

Care Quality Commission

Inspection Evidence Table

Witham Health Centre (1-9773862088)

Inspection date: Remote Searches 1 September 2021 and Site Visit 14 September 2021

Date of data download: 27 August 2021

Overall rating: Good

At the previous inspection the practice was rated Requires Improvement overall. This was because there were concerns in the key questions, Safe and Well-led.

At this inspection, we were satisfied that most of the concerns had been adequately addressed, but there were some areas that still needed further improvement, specifically:

- The population groups, patients with long term conditions and working age people (including those recently retired and students).
- The prescribing of some antibiotics.

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

Safe

Rating: Good

At the previous inspection we found that:

- Fire training was out of date for some staff
- Training for infection control had expired for the member of staff who was the lead in this area
- No infection control audit had been carried out
- PAT testing had expired
- Checks for the high-risk medication Lithium were not being carried out
- The prescribing of some antibiotics and high-risk medicines were not in line with local and national averages.
- Not all safety alerts were acted upon.

At this inspection we saw that:

- Fire training for staff was current
- Training for infection control was current, including for the lead member of staff.
- An infection control audit had been carried out in July 2021.
- PAT testing was current
- Checks for the high-risk medication Lithium were carried out in line with guidance.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Electronic pop-up alerts had been placed on the relevant patient records, so clinicians were made aware of any safeguarding issues when accessing the file. Staff were able to talk us through the steps they would follow if they had safeguarding concerns. Two members of non-clinical staff had received chaperone training (one male and one female). 	

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We looked at two staff files on the day of inspection and these contained all of the required information. 	

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: June 2021	Y
There was a record of equipment calibration. Date of last calibration: November 2020	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
A fire risk assessment had been completed. Date of completion: April 2021	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: April 2021	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: April 2021	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: July 2021	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: At the previous inspection we found that:	

1. The practice nurse was the lead for infection prevention and control. On the day of the inspection we found that infection control training had expired in April for this member of staff.
2. No practice specific infection control audit had been carried out.

At this inspection we found that:

1. The infection prevention control training for the lead in this area was current.
2. The most recent infection control audit was completed in July 2021.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice team was small, and they had worked out an effective approach to managing staff absences. Reception staff covered each other during busier times or during annual leave and were paid overtime for any extra work undertaken. • The practice used a locum member of staff to cover the lead GP's annual leave. • Equipment for the assessment of sepsis was available, including a paediatric pulse oximeter. 	

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: <ul style="list-style-type: none"> The practice had a system for checking pathology results each day and for allocating them to the correct clinician. We saw that referrals to specialist services were documented and monitored. We saw that there was no backlog of referrals to be made. 	

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) (01/07/2020 to 30/06/2021) (NHS Business Service Authority - NHSBSA)	0.77	0.74	0.69	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). (01/07/2020 to 30/06/2021) (NHSBSA)	9.8%	11.8%	10.0%	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 (01/01/2021 to 30/06/2021) (NHSBSA)	6.58	5.69	5.38	Tending towards variation (negative)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2021 to 30/06/2021) (NHSBSA)	150.5‰	133.6‰	126.0‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) (NHSBSA)	1.60	0.82	0.65	Variation (negative)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/07/2020 to 31/12/2020) (NHSBSA)	10.1‰	8.1‰	6.7‰	No statistical variation

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

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	Y
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>Explanation of any answers and additional evidence:</p> <p>At the previous inspection:</p> <ol style="list-style-type: none"> 1. We found that lithium was not checked on the monthly monitoring audit of high-risk medicines. 2. We found that the practice had no patient specific controlled drugs book to record the details of the controlled drugs that had been administered. 3. The practice had a higher than average prescribing rate for Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infections. The practice data was showing a negative variation compared to local 	

Medicines management	Y/N/Partial
and national averages. The practice performance was 7.24% compared to the local average of 5.63% and the England average of 5.6%	
At this inspection:	
<ol style="list-style-type: none"> 1. We found that patients who were prescribed lithium were monitored in line with guidance and there were no patients who were overdue for their monitoring. 2. We saw that there was a system in place to record administration of controlled drugs. 3. The practice had improved its performance for prescribing Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infections. The practice was tending towards a negative variation compared to local and national averages. The practice performance was 6.58% compared to the local average of 5.69% and the England average of 5.38%. The practice was aware of this and had a plan in place to continue to reduce the number of these medicines prescribed. 	
<ul style="list-style-type: none"> • The practice performance for prescribing average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2020 to 30/06/2021) was higher than local and national levels and higher than at the previous inspection. The practice was aware of this and told us that it was as a result of COVID-19. • On the day of inspection, we found that the practice had an effective cold chain procedure in place and staff were aware of this. Staff we spoke to told us what they would do if there was a problem with any part of the process. • The practice had a clinical pharmacist working with them on a part-time basis, whose remit included conducting medicines reviews, reviewing repeat prescription practices and carrying out audits of prescribed medicines. 	

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:	Two
Number of events that required action:	Two

Explanation of any answers and additional evidence:

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

Event	Specific action taken
A small number of patients from a local care home were given three COVID-19 vaccinations instead of two.	It was agreed that there was no risk to the patients, but they were monitored for any side effects. The practice put procedures in place to ensure vaccinating staff had an up to date list of patients for vaccinations and that sufficient time was allowed to administer the process so that vaccinating staff and care home staff were not under any time pressure.

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:	
At the previous inspection:	
<ol style="list-style-type: none">1. Safety alerts were sent to the practice nurse. This was then reviewed and if relevant it was sent to all clinical staff and added onto a spreadsheet which was kept on the shared drive and could be accessed by all staff. However, we found that the system was not monitored effectively to ensure that the relevant action had been taken.2. On the day of the inspection we carried out a search relating to two safety alerts and found that these had not been acted upon; however, the GPs were aware of these alerts.	
At this inspection:	
<ol style="list-style-type: none">1. We found that there was an effective system in place to manage safety alerts.2. We carried out searches relating to two safety alerts and found that the relevant patients had been reviewed and appropriate action taken.	

Effective

Rating: Requires Improvement

At the previous inspection, the practice was rated as requires improvement for providing effective services due to low QOF data relating to patients with long term conditions, those experiencing poor mental health and working age people.

At this inspection we found:

- The practice had made adequate improvements for patients experiencing poor mental health.
- The practice had not made adequate improvements for patients with long term conditions.
- The practice had not made adequate improvements for patients who were working age (including those recently retired and students).

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
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• GPs and nurses were aware of relevant and current evidence-based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practices guidelines. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patient's needs.	

Older people

Population group rating: Good

Findings

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medicines reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Not all patients with with long term conditions had received regular health checks.

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)	77.8%	74.8%	76.6%	No statistical variation
PCA* rate (number of PCAs).	2.3% (8)	8.9%	12.3%	N/A
The percentage of patients with COPD who have had a review, undertaken by a	77.8%	87.0%	89.4%	Tending towards variation (negative)

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)				
PCA rate (number of PCAs).	2.2% (3)	12.1%	12.7%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

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)	70.5%	79.0%	82.0%	Tending towards variation (negative)
PCA* rate (number of PCAs).	5.0% (5)	3.4%	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)	50.6%	63.7%	66.9%	Variation (negative)
PCA rate (number of PCAs).	5.2% (19)	12.5%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	67.5%	72.0%	72.4%	No statistical variation
PCA rate (number of PCAs).	9.2% (62)	5.8%	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)	93.7%	92.5%	91.8%	No statistical variation
PCA rate (number of PCAs).	3.1% (2)	3.7%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) (QOF)	69.4%	69.7%	75.9%	No statistical variation
PCA rate (number of PCAs).	10.4% (38)	9.9%	10.4%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was aware of the low performance data for 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)

- The practice was aware of the low performance data for 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)
- The practice was aware of the low performance data for 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)
- There were a number of patients who had been prescribed more than the recommended number of Short-acting, beta-agonists, (SABA), inhalers without receiving the appropriate monitoring, although no patients were deemed to be at risk.
- The practice told us that due to lack of clinical rooms in the surgery, they had been unable to complete the required health checks for all patients with long term conditions.
- In the few months prior to the inspection, the practice had commissioned two extra rooms within the surgery building to facilitate clinics for all people with long term conditions.
- A member of staff had been re-trained as a healthcare assistant and her main role was to manage the clinics for people with long term conditions.
- On the day of inspection, we saw that regular clinics had been scheduled for future months.

Families, children and young people

Population group rating: Good

Findings

- The practice has met the minimum 90% for four of five childhood immunisation uptake indicators. The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one of five childhood immunisation uptake indicators. The indicator for 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) was just below the 90% minimum at 89.7%.
- The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2019 to 31/03/2020) (NHS England)	86	88	97.7%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	73	79	92.4%	Met 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2019 to 31/03/2020) (NHS England)	72	79	91.1%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	72	79	91.1%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	61	68	89.7%	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>

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings
<ul style="list-style-type: none"> The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time. Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. Cervical cancer screening was below the national target but the practice had a plan to improve uptake.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England)	74.1%	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) (PHE)	68.5%	75.2%	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) (PHE)	59.3%	66.4%	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) (QoF)	100.0%	92.1%	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) (PHE)	72.7%	60.7%	54.2%	No statistical variation

Any additional evidence or comments

- The practice was aware of the low cancer screening data for three of the indicators and told us they had been proactive in encouraging patients to attend screening appointments using various methods of communication.
- In comparison to the data from the previous inspection, the data had improved for three of the five indicators which were comparable year on year:
 - The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). (Snapshot date: 31/03/2021) (Public Health England) was 74.1% at this inspection, compared to 72.0% at the previous inspection.
 - 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) (QoF) was 100% at this inspection, compared to 64.5% at the previous inspection.
 - The 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) (PHE) was 72.7% at this inspection compared to 48.3% at the previous inspection.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.

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

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medicines.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months. As a result of this training, staff had improved signage around the surgery to be dementia friendly.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- Patients had access to a mental health nurse who had been allocated to the practice on a part-time basis by the PCN.

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) (QOF)	84.9%	79.4%	85.4%	No statistical variation
PCA* rate (number of PCAs).	3.6% (2)	16.6%	16.6%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2019 to 31/03/2020) (QOF)	72.4%	79.4%	81.4%	No statistical variation
PCA rate (number of PCAs).	9.4% (6)	9.2%	8.0%	N/A

*PCA: Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.

Any additional evidence or comments

At the previous inspection:

1. 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 (01/04/2017 to 31/03/2018) was lower than the local and national averages. The practice performance was 63.8% compared to the local average of 85.2% and 89.5% for England.
2. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) was lower than local and national averages.

At this inspection:

1. 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) was higher than the local average and was statistically in line with the national average. The practice performance was 84.9% compared to 79.4% locally and 85.4% for England.
2. The indicator for the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) was no longer included as part of CQC monitoring.

Monitoring care and treatment

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

Indicator	Practice	England average
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Overall QOF score (out of maximum 559)	510.5	533.9
Overall QOF score (as a percentage of maximum)	91.3%	95.5%
Overall QOF PCA reporting (all domains)	4.2%	5.9%

	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 identified that diagnosis and treatment of pre-diabetes was a priority for them. They made a commitment to increase the number of patients identified and referred for treatment.</p> <ul style="list-style-type: none"> • We saw that in the first audit an average of five patients per 10,00 registered patients were identified and referred to the NHS diabetes prevention programme, (NHSDPP). • In the second audit this had increased to an average of 110 patients per 10,00 registered patients. • A third audit showed that the number of patients from both of the previous audits that the majority of patients completed the course. The number who did not complete the programme was 12. <p>The practice identified that improving end of life care was also a priority for them.</p> <ul style="list-style-type: none"> • We saw that the practice had carried out a retrospective death audit for the period 2018-2019 and found that improvements were needed. These included documented care plans, discussions at multi-disciplinary meetings, and documented Do Not Attempt Cardiopulmonary Resuscitation (DNACPR), decisions. • The practice implemented a plan to make the necessary improvements. • We saw evidence that re-audit for the period 2019- 2020 showed improvements in these areas. • The practice acknowledged that improving care plans was ongoing work. We were told that the Primary Care Network, (PCN), was in the process of recruiting a Care Co-ordinator, whose role was to be responsible for completion of care plans in conjunction with the clinician.

Effective staffing

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

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

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

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y

The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice had signed up 66 patients in August to a weight management programme via the social prescriber and the led GP. The healthcare assistant had attended training to deliver smoking cessation and advice courses in partnership with a community organisation. The practice had recently signed up to the Cancer Directed Enhanced Service to support early diagnosis of cancer. 	

Consent to care and treatment

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

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	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 Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y

Well-led

Rating: Good

Leadership capacity and capability

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

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On the day of inspection and during remote interviews, staff told us that they felt leaders were approachable at all times and that there was no need to wait for formal meetings or supervision to raise concerns or ideas. 	

- The practice was proactively trying to recruit a GP partner, and some interviews had taken place just prior to the inspection.

Vision and strategy

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

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The practice had a clear vision and a set of 10 values which the staff we spoke to were aware of. 	

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	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 candour.	Y
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	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
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff members	<ul style="list-style-type: none"> Staff we spoke to, both remotely and in person, told us that they were happy in their roles and felt supported by leaders. Staff members told us that they had the opportunity to progress. A member of staff who had recently joined the practice said the induction programme was well-organised and she had been given time and support to learn the tasks in her role.

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.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y

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.	Y
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.	
When considering service developments or changes, the impact on quality and sustainability was assessed.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice told us that a number of plans had been cascaded from NHSE and Mid Essex Clinical Commission Group and had been put in place throughout the pandemic. The practice had its own business continuity plan which they told us would be reviewed in the following six months to incorporate what had been learnt from the last 18 months. 	

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Y
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Y
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Y
The practice actively monitored the quality of access and made improvements in response to findings.	Y
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Changes had been made to infection control arrangements to protect staff and patients using the service.	Y
Staff were supported to work remotely where applicable.	
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> At the start of the pandemic, the practice had moved to a telephone triage system and made use of video and telephone consultations. To ensure staff and patient safety, barriers and markings were put in place to monitor access to the surgery, although the doors always remained open. The practice continued throughout the pandemic to do emergency blood tests, cytology and see children face to face whenever possible. In the three months prior to the inspection, the practice had increased the number of face to face appointments available. At the time of inspection, patients were offered a choice of either a face to face appointment or a telephone appointment. The practice used video consultations to support ward rounds in care homes and support housebound and vulnerable patients. These were carried with the assistance of family or a staff member. Some vulnerable patients did require face to face appointments during the pandemic and this was provided by the lead GP. 	

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

There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

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

Engagement with patients, the public, staff and external partners

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

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
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
Explanation of any answers and additional evidence: The practice provided the following examples of service improvement they were able to implement via the PCN as a result of patient feedback: <ul style="list-style-type: none">• Access to a First Contact Practitioner for physiotherapy services as patients had fed back these were difficult to access.• Access to a Social Prescriber to assist patients who were looking for help and guidance in non-clinical areas (benefits, blue badges, food banks etc.).• Access to a Clinical Pharmacist who could speak with patients who did not wish to visit the surgery just for a medication /annual review.• Access to a Mental Health Nurse to assist those patients who had difficulty accessing appointments through the local system.	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none">• The practice told us that The PPG had not been that active over the previous 18 months, due to the pandemic, although one to one conversations with members had taken place.• There were plans in place for the PPG members to meet via a Teams call in the near future.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence:	

- A member of the reception team had recently changed roles to become a healthcare assistant and she was supported to attend training and gain experience.
- The lead GP and the practice nurse used the team meetings to share knowledge and update best practice.

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](#)). Personalised Care Adjustments allow practices to remove a patient from the indicator for limited, specified reasons.
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- ‰ = per thousand.