

Care Quality Commission

Inspection Evidence Table

Four Acre Health Centre (1-600127824)

Inspection date: 7, 8, 9 and 16 March 2022

Date of data download: 7 February 2022

Overall rating: Inadequate

At the last comprehensive inspection in September 2021, the practice was rated as inadequate overall and inadequate for safe, effective and well-led. Caring and responsive were rated as requires improvement. The practice was placed into special measures and issued with two warning notices for Regulation 12 safe care and treatment and Regulation 17 good governance.

A focused inspection to check compliance with for Regulation 12, safe care and treatment, warning notice was carried out in December 2021. The provider had demonstrated improvement and the requirements of the warning notice had been met.

At this inspection March 2022, we found the Regulation 17 warning notice had been met in part. In addition, other concerns were found.

We have rated the practice inadequate overall and in the key questions safe and well-led. Effective and responsive as requires improvement and caring as good.

Safe

Rating: Inadequate

At our last comprehensive inspection in September 2021, the practice was rated as inadequate for providing safe services. This was because we found concerns in relation to medicines management; incident reporting processes and management of risk to patient safety were not effective: blank prescriptions were not kept secure and non-clinical staff did not have the appropriate level of child safeguarding training. Recruitment was not always carried out according to the practice policy or Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At this inspection 7, 8, 9 and 16 March 2022 we have rated the practice inadequate for providing safe services because:

- We found concerns related to the prescribing of controlled drugs which were re-issued without any documented patient review.
- Recruitment was not always carried out according to Schedule 3 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- The provider lacked oversight of risks relating to the premises.
- Not all staff had access to the electronic incident reporting system and the provider could not evidence all incidents reported in the logbook were investigated and resolved.

However,

- The provider had carried out comprehensive medicine reviews of patients prescribed regular repeat medicines.
- We saw improvement in safeguarding processes and appropriate safeguarding children training for non-clinical staff had been completed.
- Blank prescriptions were kept secure.

Safety systems and processes

The practice did not always have 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.	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.	Partial
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

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection September 2021, we found the electronic patient record did not always alert staff to patients whose circumstances may make them vulnerable. Non-clinical staff had not completed the appropriate level of safeguarding children training and a new member of staff did not have a pre-employment Disclosure and Barring Service (DBS) check and a risk assessment had not been undertaken in the absence of appropriate checks.</p> <p>At this inspection we saw patient records now had the appropriate safeguarding alert for those whose circumstances may make them vulnerable. Non-clinical staff had undertaken the appropriate safeguarding children training.</p> <p>DBS checks were undertaken for new staff joining the practice. However, the provider had not reviewed existing staff records and acted where DBS checks were missing.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Partial
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Recruitment checks for new staff were in place. However, existing staff records had not been reviewed to identify information that was missing and in the absence of the information, appropriate risk assessments were not undertaken. The business manager told us that this would be investigated. For example, one staff file did not contain interview notes, a signed contract or gaps in employment explained.</p>	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: Monthly walk arounds March 2022	Partial
There was a fire procedure.	Y
Date of fire risk assessment: 18/09/2017 last review 01/02/2022 Actions from fire risk assessment were not identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Monthly health and safety walk around checks of the premises were completed, documented on a checklist and things put right as shortfalls were observed.</p> <p>An overall detailed health and safety risk assessment of the premises had not been undertaken to identify risks and protect those who used the building. We observed shortfalls on inspection. For example, there had been a problem with the automatic opening doors to the practice that had been fixed, however the doors had not been regularly serviced. A radiator thermostat had broken off in a</p>	

clinic room and was placed on top of the radiator. This had been logged for repair, but the thermostat was left in the clinic room

We observed boxes containing specimen pots stored under the reception desk which prevented reception staff sitting at the desk correctly. This had not been identified as a risk or hazard.

Extensive water damage marks were observed on the carpet in reception following a tap being left on in a clinical room. The carpet could not be adequately cleaned, and the provider told us it was due to be replaced. This was not risk assessed and actions identified for when this would be completed by.

Window blinds in clinical rooms did not have cleats to break the chain if they were pulled, they had not been risk assessed and therefore could present a hazard.

Actions from the most recent fire risk assessment of the premises conducted in 2017 were overdue. For example, installation of signage to an external fire door and outdoor emergency lighting. The provider could not assure themselves that they had taken appropriate action in relation to fire safety of the premises.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
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: 09/08/2021	Partial
The practice had acted on any issues identified in infection prevention and control audits.	N
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	
<p>Actions identified as part of the infection prevention and control audit had not been reviewed since the audit had taken place in August 2021. No hand hygiene audits or cleaning checks for the clinic room privacy curtain rails had taken place.</p> <p>Some clinical rooms and communal areas were not cleaned to a high standard as we found food crumbs on the windowsill in a clinical room and a white substance on the top of the clinical examination lighting. We asked to see the cleaning records and we were told they were not kept on site. In the absence of cleaning schedules and records the provider could not be assured the premises were cleaned to the required standard.</p>	

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
There were enough staff to provide appointments and prevent staff from working excessive hours	Y
Explanation of any answers and additional evidence: Staff absences were managed using locum staff and additional staff had been recruited including a clinical pharmacist and reception staff.	

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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
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.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
Explanation of any answers and additional evidence: At our last inspection September 2021, there were 890 outstanding patient correspondence documents awaiting review.	

On this inspection, we were told an additional member of staff had been appointed to manage patient correspondence. We saw the back log of correspondence had improved and there were 208 letters outstanding from the previous six days to be reviewed and filed.

The management of test results was shared between clinicians as directed by the practice/business manager. Clinicians would review the test results they had ordered, and urgent blood results were reviewed by the on-call doctor.

Appropriate and safe use of medicines

The practice did not have effective 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) (01/10/2020 to 30/09/2021) (NHS Business Service Authority - NHSBSA)	0.86	0.80	0.71	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2020 to 30/09/2021) (NHSBSA)	7.5%	7.2%	9.8%	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 (01/04/2021 to 30/09/2021) (NHSBSA)	5.22	5.56	5.32	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	203.3‰	262.6‰	128.1‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2020 to 30/09/2021) (NHSBSA)	2.29	1.24	0.63	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2021 to 30/09/2021) (NHSBSA)	8.1‰	9.2‰	6.7‰	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.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	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
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.	Partial
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Following our last inspection in September 2021, additional staff supported the provider to complete patient medication reviews and ensure appropriate further monitoring was in place.</p> <p>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor without visiting the practice. These searches were visible to the practice.</p>	

Medicines management	Y/N/Partial
<p>Some medication reviews had taken place and did not always document whether the patient was present and involved in the review or not.</p> <p>Patients who were prescribed controlled drugs, did not always have evidence of a discussion regarding tolerance/dependence recorded in their notes and no reviews of prescribing had taken place. The practice was not consistent in their approach to monitoring patients. We found examples of patients who were prescribed high risk opiates and benzodiazepines on acute prescriptions that had been re-issued over many years without formal review.</p> <p>We discussed the above average prescribing of Hypnotics medicines with the registered manager who explained that the practice had reviewed patients previously, with a view to reducing the amount of Hypnotics prescribed. We were told the newly appointed clinical pharmacist would support this improvement going forward.</p> <p>Emergency medicines, the defibrillator and oxygen were checked monthly rather than weekly as recommended by the Resuscitation Council UK guidelines. Five ampoules of an intramuscular pain medicine had expired in December 2021 and had been checked monthly and documented as in date.</p>	

Track record on safety and lessons learned and improvements made

The practice did not have a robust system to learn and make improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	Partial
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	7
Number of events that required action:	7
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection September 2021, we found the system to learn and make improvements when things go wrong was not effective.</p> <p>On this inspection we found the practice had two processes for recording incidents. Staff recorded incidents in a book and some staff could access an electronic reporting system. Staff on site did not always have access to all of the information they needed to investigate incidents and identify the improvements required. This was due to access issues with the electronic system and lack of clarity around roles and responsibilities.</p>	

We saw there were missed opportunities for learning from some incidents. Following the inspection, the practice planned to streamline their incident reporting process to using the electronic system which would help to identify incident themes and trends.

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

Event	Specific action taken
Wrong blood form given to patient	Staff were re-trained to check all patient details before releasing any documentation and a spot check was completed by the deputy practice manager.
Acute opioid prescription was issued without review.	An audit was scheduled for three months following the incident. Staff were reminded that all medication prescribed should be linked to a diagnosis and reviewed correctly.

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:	

Effective

Rating: Requires improvement

At the last comprehensive inspection September 2021, the practice was rated as inadequate for providing effective services because: the systems to ensure all care and treatment was not effective; we found cases of missed diagnosis for diabetes and clinical audit was not planned.

At this inspection 7, 8, 9 and 16 March 2022, we have rated the practice as requires improvement for providing effective services because:

- The provider was not always able to demonstrate the competence of some staff in their role reviewing patients.
- Staff had not received appraisals since February 2020.

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

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment 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.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Y
Explanation of any answers and additional evidence: We saw improvements had been made to monitor patients and ensure appropriate blood tests had taken place.	

Patients who were overdue thyroxine monitoring had been contacted.

Effective care for the practice population

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty.
- 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.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- 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 assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

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. From our remote searches we saw some patient's medication reviews had been completed without the patient and not all medication had been reviewed.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- 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.

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)	72	79	91.1%	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) (01/04/2019 to 31/03/2020) (NHS England)	82	95	86.3%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	81	95	85.3%	Below 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)	81	95	85.3%	Below 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)	79	99	79.8%	Below 80% uptake

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 met the minimum 90% immunisation targets for one out of five childhood immunisation uptake indicators. Although the target of 90% had not been achieved for four of the five childhood immunisations the practice seen an improvement from an audit completed August 2021.
- The small number of patients affected the overall percentages seen.
- The practice had a plan to improve the uptake of childhood immunisations following an audit completed in August 2021. This included following up non-attenders, coding and sending reminder letters to parents.

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: 30/06/2021) (Public Health England)	71.1%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (PHE)	67.1%	59.3%	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) (PHE)	54.6%	60.5%	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) (PHE)	66.0%	55.8%	55.4%	No statistical variation

Any additional evidence or comments
<p>The provider was aware of the lower achievement in cervical cancer screening. The practice offered appointments throughout the day and during the evening and weekends at local hubs to improve uptake.</p> <p>The practice had undertaken a cervical smear quality improvement plan April 2021. Actions included an additional invitation letter, support for specific needs, pre-appointments, screen prompts/alerts and data cleansing. From the figures available to CQC we could see that the trend in uptake was improving.</p>

Monitoring care and treatment

The practice had a undertaken some audit activity and yet were to schedule this into a comprehensive programme of quality improvement activity to review the effectiveness and appropriateness of the care provided.

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

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

The provider had focused on improving care and treatment to patients and had undertaken some audits to review patient outcomes. However, this was not captured in an overall programme of clinical audit and quality improvement.

The lead GP told us that patients who had been discharged from hospital were contacted by phone and any concerns were passed to the on-call doctor. Patients who had frequent hospital admissions were allocated to an advanced nurse practitioner for follow up.

Discharge letters for exacerbated chronic obstructive pulmonary disease (COPD) and asthma were not routinely followed up. It is important to follow up COPD patients as untreated COPD can lead to faster progression of disease, heart problems, and worsening respiratory infections.

Effective staffing

The practice was unable to demonstrate that all 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.	Partial
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.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Partial
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Partial
Explanation of any answers and additional evidence:	
The practice did not have their own learning and development programme but participated in lunch and learn sessions led by external partners.	
Appraisals for non-clinical staff were planned and the last appraisal had been February 2020.	
The provider had not assured themselves of the training undertaken by all advanced nurse practitioners they directly employed, and a risk assessment had not been undertaken to determine which patients and conditions they were qualified to see and treat.	
We received mixed feedback from staff groups about the support and supervision they were provided with.	
The provider did not always provide support for staff or challenge performance.	

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:	

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:	

Consent to care and treatment

The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.

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

At our last inspection September 2021, the provider did not have systems in place for ensure care and treatment were in line with the Mental Capacity Act and Deprivation of Liberty Safeguards. We found improvement at this inspection.

Caring

Rating: Good

The last comprehensive inspection September 2021 the practice was rated as requires improvement for caring because:

- The provider had not ensured all patients were treated respectfully and where concerns had been identified, these had not been effectively actioned.

At this inspection 7, 8, 9 and 16 March 2022 caring is rated as Good because:

- The provider had made improvements to processes and procedures to improve patient care.

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgmental attitude towards patients.	Partial
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: We saw incidents/complaints were sometimes documented by staff as opinion rather than stating the facts of the matter. This was raised with the provider on inspection. We were told the electronic reporting system would help staff to focus on reporting the facts.	

Patient feedback	
Source	Feedback
Four Acre logbook	Staff were supportive, helpful and patients appreciated their hard work.
Feedback provided directly to CQC	Patients told us they had made formal complaints to the practice.

National GP Patient 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 (01/01/2021 to 31/03/2021)	82.8%	88.5%	89.4%	No statistical variation
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 (01/01/2021 to 31/03/2021)	79.5%	87.9%	88.4%	Tending towards 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 (01/01/2021 to 31/03/2021)	93.8%	95.0%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	79.0%	80.0%	83.0%	No statistical variation

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

Any additional evidence
The practice had paused the patient feedback exercises to concentrate on making improvements following the last inspection.

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
Explanation of any answers and additional evidence: At our last inspection the practice did not use any advocacy service and relied on patient carers and relatives. We found there had been no change since our last inspection.	

National GP Patient 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 (01/01/2021 to 31/03/2021)	91.6%	92.0%	92.9%	No statistical variation

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: The service provided appointments with interpreters when required.	

Carers	Narrative
Percentage and number of carers identified.	388 patients were registered as a carer with the practice registered list size as of 28 February 2022 of 8265 patients which equates to 4.7% of the patient population.
How the practice supported carers (including young carers).	The practice had a carers information board and provided flexible and longer appointments when needed.
How the practice supported recently bereaved patients.	Bereaved patients could be referred to the in-house counsellor.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our last inspection September 2021 the layout of the reception desk did not provide privacy and patients could be overheard.</p> <p>At this inspection the provider had introduced a queueing system to provide privacy for patients while waiting to speak to a receptionist.</p>	

Responsive

Rating: Requires improvement

At our last comprehensive inspection September 2021, we rated responsive as requires improvement for providing responsive services because the system for managing and responding to complaints was not effective.

At this inspection 7, 8, 9 and 16 March 2022 we rated the practice as requires improvement because:

- The system for managing and responding to complaints had not changed since our last inspection. The provider could not demonstrate a consistent approach to managing and learning from complaints.

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.	Partial
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
Explanation of any answers and additional evidence: The practice had worked with external agencies to make service improvements since our last inspection.	
The facilities and premises were not always assessed in a timely manner. For example, the automatic entrance door had been reported as faulty and no action had been taken to address this.	

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30
Friday	08:00 – 18:30
Appointments available:	
Monday	08:00 – 18:30
Tuesday	08:00 – 18:30
Wednesday	08:00 – 18:30
Thursday	08:00 – 18:30

Friday	08:00 – 18:30
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Further information about how the practice is responding to the needs of their population

- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travelers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travelers.

Access to the service

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

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimize the length of time people waited for care, treatment or advice	Y
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Y
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	Y
Patients with most urgent needs had their care and treatment prioritised	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients had difficulty booking an appointment by telephone</p> <p>The practice telephone system was part of the local NHS Trust telephone system and the practice did not have any control over how the system worked or the number of telephone lines coming into and out of the practice. The system only allowed up to 10 patients to queue for their telephone call to be</p>	

answered. Patients would experience the engaged tone if there were 10 calls waiting to be answered. The practice endeavored to provide additional staff to answer the phones during peak times and were liaising with the hospital and local stakeholders to improve the telephone system.

National GP Patient Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2021 to 31/03/2021)	52.0%	N/A	67.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	57.1%	64.0%	70.6%	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 (01/01/2021 to 31/03/2021)	66.1%	63.8%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	73.5%	78.1%	81.7%	No statistical variation

Listening and learning from concerns and complaints

Complaints were not always used to improve the quality of care.

Complaints	
Number of complaints received since September 2021 to February 2022.	13
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	1
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.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection September 2021, we found the provider had not developed a formal process for recording and reviewing informal concerns and comments.</p> <p>At this inspection we noted concerns reported to CQC where patients told us they had complained directly to the practice were not recorded.</p> <p>Complaints were written down in a book in reception. It was not clear how they were followed up, investigated and whether there was further communication with the patient or person who made the complaint. Following the inspection, the provider told us this would be reviewed.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Prescription not ready	Recorded telephone call reviewed. Further training for staff to understand patients with poor mental health was arranged. The complaint was scheduled to be discussed and shared with staff at the next practice meeting.
Missed appointment	A further appointment was offered to the patient.

Well-led

Rating: Inadequate

At the last comprehensive inspection September 2021, the practice was rated as inadequate for providing well-led services. This was because leaders did not demonstrate they had the capacity and skills to deliver a high quality service; there were no clear arrangements for identifying, managing and mitigating risks; operational and clinical outcomes were not audited and staff reported the practice culture needed to improve.

At this inspection 7, 8, 9 and 16 March 2022, we rated the practice as inadequate because:

- It was unclear which roles took responsibility for the day to day management of the practice.
- The provider had not addressed all the concerns identified from our last inspection and we found additional issues in relation to risk management and lack of oversight for the governance arrangements at the practice.

Leadership capacity and capability

Leaders demonstrated that they had some capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
Explanation of any answers and additional evidence: Since the last inspection in September 2021 the practice had received external support to take action to mitigate risk. Feedback from this process was positive and managers described how it had improved some practice processes that were still in the implementation phase. Leaders had focused on improving care for patients and in doing so lacked oversight in other areas of risk at the practice. Leaders and managers were committed to improving the practice. Leaders and managers had received support from peers at other practices.	

Vision and strategy

The practice had a clear vision, but it was not supported by a credible strategy to provide high quality sustainable care.

	Y/N/Partial
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The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The vision, values and strategy were created by the practice management team and communicated to staff. Staff were not always clear on the vision and values.</p> <p>The practice had focused on reviewing patients identified from our last inspection. Staff told us they were keen to help improve the service for patients but did not always feel engaged with initiatives.</p> <p>The provider had employed additional staff roles to provide care and treatment to patients. However, there were no timescales or responsible person identified to lead and support the monitoring of the strategy and engage with all staff.</p>	

Culture

The practice culture did not effectively support high quality sustainable care

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Partial
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.	Partial
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Partial
The practice encouraged candour, openness and honesty.	Partial
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection September 2021, we received mixed feedback from staff in relation to culture. The incident reporting form did not capture communication with patients as a result of an incident or actions to report in line with the duty of candour.</p> <p>On this inspection we received mixed feedback from staff about raising concerns, patient's safety, well-being and behaviour. Overall staff told us the culture at the practice had improved since the last inspection. Staff were keen to help make sustainable improvements for the service. However, we found leadership and managerial roles and responsibilities were sometimes unclear and shared rather than there being a named lead.</p> <p>The provider had not responded to the lack of leadership responsibility and taken action.</p>	

Following our inspection, the provider told us they would review the practice incident reporting system to fully implement the electronic system which include the recording of duty of candour and communication with patients or their significant others.

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

Source	Feedback
Staff questionnaire/interview	Staff told us some improvements had been made since our last inspection such as additional staff and changes to policies and procedures. However, staff felt more could be done to improve the service provided to patients and they were not always engaged in how to achieve this.

Governance arrangements

The overall governance arrangements were under review and yet to be fully implemented.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	N
There were appropriate governance arrangements with third parties.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had been supported intensively by external stakeholders since our last inspection. Staff described this as positive and it helped them focus on what needed to be done.</p> <p>At this inspection we found that some of the practice manager roles were shared and processes were being implemented and had not yet become business as usual. For example, the incident reporting process was not fully embedded by staff at the practice.</p> <p>The shared roles between the business/practice manager and deputy practice manager did not enable clear oversight for processes and procedures for running the practice. The provider had reviewed the governance structure and further action was required so staff were clear about the roles and responsibilities of others. We raised this with the provider who told us they would review the roles and responsibilities going forward.</p> <p>We found there was no oversight of health and safety and the cleaning contract for the practice. During our onsite visit we requested to see the cleaning schedule as we found the practice cleanliness was not up to a high standard. The practice was unable to provide the information at the time of request, but sent the information following the inspection and told us they had contacted the cleaning company to review the cleaning contract.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	Partial
There was a quality improvement programme in place.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
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.	Partial
Explanation of any answers and additional evidence:	
<p>At our last inspection September 2021, the management team were unable to describe the assurance systems in place to improve the service. There was no overall performance monitoring for medication and prescription reviews for patients within the practice. There were no clear arrangements for identifying, managing and mitigating risks including outstanding documentation.</p> <p>At this inspection we found comprehensive risk assessments of the building and premises had not been undertaken by the landlord and the providers risk assessments were not routinely reviewed and actions updated. During our onsite visit we requested to see supporting documentation and some information was not available.</p> <p>The provider had employed a clinical pharmacist to oversee the performance monitoring for medication and prescription reviews. This was a recent appointment and a quality improvement programme had not been agreed and implemented.</p> <p>The provider had employed an additional member of staff to complete the backlog of patient correspondence of patient records. When this staff member was on leave there was a limited number of staff who could complete this task, which resulted in further backlogs. The provider told us that going forward reception staff would be trained in all areas so there was more flexibility for cover. During our inspection we saw the backlog of correspondence documents for coding had improved and the period for the backlog had reduced from 10 months to a week.</p>	

The practice had limited 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.	Partial
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Partial
Staff were supported to work remotely where applicable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice telephone system was commissioned by the clinical commissioning group and the practice did not monitor the quality of access for telephone calls for improvement. We raised this with the provider during our inspection and were told they would contact the telephone service to support in monitoring the number of calls and staff answering the phones to make improvements.</p> <p>The recovery plans to manage backlogs included the employment of additional staff. For example, a clinical pharmacist to support with medicine reviews and appropriate monitoring.</p> <p>We found infection control audit actions from August 2021 had not yet been completed.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	Partial
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<p>At our last inspection September 2021, the practice did not always use the information they held to improve performance and hold staff to account and improve performance.</p> <p>On this inspection we found the lead GP and practice/business manager did not use the information they held to improve performance. Where areas of concern had been highlighted there was no monitoring to ensure required improvements were made. Actions identified from previous risk assessments were not completed. The provider did not have adequate oversight of all the risks in one accessible place.</p>	

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:	

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.	Partial
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<p>We saw patients' feedback had been recorded in a logbook, but this did not capture what had been done to use the information to improve services and culture.</p> <p>Staff had been focused on improving the medication reviews and monitoring for patients and had had limited opportunity to reflect in the planning and delivery of services.</p> <p>The patient participation group meetings had not continued since the last inspection. No meetings had taken place from September 2021 until February 2022.</p>	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had external support and had prioritised and focused on improving patient care and treatment.</p> <p>The practice had recruited additional staff to support the service going forward and had invested in a blood pressure and weight machine. This was not in operation at the time of the inspection but would support the practice for patients to drop into the surgery for a blood pressure and weight check more easily.</p>	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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