

Care Quality Commission

Inspection Evidence Table

Four Acre Health Centre (1-600127824)

Inspection date: 16, 21 November and 9 December 2022

Date of data download: 24 October 2022

Overall rating: Requires improvement

At the last inspection March 2022, the practice was rated as inadequate overall and in the key questions safe and well-led. Effective and responsive were rated requires improvement and caring was good. The practice remained in special measures and was issued with a requirement notice for Regulation 12 safe care and treatment, a warning notice for Regulation 15 Premises and equipment and conditions of registration for Regulation 17 Good governance.

At this inspection in November 2022, we have rated the practice as requires improvement overall and for responsive and well-led. Safe, caring and effective are rated as good. We found the provider had made improvements to address the findings from the last inspection, but further improvements were needed to embed systems and processes.

Safe

Rating: Good

At the last comprehensive inspection March 2022, the practice was rated as inadequate for providing safe services. This was 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.

At this inspection in November 2022, we have rated the practice as good for providing safe services because:

- The provider had oversight of risks relating to the premises and were working through an action plan.
- The concerns in relation to the prescribing of controlled drugs which were re-issued without any documented patient review had been addressed.
- The recruitment process had been reviewed and actions taken to address the findings from the last inspection.
- The provider now had one electronic incident reporting system

However:

- Staff told us of incidents that had not been recorded on the electronic reporting system at the time of the inspection.

Safety systems and processes

The practice had 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.	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
Explanation of any answers and additional evidence: At our last inspection in March 2022, we found DBS checks had not been reviewed for existing staff records and acted on where DBS checks were missing.	

Safeguarding	Y/N/Partial
At this inspection we found action had been taken to address missing DBS checks. Staff recruited since the last inspection had undergone a DBS check prior to employment.	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Y

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 29 June 2022	Partial
There was a fire procedure. Date of fire risk assessment: 8 July 2022	Y
Actions from fire risk assessment were identified and completed.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection 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. Actions from the fire risk assessment completed in 2017 were overdue.</p> <p>At this inspection we found detailed assessments had been completed and the provider was working with the landlords to address the actions needed for improvement. The improvement work was expected to be completed January 2023. Shortfalls we had previously observed had been addressed.</p>	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 26 May 2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At the last inspection in March 2022, we found some clinical rooms and communal areas were not cleaned to a high standard and cleaning schedules and records were not kept on site. Hand hygiene audits had not taken place.</p>	

At this inspection we found the provider had reviewed the cleaning contract and retained a cleaning schedule and cleaning log on site. We observed the standard of cleanliness for clinical and communal areas had improved and hand hygiene audits had been completed for clinical staff.

The practice refurbishment work was in progress and planned to be completed January 2023.

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: The provider used locum and agency staff to cover clinical absences. There was a clinical and non-clinical staff induction process.	

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.	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: Review of patient records in relation to the clinical searches identified that care records were managed in line with current guidance.	

Clinicians would review the test results they had ordered and urgent blood results were reviewed by the on-call doctor.

Patient correspondence was assigned to medical staff for review. We saw one GP had five correspondence documents assigned when absent from the practice. We raised this with the provider who moved the documents to another GP for review.

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHS Business Service Authority - NHSBSA)	1.04	0.91	0.82	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2021 to 30/06/2022) (NHSBSA)	6.1%	6.1%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2022 to 30/06/2022) (NHSBSA)	5.29	5.73	5.31	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	211.0‰	260.4‰	128.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2021 to 30/06/2022) (NHSBSA)	2.10	1.16	0.59	Significant Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2022 to 30/06/2022) (NHSBSA)	9.0‰	9.0‰	6.8‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y

Medicines management	Y/N/Partial
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. ¹	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. ²	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 and Improvement 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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</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> <p>We saw improvement with medication reviews since the last inspection. For example, patients who were prescribed controlled drugs had evidence of a discussion regarding tolerance/dependence. Patients who were prescribed opiates and benzodiazepines on acute prescriptions had been reviewed and included a reduction plan. We saw a reduction in hypnotic prescribing since the last inspection.</p>	

Medicines management	Y/N/Partial
The practice was able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required. Patients had blood tests arranged that were reviewed prior to prescribing high risk medicines.	
We saw improvements from the last inspection in monitoring and recalling patients had been sustained. The clinical searches identified a total of 942 patients taking a medicine or group of medicines which may be used to treat high blood pressure and heart failure. Of these we identified 13 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found three patients had been reviewed and two other had not received a prescription for the medicine in the last three years.	
The clinical review of patients noted identified that all patients reviewed on high risk medicine methotrexate (used to treat conditions such as rheumatoid arthritis) had received the appropriate monitoring.	
Emergency medicines, the defibrillator and oxygen were checked weekly as recommended by the Resuscitation Council UK guidelines.	

Track record on safety and lessons learned and improvements made

The practice had a 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.	Y
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.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	29
Number of events that required action:	29
Explanation of any answers and additional evidence:	
At the last inspection we found the practice had two processes for recording incidents and there was a lack of clarity around roles and responsibilities for investigating incidents.	
At this inspection one electronic system for recording incidents was in place. We were told of an incident that had required external support, but this had not been recorded on the electronic system and was added after the inspection for investigation and review. There were 11 incidents, categorised as low risk, that were waiting action since 12 October 2022. In the absence of the person who managed the system, roles and responsibilities were unclear for other staff who took the lead.	
We saw actions had been taken following other incidents which included additional training to support staff. Incidents were overseen by the lead GP and deputy practice manager at the time of the inspection..	

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

Event	Specific action taken
Wrong blood form given to patient.	Staff training needs identified.
Incorrect patient contact details logged.	Staff training needs identified.

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: We saw examples of actions taken on recent alerts, for example, regarding citalopram. All patients had had recent discussion, with a clinician, about the risks and side effects.	

Effective

Rating: Good

At the last inspection March 2022, the practice was rated as requires improvement for providing effective services because; the provider was not always able to demonstrate the competence of some staff in the role of reviewing patients and staff had not received appraisals since February 2020.

At this inspection we have rated the practice as good for providing effective services because:

- The provider demonstrated staff competence in the role of reviewing patients.

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

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	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 prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	

Effective care for the practice population

Findings
<ul style="list-style-type: none">• 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. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- 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.
- 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

As part of our inspection, we conducted a series of patient clinical records searches to review the practice's procedures for the management of patients with long term conditions.

- The clinical record searches found patients with long term conditions were reviewed and recalled appropriately. We saw improvement in the documentation for medication reviews since the last inspection.
- The clinical searches identified 13 patients out of 314 on thyroid replacement had not had a monitoring blood test in the last 18 months. We reviewed 5 patient records and the practice were following their processes for recall and patients had not responded.
- Patients diagnosed with chronic kidney disease clinical search identified 64 patients. From these we reviewed four records which identified national guidance was being followed.
- 2 patients with blood tests indicating diabetes, had been reviewed and further appointments to monitor care was scheduled.
- The clinical searches identified 33 patients out of 535 patients who had poor control of their diabetes documented. We reviewed 5 records and found their condition was being appropriately reviewed.
- The clinical search identified 62 patients prescribed Gabapentoid who did not have a documented review in the previous 3 months. From these we reviewed 5 records, all of which reviewed in line with national guidance.
- 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.
- Patients with asthma were offered an asthma management plan.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- We saw that 61 patients with poorly controlled asthma were reviewed to ensure they could be offered treatment or monitoring to improve control.
- 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.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	73	80	91.3%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	76	84.2%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	64	76	84.2%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	65	76	85.5%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	78	92	84.8%	Below 90% minimum

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

Any additional evidence or comments

- The practice had met the minimum 90% immunisation targets for one out of the five childhood immunisation uptake indicators. However, evidence and data submitted by the provider assured us that they were proactively working to increase childhood immunisation uptake and had been successful in doing so.

- Two practice nurses offered appointments for childhood vaccinations could be pre-booked or offered at short notice or opportunistically between 8.30am to 6.30pm daily.
- Any patient that did not attend, parent or carer was contacted to book another appointment. We saw evidence of this during inspection.
- The practice offered themed clinics to encourage attendance and positive experiences to attend the practice such as Halloween and Christmas.
- At the time of the inspection the local area did not have support from Health visitors and the practice worked closely with the improving immunisation team to improve uptake.

Cancer Indicators	Practice	SICBL average	England average	England comparison
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (Snapshot date: 30/06/2022) (UK Health and Security Agency)	70.2%	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) (UKHSA)	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) (UKHSA)	54.6%	60.4%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	66.0%	55.8%	55.4%	No statistical variation

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Any additional evidence or comments
<p>The provider was aware of the 80% target set by the World Health Organisation for cervical cancer screening and had a plan in place to increase uptake. This included:</p> <ul style="list-style-type: none"> • Screen prompts/alerts for clinicians to raise awareness that screening was available to eligible patients. • Awareness campaigns and posters in the practice waiting room. • Data cleansing so the practice identified eligible women on the practice record system. • Providing a variety of appointment times so women could attend the practice before or after work. • Providing patient information so women make an informed choice (why they are offered screening, what happens, benefits and risks, potential outcomes and what happens to their screening record). • Creating a positive experience.

Monitoring care and treatment

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

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	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

<p>The practice had undertaken audits to improve services. For example:</p> <ul style="list-style-type: none"> • Amputation in patients with diabetes mellitus-the audit identified patients with multiple co-morbidities for review and referred patients to supporting services. • Children did not attend appointment-the audit identified 45 appointments children had not attended that required follow up. This included GP and secondary care appointments. The practice arranged for follow up appointments and referrals where required to ensure the children were seen by an appropriate clinician. • Infant prescribing audit-the audit assessed the Pan Mersey guidance on the prescribing of infant formula in cow's milk protein allergy and lactose intolerance comparing pre and post intervention. The audit identified coding issues on the patient records, not all prescriptions had followed the guidance, some patients did not attend appointments with the dietitian. The patients were followed up to improve the care and treatment. A second cycle audit was completed and improvement was seen. A further audit was planned to review patients to check dietitian appointments were attended, patients had the correct code on their record and prescribing guidance was followed. • Opioid review audit-the audit reviewed a sample of 4 clinicians medication reviews to check safe care and treatment was given for patients prescribed opioids. The audit assessed the clinician reviews against the prescribing policy for opioids. Checks included the standard template had been used for the consultation, the patient record was coded correctly, the frequency the prescription was issued was documented, for female patients the possibility of pregnancy was recorded, and patients were followed up. Changes were made to the consultation template to ensure all the information required was captured. 	
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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.	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.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Since the last inspection the practice had identified a learning and development programme which included on-line learning and lunch and learn sessions. For example, the practice had recently had a safeguarding session to discuss changes coming to the national systems and processes.</p> <p>The practice offered training and learning opportunities for staff development.</p> <p>New reception and administration staff undertook a period of induction training and there were plans for all non-clinical staff to be trained in patient related roles to increase capacity during busy times and cover absences. GP assistants had been recruited and were being trained in practice systems and processes.</p> <p>Non-clinical staff appraisals had been completed for most staff and personal development plans were to be finalised.</p>	

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: The practice website provided information about local and national support groups available.	

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.	Y
Explanation of any answers and additional evidence:	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	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
Explanation of any answers and additional evidence: We saw staff training had been undertaken for customer service since the last inspection.	

Patient feedback	
Source	Feedback
Four Acre compliments	Staff were supportive, helpful and patients appreciated their hard work
Patients	Reception staff were friendly. Great friendly surgery. The service is excellent

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2022 to 30/04/2022)	82.9%	85.1%	84.7%	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 (01/01/2022 to 30/04/2022)	82.8%	83.6%	83.5%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2022 to 30/04/2022)	89.7%	92.4%	93.1%	No statistical variation

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2022 to 30/04/2022)	65.7%	67.9%	72.4%	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 and had continued the patient participation group meetings.

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 the last inspection the practice did not use any advocacy services and relied on patient carers and relatives. We found patients were signposted to supporting services where possible.	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2022 to 30/04/2022)	91.6%	90.0%	89.9%	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.	391 patients were registered as a carer with the practice. The registered list size as of 11 November 2022 was 8116 patients, which equates to 4.8% of the practice 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
Explanation of any answers and additional evidence: The practice had continued to operate a queueing system to provide privacy for patients while waiting to speak to a receptionist.	

Responsive

Rating: Requires improvement

At the last inspection in March 2022, we rated the practice as requires improvement because the provider could not demonstrate a consistent approach to managing and learning from complaints.

At this inspection in November 2022 we rated the practice as requires improvement because:

- Telephone access and satisfaction with making an appointment remained below local and national averages. The provider was aware of this and working with external stakeholders to improve this.
- A system for managing and responding to complaints was now in place but investigations and actions taken were not always recorded.

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 provider worked with the landlords to make improvements and were working through a refurbishment plan. We found clinic room 6 carpet flooring had not been replaced at the time of the inspection and was expected to be completed by the end of January 2023.	

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

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • 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. • The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

Access to the service

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

	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 (including those who might be digitally excluded).	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>At the last inspection in March 2022 patients had difficulty booking an appointment by telephone and were working with external stakeholders to improve the system.</p> <p>Since the last inspection the practice no longer provided extended hour appointments on Tuesday evenings. These were now provided as part of the primary care network.</p> <p>At this inspection we found the commissioners held the contract for the telephone service and worked with the practice to monitor calls including, number of calls, abandonment rates and peak times.</p>	

We saw 8 patients queuing outside waiting for the practice to open at 8am during the onsite inspection. We were told some patients preferred to attend the practice to make an appointment than use the telephone. Patients could complete an electronic form or telephone the practice to book an appointment with a clinician. Limited appointments could be booked on the day and pre-bookable appointments were made by clinicians for patient follow up. Following assessment by NHS 111, if indicated, patients could be directly booked onto an appointment to see a clinician at this practice and others in the area.

The deputy practice manager monitored the appointment bookings to ensure bookings were coded correctly and utilised appropriately. We saw 1135 patients had not attended for an appointment from 1 April 2022 to 20 November 2022.

We saw demand for appointments at the practice had increased and the practice was delivering more appointments than before the pandemic. Patients were signposted to other services where possible.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2022 to 30/04/2022)	22.2%	N/A	52.7%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	34.6%	47.0%	56.2%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2022 to 30/04/2022)	41.5%	47.7%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	65.8%	69.8%	71.9%	No statistical variation

Any additional evidence or comments

The practice was aware of the poor results about getting through to the practice by telephone and less satisfaction with the overall experience of making an appointment. Patients could use the electronic booking system but there had been poor uptake for this. The practice encouraged staff to sign post patients to the most appropriate clinician such as a pharmacist or first contact physiotherapist.

The practice telephone system was part of the local hospital telephone network and were not able to adjust the number of lines coming into the practice or add any additional messaging. Additional staff were trained to answer the phones during peak times and the provider was liaising with the hospital and local stakeholders to improve the system.

Source	Feedback
For example, NHS Choices	4 out of 4 reviews since our last inspection were positive and included: Submitted an electronic request and had a call the same day.

Listening and learning from concerns and complaints

Complaints were used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	20
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Partial
Explanation of any answers and additional evidence:	
<p>At the last inspection in March 2022 we noted concerns reported to CQC where patients told us they had complained directly to the practice and had not been recorded. Complaints were written in a book and it was not clear how they were followed up, investigated and whether there had been further communication with the patient or person who made the complaint.</p> <p>As this inspection we found the complaints process had been reviewed and the provider had moved to an electronic system. We saw concerns that had been reported to CQC where patients told us they had complained directly to the practice had been recorded on the electronic system. We saw complaint investigations and actions were not always recorded following a management role vacancy.</p> <p>The provider had identified staff training needs from complaints received and plans for improvement included training administration and reception staff in all areas to provide increased flexibility for cover.</p>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Wrong appointment given	Staff training needs identified and new appointment given.
Items missed off prescription	Staff training needs identified and prescription items issued.
Incorrect number on patient record	Staff training needs identified and patient number corrected.

Well-led

Rating: Requires improvement

At our last inspection in March 2022, we rated the practice as inadequate for providing well-led services 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.

At this inspection in November 2022, we rated the practice as requires improvement for providing well-led services because:

- The provider had improved systems and processes for risk management, governance arrangements, incidents and complaints but further work was needed to embed them.
- Policies and procedures were not always specific to the practice.

Leadership capacity and capability

Leaders could demonstrate that they had capacity and skills to deliver high quality sustainable care.

	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.	Partial
Explanation of any answers and additional evidence: At the last inspection we found leaders had been focused on improving care for patients and in doing so lacked oversight in other areas of risk at the practice. At this inspection we found the provider had continued to make improvements for patient care and support additional training for staff. We received mixed reviews from staff about the visibility and approachability of leaders. The practice manager role was vacant at the time of time of the inspection and recruitment to the role was in progress. Contingency plans were in place to cover leave and absence of leaders and managers.	

Vision and strategy

The practice had a clear vision and 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.	Y
<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. They were reviewed with staff May 2022 and no changes were made.</p> <p>The practice had focused on reviewing patients identified from the 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 an action plan to monitor improvement plans for the service which included the refurbishment of the premises.</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.	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.	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 in March 2022 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>At this inspection we received mixed feedback from staff about raising concerns, patient safety, wellbeing and leadership. We found the culture had deteriorated since the last inspection. Relationships and communication between managers and staff were strained. In the absence of a practice manager, the leadership and managerial roles and responsibilities were shared between the deputy practice manager and lead GP.</p> <p>The provider had reviewed the incident reporting system and implemented an electronic system which was supported by the commissioners.</p>	

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

Source	Feedback
Staff questionnaire/interviews	Staff were concerned about an increased workload needed to meet the demand on the service.

Governance arrangements

The overall governance arrangements were under review.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:	
<p>We found following the last inspection in March 2022 roles and responsibilities had been reviewed for the management and governance of the practice. Third party contracts had been reviewed and a new cleaning contract was in place.</p> <p>Due to changes in the lead roles at the practice, the governance arrangements were under review to embed and maintain systems and processes for incidents and complaints.</p> <p>We saw additional policies had been written since the last inspection including performance management, incident reporting pathway and cleaning policy in line with COVID-19 pandemic. However, some policies for example, the incident reporting and management policy was not specific to the practice and related to NHS services. In the absence of practice detail, staff did not have sufficient information to follow. The policies did not include a review date or named person responsible.</p>	

Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
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.	Partial
Explanation of any answers and additional evidence:	
<p>At the last inspection in March 2022 we found comprehensive risk assessments of the building and premises had not been undertaken by the landlord and the provider's risk assessments were not routinely reviewed and actions updated.</p> <p>At this inspection we found full risk assessments for the building and premises had been completed with an action plan to monitor progress. Additional risk assessments had been completed where appropriate. For example, a risk assessment in the absence of the lead GP which identified the cover arrangements in place and contact details.</p> <p>Since the last inspection the clinical pharmacist had overseen the performance monitoring for medication and prescription reviews. A quality improvement programme was now in place and monitored.</p> <p>In the absence of a practice manager some systems had not reviewed as regularly as planned. We saw correspondence documents for an absent clinician were outstanding and this was raised with the provider during the inspection. These were reassigned to another clinician for review.</p>	

Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:	
<p>Since the last inspection we found the lead GP had identified areas of improvement for the practice and held staff to account. The provider had oversight of all the risks and was working towards improving the systems and processes that had been put in 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
Staff are supported to work remotely where applicable.	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.	Y
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.	Y
Explanation of any answers and additional evidence: Since the last inspection the patient participation group meetings had continued. They were keen to recruit additional members as numbers had reduced following the pandemic. Staff told us they were concerned there were not enough appointments for patients to book on the day and were concerned as locum GP hours had been reduced. We raised this with the provider who told us they were supported by the commissioners to monitor and review appointments as the demand had increased following the pandemic. The practice encouraged staff to promote and refer patients to other sources of support. For example first contact physiotherapy and local pharmacy services.	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Partial
Explanation of any answers and additional evidence: The practice had received external support following the last inspection and at the time of this inspection this this had been withdrawn as the practice systems and processes had been implemented. Staff training needs had been identified for non-clinical staff to provide more flexibility for cover arrangements.	

The practice had invested in a blood pressure and weight machine to support the practice so patients could drop into the surgery for a blood pressure and weight check more easily.

The practice had an audit schedule and were working through the refurbishment action plans for the premises.

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 SICBL 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 SICBL average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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