP was made for the patient to be seen.

Well-led

Rating: Requires improvement

At the previous inspection we rated the practice as inadequate for the well led question as the leadership team were unable to demonstrate they had the skills or capacity to deliver quality sustainable care and monitor governance processes effectively.

At this inspection systems and processes had been reviewed to ensure the practice was able to provide quality care, however feedback from staff demonstrated a lack of care for staff wellbeing. We have now rated the practice as requires improvement for providing well led services.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Partial
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The provider had responded positively to the concerns that had been identified at the previous inspection and had strengthened the leadership team with two new GP partners and a practice manager at Clifton Medical Centre and Stone Cross Medical Centre to support with the management of the practices and oversee all clinical areas. This had given the provider the opportunity to focus on Swanpool Medical Centre and implement systems to effectively lead and drive improvement.• The future leadership of the practice had been planned with the recruitment of new clinical staff to lead the practice into the future.• The practice had sought help to make improvements. This included external help from the Royal College of General Practitioners (RCGP).• At the previous inspection we identified significant failings in the care of patients, this included: safeguarding concerns not being actioned, the lack of management of patients with long term conditions and inadequate clinical oversight to ensure patients were receiving adequate care and treatment. We carried out a remote review of a random sample of patients' records at this inspection and found improvements in patient care, record keeping, effective processes for the actioning and review of safeguarding concerns and a clinical supervision plan in place to actively monitor clinical consultations and prescribing.• We spoke with a range of staff and received mixed responses to leaders being approachable. Some staff told us it was difficult at times to speak with the senior management team.	

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Since the last inspection, the practice had prioritised the work that was required to ensure improvements were made to both quality and sustainability. An action plan had been devised and implemented to monitor progress. • As part of the strategy for improvement, the leadership team had plans to strengthen the workforce, open more amber clinics for patients to be seen and implement a more centralized system across all sites. • A business plan was in place which they had updated to ensure future plans for improvement were included and collaboration with the primary care network continued. 	

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.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Partial
There was a strong emphasis on the safety and well-being of staff.	Partial
There were systems to ensure compliance with the requirements of the duty of candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Some staff told us their wellbeing was not considered with the constant pressure they were under due to staff shortages and lack of communication. Staff said they were behind in doing some of the tasks they had been allocated. This was highlighted when we carried out a remote review of the clinical system and found tasks that had been allocated to administration staff had not been actioned. For example we found 405 miscellaneous tasks awaiting action dating back from March 2021. 	

- On speaking with a range of staff we found no improvements in communication had been made since the previous inspection and some staff still felt unable to raise concerns without fear of retribution. Staff told us they were not encouraged to be open and honest.
- Individual Covid risk assessments had been completed for each member of staff to ensure staff were identified who may be in a higher risk category. The practice had adapted working processes to help keep staff safe, such as social distancing measures put in place.
- Protective Personal Equipment (PPE) was available for all staff to provide protection during the COVID-19 pandemic.
- We saw from training records that most staff had completed their Equality and Diversity training.
- Staff were aware of duty of candour and told us that they offered an apology when things went wrong.

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

Source	Feedback
Staff	Staff told us they were under lots of pressure due to staff shortages and no one in the senior management team was listening when they expressed their concerns.

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.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Safety policies and procedures had been updated and implemented to ensure staff had information available to support them within their role. • The practice had reviewed some their governance arrangements to ensure risks to patients were considered, managed and mitigated appropriately. However, we found areas that needed further improvements. For example: administration requests not being actioned. • Risk assessments had been completed including for fire, health and safety and infection control. Action plans were in place and monitored regularly to review progress. • The recruitment of staff had been strengthened to ensure all the appropriate checks were carried out prior to employment. Personnel folders were in place and a process was in place to ensure checks of clinical registration was completed. • A clinical lead was now in place who carried out a supervisory role ensuring that regular reviews of clinical consultations and prescribing were carried out. Feedback was provided on a regular basis to each individual clinician. Clinical meetings had also been implemented every six to eight weeks to discuss any clinical updates, safeguarding concerns and the latest guidelines. • Safety netting systems had been improved to ensure patients who were urgently referred had been dealt with appropriately. 	

Managing risks, issues and performance

There were some 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.	Partial
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Processes had been strengthened to monitor and address current and future risks, including risks to patient safety. However, outstanding administration tasks placed patients at potential risk as concerns identified by clinical staff were not acted on in a timely manner. Staff had completed training relevant to their role and a training matrix had been implemented which was being monitored by the leadership team to ensure all staff were up to date with training relevant to their role. The practice had introduced a system to ensure processes to manage current and future performance was monitored. This was achieved through regular audits of patient consultations and prescribing decisions. A clinical lead was now in place who provided clinical supervision and support. A review of safety alerts and incidents was now in place to ensure all the relevant actions had been completed and to mitigate future risk. A programme of clinical audits was now in place to monitor the quality of care and outcomes for patients. With the support of the Royal College of General Practitioners (RCGP), the practice had a clear action plan in place to address quality improvements and ensure sustainability was achievable. The practice had a Business Continuity Plan in place that had been updated to reflect issues relating to the COVID-19 pandemic. Staff we spoke with were aware of the plan. 	

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.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Partial
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • The leadership team told us that they had continued services throughout the COVID-19 pandemic and did not have any backlogs that needed to be addressed. However, on reviewing the clinical system we found significant numbers of administration tasks that had not been acted on. • For patients that required secondary care appointments, this was being monitored and patients were re-assessed if the clinicians felt it was appropriate. • We were told that individual risk assessments had been completed to identify staff who were in a vulnerable category during the COVID-19 pandemic. • Patients that were potentially digitally excluded could still contact the practice via telephone and were assessed by a clinical member of staff, and if a face to face appointment was required the patient was invited in. • Infection prevention and control measures had been put in place to maintain staff and patient safety during the COVID-19 pandemic. The wearing of face masks for patients and staff and social distancing within the practice through staff bubbles and social distancing were in place where possible. • Patients who required a face to face appointment had their temperatures taken before entering the premises and hand sanitizer was provided. 	

Appropriate and accurate information

There was a lack of 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.	Y
Performance information was used to hold staff and management to account.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	Partial
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We found on reviewing the clinical system that there were numerous outstanding tasks for the administration team that had not been actioned. There was no evidence to demonstrate that the leadership team were aware of this backlog and this had not been addressed through performance reviews or team meetings. The leadership team had been strengthened with new clinical staff now in place. This supported effective monitoring of patient care and on reviewing a sample of patients' records we found no concerns in the management of patients care and treatment. The leadership team undertook reviews of practice performance against the Quality Outcomes Framework (QOF) and the Primary Care Commissioning Framework (PCCF), a target driven programme of quality improvement implemented by the Clinical Commissioning Group. Regular clinical and staff meetings were now being held to discuss what needed to be done to make improvements. Staff were tasked with calling patients in for their annual health reviews, however we found these were not being acted on with delays in patients being contacted to organise relevant appointments with clinicians. 	

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

The practice advised patients on how to protect their online information.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Practice staff were aware of action to take to ensure confidentiality when working remotely and ensured patients identity was checked when consulting with them. Calls made to the practice were recorded. This was stated on the telephone message when requesting an appointment. Online consultations took place in consultation rooms with the doors closed to protect the patients' privacy. 	

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	N
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Since the previous inspection, the practice had implemented processes to review and act on patients' comments to improve services. Since the previous inspection, the practice had received support from external organisations, this included the Royal College of General Practitioners (RCGP). We found the leadership team had engaged with the RCGP to devise an action plan and implement changes to improve quality and ensure patients were receiving the appropriate care and treatment. Safeguarding processes had been highlighted as a serious concern at the last inspection. One of the clinical leads had engaged with the local safeguarding organisations to review their data and ensure all registers were up to date. A monthly audit of the register was completed and any records that were incomplete were discussed at multi-disciplinary team meetings. The management team had reviewed the results of the last patient survey with staff and the action plan was on display in staff areas to ensure staff were aware of what improvements were needed to improve patient satisfaction. Due to the COVID-19 pandemic, the practice had not been able to sustain a patient participation group. We were told there were plans in place to encourage patients to join a group in the near future and new ways of sharing information were being reviewed. Since the inspection, the provider has informed us that the PPG have been contacted to organise a virtual PPG meeting. The practice had implemented staff meetings to ensure staff were involved in decisions about the practice. Staff we spoke with told us they had minimal opportunities to share their views and ideas. The practice worked within their local Primary Care Network and local Clinical Commissioning Group to discuss and address challenges. For example, the practice had operated amber and red sites during the COVID-19 pandemic in the management of patients with COVID-19 symptoms. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none">• The practice had been through a difficult year with the COVID-19 pandemic and the outcome of the previous inspection where numerous concerns had been identified.• The leadership team had reviewed what actions were needed and had prioritised each task to ensure systems and processes were implemented effectively.• Effective processes were in place to ensure staff were up to date with training relevant to their role.	

Examples of continuous learning and improvement

The practice had implemented a range of processes to improve and strengthen their systems. Continuous monitoring of practice procedures, clinical outcomes, clinical registers and staff training were now in place to ensure improvements were maintained. Regular audits had been introduced to monitor quality improvement and ensure the information that was held for each patient was accurate, this included effective safeguarding registers.

The practice had a plan in place to ensure the future of the practice was maintained through effective leadership, staff development, robust governance arrangements, clinical supervision and the management of risk.

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.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ***PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- ‰ = per thousand.