

Care Quality Commission

Inspection Evidence Table

Tollgate Health Centre (1-6161134058)

Inspection date: 09 April 2021

Date of data download: 24 February 2021

Overall rating: Inadequate

Following our last inspection the practice was rated overall good. Safe, caring, responsive and well-led key questions were rated good, and the effective key question was rated requires improvement. This was due to finding no system of clinical audit to provide patient quality improvement. This affected all the population groups, so all were rated requires improvement. We also told the provider they should make improvements to their infection control systems to ensure trends were recognised, and to improve the identification of carers to ensure carers were supported.

During this inspection we rated the practice as inadequate overall. Specifically, we rated the caring and responsive key questions as inadequate, which meant that the practice was rated as inadequate overall.

We found many of the national survey indicators published in July 2020 were significantly below local and national averages. This applied to both the caring and responsive key questions. The practice had not monitored patient satisfaction to understand why patient experience was so significantly lower than previous years, and did not have an improvement plan in place. Also, there was no improvement in identifying patients that were carers or a policy to inform patients how to protect their patients' online information. The issues found affected all population groups, so they were all rated inadequate.

This inspection was triggered following concerns raised to the Care Quality Commission, and following two recent quality visits from the North East Essex Clinical Commissioning Group, who informed us about concerns relating to the management of the practice.

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

Safe Rating: Requires Improvement

The safe domain was rated good following our last inspection. We rated this domain requires improvement at this inspection because; there was no adult safeguarding policy, there was no procedure for patients presenting that were deteriorating or acutely unwell, there was no formal process to carry out premises health and safety risk assessments, there was no documented hand washing monitoring or auditing, controlled drug prescribing was not monitored for safety, and there was no process within the prescribing policy to raise concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
There were policies covering adult and child safeguarding which were accessible to all staff.	Partial
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular ad hoc 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
The practice had a list of the lead staff members roles that were accessible to all staff members. When staff were asked who the safeguarding lead was, we were shown the list. Although not all the practice policies and procedures had been reviewed, an action plan to review them all was in progress. There was no adult safeguarding policy at the practice.	
There was a principle safeguarding lead and a deputy that were trained to level three. All clinical and non-clinical staff had received safeguarding training via e-learning to the appropriate level, this was seen on the staff training record. The safeguarding lead told us they attended the regular local safeguarding meetings.	
Staff acting as chaperones had received e-learning training.	

Safety systems and processes

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

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
The practice had recently recruited a new practice manager, deputy practice manager and reception staff members since the previous inspection. The recruitments had been supported by the North East Essex Clinical Commissioning Group human resources team during lockdown of the COVID 19 restrictions.	
Assurance was provided that disclosure and barring service (DBS) checks had been carried out for all staff working at the practice. We also received assurance of vaccination, and clinical registration assurance.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:	Y March 2020
There was a record of equipment calibration. Date of last calibration:	Y June 2020
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check:	Y 07/04/2021
There was a log of fire drills. Date of last drill:	Y 27/03/2021
There was a record of fire alarm checks. Date of last check:	Y Weekly
There was a record of fire training for staff.	Y
There were fire marshals.	5
A fire risk assessment had been completed. Date of completion:	Y 07/04/2021
Actions from fire risk assessment were identified and completed.	Y
Although the portable appliance testing had past the date for review, we were shown the this had been requested and was booked for June 2021. This had been delayed due to COVID 19 restrictions. The recent fire drill had successfully cleared the practice building of all staff and patients in a safe and timely manner to the designated assembly area in the car park.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment:	Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment:	Partial
We were told that risk assessments were carried out on a daily basis as part of staff working duties but there was no evidence produced that these were being carried out. Part of the practice action plan was to formalise and document these assessments.	

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y

Date of last infection prevention and control audit:	12/10/2020
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>The infection prevention control (IPC) lead explained how they kept up to date with the changing advice and guidance from NHS England to ensure the practice was COVID 19 restrictions secure. The IPC lead told us they had requested additional training to support the practice which would be provided soon.</p> <p>Staff we spoke with verified they had received training and information about IPC and how to minimise risks to themselves and others during the pandemic. All those we spoke with knew who the IPC lead at the practice was, and were aware of their own role to reduce COVID 19 restrictions transmission.</p> <p>Clinicians confirmed they cleaned down their consultation areas and rooms between face-to-face patient appointments. Each clinician had their own supply of cleaning materials and were responsible for maintaining the cleanliness before, between, and after each patient consultation. Staff also confirmed they had sufficient personal protection equipment (PPE) to prevent COVID 19 virus spread.</p> <p>The practice had cleaning schedules and room checklists to monitor the quality and cleanliness of cleaning undertaken.</p> <p>Although most tasks within the infection control audit had been completed, we noted hand washing monitoring had not been documented and audited.</p>	

Risks to patients

There were 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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	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 was a process in the practice for urgent clinical review of deteriorating or acutely unwell patients.	Partial
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Sepsis flow diagrams were displayed in all the clinical areas and consultation rooms throughout the practice.</p> <p>Although when we spoke with the clinicians, they gave us their own approaches to the deteriorating or acutely unwell patient process, there was not a practice wide procedure to ensure patients were followed</p>	

up consistently. Although patients were being cared for safely, the practice told us this would be added to their action plan of improvement work.

Patients with on-going healthcare conditions had treatment plans that had been modified in line with National Institute for Health and Care Excellence (NICE), Public Health England (PHE) and local guidance in response to the COVID 19 restrictions.

There were records of regular checks of the oxygen, defibrillator, emergency, and anaphylactic shock medicines. The stock levels and expiry dates for medicines and equipment was documented monthly and was stored securely.

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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented 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
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
Urgent results were phoned into the practice by the pathology laboratory and passed to the duty doctor for prompt action. Results were forwarded to the GP that requested them; however, a GP partner monitored the global practice inbox daily to ensure all results were cleared and acted on each day.	
We were told patient information from multiple services, including discharge letters, was added to patient records. Although a formal protocol regarding correspondence from multiple services about patients had not been developed, the leaders at the practice told us this process would be added to the practice improvement action plan.	
The practice told us that the practice, hospice, district nursing service and community nurses all used the same patient records system, this supported multiple services having access to important patient information instantly, for example “do not attempt cardiopulmonary resuscitation” (DNACPR) patient wishes.	

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHS Business Service Authority - NHSBSA)	0.78	0.90	0.76	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). (01/01/2020 to 31/12/2020) (NHSBSA)	10.4%	11.3%	9.5%	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 (01/07/2020 to 31/12/2020) (NHSBSA)	5.49	5.60	5.33	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	135.4‰	179.5‰	127.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2020 to 31/12/2020) (NHSBSA)	0.79	1.15	0.67	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

Medicines management	Y/N/Partial
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.	Partial
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
<p>We were told only GPs and the pharmacist working at the practice could make medicine dose changes from correspondence received at the practice.</p> <p>Patients taking high risk medicines had alerts on their computer patient records to warn clinicians if patients were overdue pathology monitoring, or medicine reviews. A pharmacist recently employed by the primary care network (PCN) that Tollgate Health Centre was a member, had been assigned to run searches to identify patients requiring additional monitoring and review.</p> <p>The senior GP told us they would contact the clinical commissioning group medicines management team lead to raise concerns around controlled drugs to liaise with the NHS England Area Team Controlled Drugs Accountable Officer. We found this arrangement was not part of the current prescribing policy.</p> <p>The practice had undertaken an antimicrobial audit as part of the local medicine's management team suite of audits. The reflective learning session held after the audit showed clinicians needed to educate patients and provide information leaflets when prescribing antibiotics, the importance of delay, and to adhere to North East Essex Clinical Commissioning group guidelines.</p>	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y

There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7
Staff interviewed understood how to raise a significant event. They told us concerns were discussed at practice meetings.	
Our review of a sample of significant event records showed they were documented and managed.	

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

Event	Specific action taken
Patient returned controlled drug medicines, later found in an unlocked staff accessible drawer.	Medicines removed from drawer, recorded, and locked in cupboard with list. The whole surgery checked for any other medicines. Staff involved suspended and IT access disabled, computers and keys returned. Audits carried out on members of staff regarding producing repeat prescriptions. Alarm code changed and a prescribing policy implemented 12/12/20.
Certification of death	Patient died at home and staff informed at 8am that visit to produce a death certification needed. Visit not done until after 12.00pm. Practice had recognised this visit should have been carried out sooner and caused great distress to bereaved.

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
The practice had an effective system to manage patient safety alerts. We saw they were shared appropriately and actioned. Records of recent alerts were available, and the actions taken in response to these.	

Effective

Rating: Requires Improvement

Following our last inspection in February 2019, the practice was rated requires improvement for providing effective services. A requirement notice was issued for breach of regulation 17(1) Good governance. The practice was required to implement an effective quality improvement process, including clinical audit. The requirement notice from the previous inspection had not been acted on. This breach affected all the population groups so they were also rated as requires improvement.

We rated this key question as requires improvement at this inspection because; there was no consistent approach at the practice to follow up patients presenting with symptoms which could indicate serious illness in a timely and appropriate way, the practice did not monitor their consent process, data for the management of patients with asthma and those suffering from poor mental health was significantly below the local and national average and there was no action plan to improve, the practice had not held any multi-disciplinary team meetings for over a year to discuss the planning and care of relevant patients, and there was no policy for the online services they provided. The practice also did not have a comprehensive programme of audit activity, including clinical audit. This issue was highlighted at the last inspection. The lack of clinical audit, and consent monitoring concerns found at this inspection affected all the population groups. The monitoring concerns for those with long term conditions or those experiencing poor mental health that affected these population groups are the reason we rated them requires improvement.

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.	N
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 used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
One of the GP partners and one other GP at the practice, trains GP registrars working at the practice. They also provided training each week for all GPs at the practice, and monthly for nurses.	

We were told the practice did not have a standardised approach to follow up patients with symptoms that could indicate a serious illness. However, stated they would establish this as a practice wide procedure for the future.

Long term condition management recalls were used to review/update medication and treatment.

Software templates were now being used consistently by all clinicians at the practice to provide reliable structured care, and referral pathways.

Older people

Population group rating: Requires Improvement

Findings

The practice had adjusted the way it worked, to provide safe care, and treatment for older people during the COVID 19 restrictions.

Since the COVID 19 restrictions health checks, including frailty assessments, were offered to patients over 75 years of age over the telephone in accordance with changing guidance to ensure the safety of patients.

The practice provided residential care home visits, carried out remotely through telephone and video calls since the beginning of the COVID 19 restrictions.

The practice had introduced a safe system for older people to continue to provide flu, shingles, and pneumonia vaccinations.

People with long-term conditions

Population group rating: Requires Improvement

Findings

The practice had adjusted the way it worked, to provide safe care, and treatment for people with long-term conditions during the COVID 19 restrictions .

The GPs worked with other health and care professionals to deliver a coordinated package of care for patients with complex needs. This was carried out on an ad hoc when needed basis when we inspected the practice but we were told that multidisciplinary meetings were in the process of being set up to ensure a consistent practice wide approach for the future.

Staff responsible for reviewing patients with long-term conditions had received specific training.

Although the practice did not have a consistent practice wide approach to follow up patients who had received treatment in hospital or through out of hours services, for example an acute exacerbation of asthma, the clinicians told us they reviewed the discharge letters and ensured peoples care plans and prescriptions were updated to reflect any extra or changed needs.

The practice shared information with relevant professionals when deciding care delivery for patients with long-term conditions.

Searches we carried out on the practice patient records system showed adults with newly diagnosed cardio-vascular disease were offered statins. Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

However the data and searches carried out during the inspection process showed a low percentage of patients with asthma were offered an asthma management plan.

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions. (01/04/2019 to 31/03/2020) (QOF)	56.4%	75.3%	76.6%	Significant Variation (negative)
PCA* rate (number of PCAs).	3.6% (20)	10.2%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	91.3%	87.8%	89.4%	No statistical variation
PCA rate (number of PCAs).	14.9% (14)	9.9%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	75.5%	81.2%	82.0%	No statistical variation
PCA rate (number of PCAs).	2.7% (3)	3.2%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	66.9%	66.7%	66.9%	No statistical variation
PCA rate (number of PCAs).	6.3% (17)	9.2%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the	67.6%	71.7%	72.4%	No statistical variation

preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) _(QOF)				
PCA rate (number of PCAs).	2.1% (15)	4.6%	7.1%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2019 to 31/03/2020) _(QOF)	91.1%	92.3%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.8% (4)	4.1%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) _(QOF)	83.4%	78.1%	75.9%	No statistical variation
PCA rate (number of PCAs).	6.6% (18)	6.0%	10.4%	N/A

Any additional evidence or comments

Personalised care adjustment (PCA) rates. PCA's allow practices to differentiate between the reasons for adjusting care and removing a patient from the indicator denominator. The practice PCA rates were lower than the England average.

When asked about the poor result for the Asthma review indicator, we were told there was inconsistency within the practice when coding patients with long term conditions and would discuss this with the nurse(s) looking after asthma patients. We were also told that now they were using consistent templates this would reduce the coding concerns. However, we found that the practice were not aware of the data published in October 2020 and had not produced an action plan to improve. There was no clear evidence this was just a coding issue.

Before 2020 previous performance for asthma had been in line with local and national averages for this indicator.

Families, children and young people

Population group rating: Requires Improvement

Findings

The practice had met the minimum 90% for all childhood immunisation uptake indicators. The practice had met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for three of the childhood immunisation uptake indicators.

The practice nursing staff contacted the parents or guardians of children due to have childhood immunisation. The nurses followed up failed attendances for immunisation.

Staff held the appropriate skills and training to carry out reviews for this population group. Young people could access services for sexual health and contraception.

Working age people (including those recently retired and students) Population group rating: Requires Improvement

Findings				
<p>The practice had adjusted the way it worked, to provide safe care, and treatment for working age people (including those recently retired and students) during the COVID 19 restrictions.</p> <p>The practice patient system identified patients eligible to have the meningitis vaccine, for example before attending university for the first time.</p> <p>Patients access to health assessments and checks including NHS checks for patients aged 40 to 74, had been limited due to the COVID 19 restrictions.</p> <p>Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.</p>				
<p>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)</p>				
<p>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)</p>	116	120	96.7%	Met 95% WHO based target
<p>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)</p>	116	120	96.7%	Met 95% WHO based target
<p>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)</p>	114	120	95.0%	Met 95% WHO based target
<p>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)</p>	105	114	92.1%	Met 90% minimum

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: 30/09/2020) <small>(Public Health England)</small>	75.5%	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	73.0%	74.1%	70.1%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2019 to 31/03/2020) <small>(PHE)</small>	67.2%	N/A	63.8%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis (01/04/2019 to 31/03/2020) <small>(QoF)</small>	95.0%	91.9%	92.7%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2019 to 31/03/2020) <small>(PHE)</small>	61.5%	57.6%	54.2%	No statistical variation

Any additional evidence or comments

We asked about the practice low cervical screening indicator. The GP partners told us that since the data had been collected, they had increased the appointments to meet the indicator target. We were provided unvalidated data from the practice computer system which showed they had reached the 80% target. (We await confirmation from the next published Public Health England data).

People whose circumstances make them vulnerable Population group rating: Requires Improvement

Findings

The practice had considered the way to provide safe care, and treatment for people with whose circumstances make them vulnerable during COVID19 restrictions.

The majority of patients with a learning disability were provided a face to face health check at the practice, where appropriate a telephone health check was offered.

End of life care was delivered in a coordinated way and discussed at the practice palliative care meetings, which took into account needs of those whose circumstances may make them vulnerable.

The nursing team vaccinated patients with an underlying medical condition to maintain the recommended schedule whilst ensuring people were safe during COVID 19 restrictions.

**People experiencing poor mental health
(including people with dementia)**

**Population group rating: Requires
Improvement**

Findings

The practice had adjusted the way it worked, to provide safe care, and treatment for people experiencing poor mental health (including people with dementia) during the COVID 19 restrictions.

Patients with mental health were offered telephone support with referral and signposting to support services during an acute episode of their illness during the COVID 19 restrictions.

The practice provided telephone assessments to review the physical health of people with mental illness, and to signpost them to support services to help manage lifestyle choices.

There was no consistent system at the practice to follow-up patients who failed to attend for administration of long-term medication or care planning. This was reflected in the significantly negative mental health quality indicator for comprehensive agreed care planning documented in records.

Any additional evidence or comments

When we asked about the significantly negative percentage of agreed care plans for patients with schizophrenia, bipolar affective disorder and other psychoses documented at the practice, the GPs explained since January 2021 they had contacted patients to arrange appointments where agreed care plans could be produced, coded and recorded for patients affected by this mental health indicator. However, this data was published in October 2020 and since that date they could not evidence a plan in place to improve this performance. Before 2020 previous performance for this indicator had been in line with local and national averages for this indicator.

Personalised care adjustment (PCA) rates. PCA's allow practices to differentiate between the reasons for adjusting care and removing a patient from the indicator denominator. The practice PCA rates although higher than the North East Essex Clinical Commissioning Group (CCG) were in line with the England average.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	495.34	Not Available	533.9
Overall QOF score (as a percentage of maximum)	88.6%	Not Available	95.5%
Overall QOF PCA reporting (all domains key questions)	4.4%	Not Available	5.9%

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	28.2%	81.3%	85.4%	Significant Variation (negative)
PCA rate (number of PCAs).	4.1% (3)	13.9%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	78.3%	81.5%	81.4%	No statistical variation
PCA rate (number of PCAs).	8.0% (4)	5.9%	8.0%	N/A

Any additional evidence or comments

The GPs had taken part in the local CCG medicines optimisation quality improvement audits, however, the practice had not used the outcomes to make changes to care and treatment at the practice. The practice noted the dementia coding audit showed an improvement, however, the long-term steroids use for osteoporosis had not been re-run. Audits produced from the practice system without a second cycle could not be used to identify improvement processes.

Overall in relation to audits we found they were not effective. There was no analysis finding and conclusions to identify where improvements could be made. They had not completed two cycle audits.

A two cycle telephone audit had shown improved access for patients after the telephone system had failed.

The practice monitored and recorded updates and changes from discharge letters.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	N
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N

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

The practice had not carried out any clinical audits with two cycles to identify improvement work. Any of the first cycle audits at the practice had not been completed effectively and were lacking analysis, conclusions and improvement plans.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	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
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	N/A
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y

The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>The additional roles at the practice employed by the primary care network (PCN) provided the assurance of skills, knowledge and experience to deliver effective care, for the physiotherapist, clinical pharmacist and pharmacy technician.</p> <p>The practice trained GP registrars at the practice. Registrars are fully qualified doctors and are registered on the General Medical Council (GMC) list, they carry out a further three years of training experience at a training practice to qualify as a GP. The practice had two GP registrars working at the practice on the day we inspected and we interviewed them about working at the practice. The registrars we spoke with told us they were provided support for their clinical work and given dedicated time for self-learning and guided learning.</p> <p>We found no formal recorded process to assure/access long term clinicians performance working at the practice, although the senior GPs told us that random informal checks were carried out. We did see evidence of staff appraisals and supervision work for GP registrars and nurses. This was an area of work going forward that the practice told us they would formalise to monitor the quality of clinicians' work.</p>	

Effective staffing

The practice staff had the skills, knowledge and experience to carry out their roles.

Coordinating care and treatment

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

Indicator	Y/N/Partial
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centered care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
<p>The practice discussed end of life care with the palliative care teams at regular meetings, however, communication with social care and other community care teams had ceased over a year ago. This meant there was a lack of consistency to assess, plan and deliver patient care and treatment with other organisations. We were told that the practice planned to re-arrange these regular multidisciplinary meetings and was part of their improvement action plan.</p>	

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 carer's as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
The clinicians explained that even through the COVID 19 restrictions they had continued their health and welfare work with patients via remote video and telephone calls. We were also told patients were still called to the practice when needed.	

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
The practice monitored the process for seeking consent appropriately.	N
Policies for any online services offered were in line with national guidance.	N
Clinicians showed us how they recorded patient consent and decision making processes. Although the practice did not monitor this process, we saw it had been recorded appropriately and consistently.	
We saw information for patients on the practice new patient information form offering guidance on online services. However, this guidance was not available on the practice website or in a policy.	

Caring

Rating: Inadequate

The caring domain was rated good following our last inspection. Patient experience indicators published to inform the last inspection showed no statistical variation with local and national survey indicators. The reason for rating caring inadequate at this inspection was due to many of the national survey indicators published in July 2020 being significantly below local and national averages. We found the practice had not monitored patient satisfaction to understand why in the July 2020 GP survey patient experience was so significantly lower than previous years, and did not have an improvement plan in place. The practice had also not taken any action to improve the identification of patients that were carers despite this being identified at the last inspection in 2019, and no policy to inform patients regarding the practice information sharing protocol, or how to protect patients' online information.

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

Source	Feedback
Patients spoken with during the inspection	We spoke with four patients on the day of inspection. They all told us access to appointments by telephone had improved considerably since December 2020. We were also told that future health monitoring appointments were easier to obtain.

NHS Choices comments	<p>Four of the comments between March and November in the last year were very negative about access via the phone and available appointments. These comments had been rated one star.</p> <p>The fifth comment from December 2020 was very positive rating five stars (see below). <i>“This practice has had a complete turnaround in the last couple of months, the staff are very helpful and appointments are now available.”</i></p>
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Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2020 to 31/03/2020)	67.7%	85.9%	88.5%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2020 to 31/03/2020)	63.5%	84.6%	87.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2020 to 31/03/2020)	90.8%	94.9%	95.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2020 to 31/03/2020)	49.7%	77.2%	81.8%	Significant Variation (negative)

Any additional evidence or comments

We asked what work the practice had done to improve the patient experience at the practice. They were unable to provide any evidence based on their poor patient experience concerns.

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

Any additional evidence

We found that the practice showed no awareness of the July 2020 GP survey data results, had not monitored performance, and there was no action plan in place to improve. The leadership at the practice told us they were now reviewing the negative indicators within the last GP survey and had plans to sign-up to a pilot service to gather patient experience. Previous survey data was in line with local and national averages.

We were also told compliments received at the practice were shared with all staff members during practice 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
When clinicians were delayed in an appointment with a patient, they told us a task message was sent to the receptionists to inform patients waiting that there would be a delay.	
We were told that easy read and pictorial materials were not currently available, however, they would be providing these for the future.	

Source	Feedback
Interviews with patients.	The four patients we spoke with all confirmed they had been involved in their treatment. Those patients seeing the nursing team told us they listened, treated them with respect, and explained things in a way that could be easily understood.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2020 to 31/03/2020)	83.3%	92.7%	93.0%	Tending towards variation (negative)

Any additional evidence or comments

Clinicians monitoring and reviewing people with long term conditions showed us the leaflets and print-outs they gave to patients during appointments.

	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.	On request
Information about support groups was available on the practice website.	Y
A translation service was available if needed.	
Paper information leaflets were readily available in the practice waiting area.	

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 70 patients as carers. This equated to 0.5% of the patient population. We were told this low percentage was a coding issue and they would be reviewing and updating their carers list as part of their practice improvement action plan. The practice had taken no action to improve since being asked to do so at the last inspection in 2019.
How the practice supported carers (including young carers).	Practice staff and the GP care advisor guided carers to the opportunities of support. Carers were offered a flu vaccination.
How the practice supported recently bereaved patients.	The practice provided support to patients on an individual basis and this included a with sympathy card. Patients were signposted to bereavement support services available locally.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	N/A during COVID 19 restrictions
There were arrangements to ensure confidentiality at the reception desk.	N/A during COVID 19 restrictions
<p>In line with COVID 19 restrictions in the infection prevention and control procedures the practice ensured that fewer patients were seen for face to face consultations on site at the practice.</p> <p>The practice door was closed, and the reception desk had been moved so staff had a good view of people approaching the practice door. Patients with an appointment had their temperature checked before stepping over the threshold and were then guided to the hand sanitation station. We saw the chairs that people sat on while waiting for their appointment were cleaned thoroughly after each person vacated them.</p> <p>We were shown the cleaning procedures carried out between each patient's appointment within all the consultation rooms.</p>	

If the practice offered online services:

	Y/N/Partial
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.	Partial
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.	N
<p>As a result of the COVID 19 restrictions the practice had introduced telephone and video consultations.</p> <p>We were shown the area on patient records where written and verbal consent was recorded.</p> <p>The new patient registration documents advised patients regarding the practice information sharing protocol and protecting their online information. However, this was the only practice document that the information sharing protocol, and protecting patient online information was available for patients to view. We were told that this information would be added to the practice website along with the information sharing protocol to improve patient awareness.</p>	

Responsive

Rating: Inadequate

The responsive domain was rated good following our last inspection. Patient experience indicators published to inform the last inspection showed no statistical variation with local and national survey indicators. The reason for rating responsive services Inadequate at this inspection was due to many of the national survey indicators published in July 2020 being significantly below local and national averages. This shows the practice had not been responsive or acted to improve patients' experience of care and treatment. The practice had not taken any action to understand why their patients' experience had declined so significantly in one year. The issues we found affected all population groups, so they were all rated as inadequate.

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.	Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<p>The practice had not formally developed a needs assessment plan to meet its local population needs. Although, they did tell us they worked closely with their primary care network partners to this end.</p> <p>National and local guidelines were being followed to ensure that patients, staff and practice visitors were as safe as possible from the risk of cross infection during the COVID 19 restrictions.</p> <p>Telephone and video appointments were available for patients requiring them, and if the patient assessed required a face to face appointment at the practice they were provided.</p>	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8:30am -1pm closed 2pm - 6:30pm
Tuesday	8:30am -1pm closed 2pm - 6:30pm
Wednesday	8:30am -1pm closed 2pm - 6:30pm
Thursday	8:30am -1pm closed 2pm - 6:30pm
Friday	8:30am -1pm closed 2pm - 6:30pm
Saturday	Closed
Sunday	Closed

Nurse Led Clinics

Monday	7am – 8am
Wednesday	7am – 8am

Older people

Population group rating: Inadequate

Findings

The practice had adapted the way it delivered its services for older people to ensure they continued to receive safe care and appropriate monitoring of their health during the COVID 19 restrictions.

Patients had a named GP to support them in whatever setting they lived.

The practice was responsive to the needs of older patients, and using the primary care network visiting service, patients could request a home visit outside core hours when needed.

A significant incident regarding a delay when producing a death certificate had created learning for the whole practice to recognise the effect on this family's grief. Also under consideration was the religious and cultural observances, to support death certification for prompt burial in line with families' wishes.

People with long-term conditions

Population group rating: Inadequate

Findings

The practice had adapted the way it delivered its services for people with long term conditions to ensure they continued to receive safe care and appropriate monitoring of their health during the COVID 19 restrictions.

Telephone monitoring was undertaken in the first instance for those suffering an acute exacerbation of their long-term condition. People were offered either a face to face review or referred to a specialist nurse or clinical service for additional monitoring and treatment.

Care and treatment for people with long-term conditions approaching the end of life was coordinated with the palliative care team in the regular meetings attended.

Families, children and young people

Population group rating: Inadequate

Findings

Staff had received training for child safeguarding and were observant when reviewing incoming correspondence.

The practice offered a childhood immunisation programme and encouraged and supported families to ensure children received their vaccinations. This service had been adapted during the COVID 19 restrictions to keep people safe.

The practice was responsive to the needs of families, children and young people who were able to use the primary care network appointment system outside core hours when needed. This service included appointments up to 8pm during the week and Saturday and Sunday mornings.

Telephone advice could be booked for the nurses and GPs to support the needs of this population group. Additional nurse appointments were available from 7am – 8am on Mondays and Wednesdays so school age children did not need to miss school.

**Working age people
(including those recently
retired and students)**

Population group rating: Inadequate

Findings

The practice was responsive to the needs of working age people (including those recently retired and students) who were able to use the local primary care network appointment system outside core hours when needed. This service included appointments up to 8pm during the week and Saturday and Sunday mornings.

Telephone advice could be booked for the nurses and GPs to support the needs of this population group.

Additional nurse appointments were available from 7am – 8am on Mondays and Wednesdays.

**People whose
circumstances make them
vulnerable**

Population group rating: Inadequate

Findings

The practice had adapted the way it delivered its services for people whose circumstances make them vulnerable to ensure they continued to receive safe care and appropriate monitoring of their health during the COVID 19 restrictions.

This population group were able to use the primary care network appointment and visiting service outside core hours when needed.

People in vulnerable circumstances were able to register with the practice, this included those with no fixed abode such as homeless people and travellers.

**People experiencing poor mental
health (including people with
dementia)**

Population group rating: Inadequate

Findings

Staff interviewed had received dementia awareness training to support patients with mental health needs and those patients living with dementia.

The practice GP care advisor was aware of support groups within the area and signposted patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
The four patients we spoke with were positive about the access of treatment since January 2021 at the practice. Due to the COVID 19 restrictions, face to face appointments were prioritised on the telephone by a clinician and prioritised for urgency and medical need.	

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 (01/01/2020 to 31/03/2020)	20.1%	N/A	65.2%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2020 to 31/03/2020)	29.3%	59.5%	65.5%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2020 to 31/03/2020)	25.3%	60.7%	63.0%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2020 to 31/03/2020)	41.0%	69.0%	72.7%	Significant Variation (negative)

Any additional evidence or comments

We asked about the negative responses in the last GP survey. We were told the reception staff had received training in January 2021 to improve patient communications. However, no actions to improve patient experience had been taken between July when the data was published and December 2020.

The training was to introduce consistency from staff when people contacted the practice. We found that patients had noticed the changes made when we spoke with them on the day we inspected, commenting that staff had been very helpful when answering the phone.

The telephone system had been audited to understand the practice's patient population needs, due to complaints being raised. The practice had carried out staff training in January 2021, in reaction to the concerns raised by the Care Quality Commission (CQC) and North East Essex Clinical Commissioning Group (CCG). Since this training, no further complaints about practice staff courtesy when answering the telephone or access via the telephone system had been received.

During the day of inspection patients we spoke with had noted how much easier it was to access the practice by phone and that the staff were helpful and efficient.

The leadership at the practice told us they had plans to sign-up to a pilot service to gather patient experience. The aim of this plan was to understand patients' opinions as they were improving the service.

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

Listening and learning from concerns and complaints

Complaints	
Number of complaints received in the last year.	16
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.	Y
We did not see evidence of improvement driven by complaints until January 2021. Since the employment of the full-time permanent practice manager in January 2021 it was clear complaints now drove improvement at the practice. Learning from complaints had been discussed at the latest practice meeting during the practice half day lockdown. This showed a positive trend of improvement.	

Staff we spoke with were able to explain clearly the advice they would give to patients that wanted to complain and how to escalate this process. Paper leaflets were prominently displayed in the waiting room and information was accessible on the practice website.

Complaint	Specific action taken
Not given privacy when attending for smear test	Spoken to patient who was unhappy that their dignity was not considered during a recent smear test. The patient was informed the nurse that provided the test no longer worked at the surgery. This issue was raised with the clinical team at the meeting on 22 February 2021 for learning purposes. The patient was happy with this outcome.
Ongoing issues with prescription ordering	A discussion with the patient regarding a plan going forward included liaising directly with prescription clerk when ordering medication. The prescription clerk was informed and asked to monitor requests going forward to improve the prescription ordering pathway for this patient.

Well-led

Rating: Requires Improvement

The well-led domain was rated good following our last inspection. Since that inspection, the practice had gone through a number of clinical leadership, retirement, management changes and periods of reduced staffing levels. The reason for rating well-led requires improvement at this inspection was because although over the last four months there were changes that appeared positive, we could not be assured this would continue, as time was needed to embed the new values at the practice. Leaders at the practice in 2020 had not shown they understood the challenges to quality and sustainability. They lacked a leadership development, and succession plan. There was no systematic programme of clinical and internal audit or effective arrangements for identifying, managing and mitigating risks. We also found policies needed reviewing/updating to meet local and national guidelines, that patient views were not acted on to improve services or practice culture and the practice did not have an active Patient Participation Group.

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Partial
<p>We found that the leadership at the practice lacked focus and direction in the past 12 to 18 months. The practice had been reactive but not proactive in their approach to leadership. This has been the subject of concern and has been monitored by the Care Quality Commission (CQC) and the North East Essex Clinical Commissioning Group (CCG).</p> <p>Reactive actions had been undertaken by the practice recently, and an improvement action plan had been developed to direct performance at the practice, including procedures, policies, and services. A new practice manager had also been employed in January 2021 to drive the necessary improvements.</p> <p>The improvement action plan had been put into place since January 2021. We saw the new practice manager had been sent on a development course and staff told us about recent training and development they had received because they had taken on new roles at the practice.</p> <p>The leaders at the practice told us, they did not have a succession plan currently but this was part of the improvement action plan they had agreed with the local CCG for the future.</p> <p>As a result of these changes, we found a trend of improvement across the board, but the practice needed more time to embed these leadership processes to maintain performance.</p>	

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
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Partial
Staff knew and understood the vision, values and strategy and their role in achieving them.	Partial
Progress against delivery of the strategy was monitored.	N
Staff told us that the practice new values had been conveyed to them verbally during recent practice meetings, however, there was not a formal statement. Practice leaders told us this would be uploaded to the practice website in the near future.	
The practice was currently working through an improvement action plan to meet and achieve their priorities. The practice had worked with the North East Essex Clinical Commissioning Group (CCG) to develop their improvement action plan following two quality visits carried out by the CCG.	
We were unable to gauge the progress against the delivery of a strategy as this had not been fully developed or embedded at the time of the inspection.	

Culture

The practice culture did not effectively drive high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behavior inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candor.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candor, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Although not all the policies and procedures had been reviewed and updated, we were assured this was being prioritised and the practice shared with us those they had reviewed.	

We were advised by management at the practice a new staff handbook was in development to support staff with the arrangements at the practice for requirements of duty of candor, raising concerns and whistleblowing, and how to access a freedom to speak up guardian.

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

Source	Feedback
Staff members	Those staff members we spoke with were all very positive about the new processes and procedures being set-up by the management at the practice.
	Staff spoke positively about working at the practice since January 2021 and confirmed they felt able to raise issues and concerns knowing they would be supported to do so.
	Staff told us they felt safe working during the COVID 19 restrictions and were supported with personal protective equipment (PPE) and the infection control related guidance.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>For the nine months prior to this inspection both the Care Quality Commission (CQC) and the clinical commissioning group (CCG) had received various concerns and issues. We had contacted the practice and requested they acted to improve their service provision. The CCG had made two quality visits and provided the practice with human resources, and temporary managerial support to help the practice achieve the actions on the improvement action plans they had been given.</p> <p>This inspection identified significant improvements in the last four months to monitor, review and develop the services they delivered at the practice, and the staff teams.</p> <p>These included:</p> <ul style="list-style-type: none"> • The recruitment of a new practice manager and deputy. • The implementation of an improvement action plan. • Review and update of policies and making them accessible to all staff. • Infection prevention and control (IPC) implemented in accordance with changing national and regional guidance to minimise the risks due to COVID 19 restrictions. A number of monitoring and regular spot checks had been put into place to achieve this. 	

Managing risks, issues and performance

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

	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 systematic programme of clinical and internal audit.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Partial
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
<p>Leaders at the practice told us that although they carried out daily risk assessments of premises and staffing needs, this process was not formalised, and they could provide no evidence. There was a lack of quality assurance programme, including clinical audit.</p> <p>Since the arrival of the new practice manager, the monitoring of performance had improved. Further work was required to ensure that this was practice-wide.</p> <p>There was a practice business continuity plan, however, this needed to be updated to include major incident planning and the contact details of new staff.</p>	

Appropriate and accurate information

There was no demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	N
<p>The practice monitored data from the Quality Outcomes Framework (QOF) and worked with the clinical commissioning group medicine optimisation team to monitor their performance.</p> <p>We were told there were issues regarding coding of patients care at the practice, this meant some of the data could not be relied on as accurate. The staff at the practice were now using software templates to reduce this concern.</p>	

If the practice offered online services:

	Y/N/Partial
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
Any unusual access was identified and followed up.	Y

Engagement with patients, the public, staff and external partners

The practice did not 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.	N
The practice had an active Patient Participation Group.	N
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
No actions had been taken resulting from the significantly negative patient experiences within the 2020 GP patient survey.	
The practice manager told us about the plans to re-instate the Patient Participation Group, however this had been delayed due to COVID 19 restrictions.	
The practice worked with their GP practice partners within the primary care network (PCN) to support the delivery of their patient population needs.	

Continuous improvement and innovation

There was little 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
The improvement action plan had been produced for the practice by the clinical commissioning group (CCG) following quality visits being carried out.	
Leadership roles and responsibilities had been established over the last four months and conveyed to all staff.	

Quality improvement audits had been started however, there had not been enough time elapsed to run a second cycle to show any improvement work was effective.

Examples of continuous learning and improvement

There were no examples.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **PHE:** Public Health England.
- **QOF:** Quality and Outcomes Framework.

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