

Care Quality Commission

Inspection Evidence Table

The Laurie Pike Health Centre (1-540378439)

Inspection date: 27 February 2019

Date of data download: 19 February 2019

Overall rating: Requires Improvement

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Safe

Rating: Requires Improvement

Safety systems and processes

The practice had systems, practices and processes to keep people safe and safeguarded from abuse. However, we noted gaps in the governance of some of these systems.

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.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	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:	

Safeguarding	Y/N/Partial
<ul style="list-style-type: none"> We saw evidence to support that regular safeguarding meetings took place with representation from other health and social care services. This included liaison and joint working with health visitors. Staff we spoke with were familiar with the practices safeguarding protocols, they knew how to report safeguarding concerns and were aware of who the child and adult safeguarding leads were in practice. We saw that most of the clinical staff had completed IRIS training (Identification and Referral to Improve Safety) for domestic violence and abuse, further training for other staff had been arranged for March 2019 	

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 and 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
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: The practice provided evidence to demonstrate that they operated a comprehensive system of checking staff immunisation against infection diseases. Staff were also offered a flu vaccination.	

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: The Laurie Pike Health Centre: 1 August 2018 Shanklin House branch surgery: 11 September 2018	Y
There was a record of equipment calibration. Date of last calibration: The Laurie Pike Health Centre: 1 August 2018 Shanklin House branch surgery: 11 September 2018	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Partial
There was a fire procedure.	Y
There was a record of fire extinguisher checks. The Laurie Pike Health Centre: March 2018 Shanklin House branch surgery: May 2018	Y
There was a log of fire drills.	Y

Date of last drill at the Laurie Pike Health Centre: 9 January 2019	
Date of last drill at Shanklin House branch surgery: 21 February 2019	
There was a record of fire alarm checks. These were done weekly at both sites, last test recorded as 25 February 2019 at the time of our inspection.	Y
There was a record of fire training for staff. Date of last training: June 2018	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: The Laurie Pike Health Centre: 21 January 2019 Shanklin House branch surgery: 21 February 2019	Y
Actions from fire risk assessment were identified and completed.	Partial
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> We saw evidence of risk assessments for the storage of hazardous substances at The Laurie Pike Health Centre but there was no evidence provided for the branch practice at Shanklin House Surgery. Following our inspection, the practice advised that these were in place at Shanklin House Surgery and provided evidence to support this following our inspection. We saw examples of actions completed in the fire risk assessment for The Laurie Pike Health Centre, this included completion of fire drills and keeping records to support this. At the practices branch based at Shanklin House Surgery however we noted that the fire exits were marked but the fire action signs did not provide details of the fire assembly point. 	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: The Laurie Pike Health Centre: 21 January 2019 Shanklin House branch surgery: 30 March 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: The Laurie Pike Health Centre: 3 September 2018 Shanklin House branch surgery: 30 March 2019	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not always met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audits The Laurie Pike Health Centre: 25 January 2019	Y

Shanklin House branch surgery: 4 February 2019	
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice could not provide evidence of completed cleaning schedules for the Laurie Pike Health Centre. In addition, the practice could not provide records for the deep cleaning of the carpets in two consulting rooms and for the cleaning of the medical equipment at Shanklin House Surgery. On discussing this with members of the management team we were informed that the practice and overarching provider organisation, the Modality Partnership, had been in contact with their cleaning provider to request that these records were completed but had been unsuccessful in this request. We saw that the practice had plans to revisit this matter with the view to resolve the issue of limited record keeping for the cleaning of their practice premises. We observed that both practice sites (The Laurie Pike Health Centre and the branch practice at Shanklin Health Surgery) were visibly clean on the day of our inspection. Although feedback from two patients highlighted that they had experienced an untidy and unclean environment at The Laurie Pike Health Centre previously. We saw evidence of completed infection control audits for both practice sites. There was evidence of completed actions at The Laurie Pike Health Centre for example, the replacement of an examination couch which was worn and a potential infection control risk. Although we saw evidence of a completed infection control audit for the branch practice at Shanklin House Surgery, the practice could not provide evidence of a completed action plan in relation to areas identified for improvement. Following our inspection, the practice advised that there was an action plan in place at Shanklin House Surgery and provided evidence to support this following our inspection. However, we noted that the action plan provided was dated as April 2018 and therefore did not highlight actions set following the most recent infection prevention control audit in February 2019 where some areas had been marked as requiring action. For example, the most recent audit highlighted that a 'No' was applied in response to a question asked about cleaning surfaces, however no action was set in relation to this. There was no evidence provided to support this following the inspection, as the evidence did not reflect the most recent infection control audit for the branch surgery. We saw evidence of a completed Legionella risk assessment for both practice sites however, on further review of the risk assessment for the Laurie Pike Health Centre we noted that some risks were highlighted as requiring action on a monthly basis. A three-month timeframe for completion had been applied to some of the risks and actions such as monthly temperature checks and twice weekly flushing of the water systems were due by May 2017. However, the practice could not provide evidence to assure that these actions had been completed. 	

Risks to patients

There was evidence of adequate systems to assess, monitor and manage risks to patient safety in some areas.

	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
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	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 such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We observed that there was effective approach to managing staffing and resources at the practice. At the time of our inspection there was no Practice Manager in post however an Area Manager from the practices provider organisation, the Modality Partnership, was appointed in the meantime to oversee the daily management of the practice; across the two practice sites. The practice had recruited a Patient Services Manager to manage the daily running of the practice from April 2019. We also saw that following staffing and restructure changes, the practice had recognised the need to expand their nursing team and two practice nurses had been recruited; these nurses were due to join the practice at the beginning of March 2019. In the meantime, we noted that the nursing team was supported by a locum nurse, the locum nurse spoke positively about the practice and felt very much integrated with the team. In addition, the practice had appointed three full time receptionists to help support their administrative and receptionist functions.</p>	

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.	Y
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
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
Explanation of any answers and additional evidence: We saw evidence to support that patients receiving palliative care had information shared in a timely and effective way and received joined up care as required. The practice also monitored their two-week-wait referrals closely and ensured that any non-attenders were followed up, we saw records kept supporting this process.	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation. However, we noted some gaps in the effectiveness of these systems.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHS Business Service Authority - NHSBSA)	0.64	0.97	0.94	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	4.2%	5.7%	8.7%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2018 to 30/09/2018) (NHSBSA)	4.95	5.22	5.64	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2018 to 30/09/2018) (NHSBSA)	1.39	1.78	2.22	No statistical variation

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

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Partial
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
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
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	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> <ul style="list-style-type: none"> • Although we found that prescription stationary was kept securely and a system was in place to monitor their use, we found that there had been gaps in the record keeping of this system which indicated that the whereabouts of the prescriptions were not always clearly identifiable. We also noted that in some cases records were not being dated as required. • During our inspection saw evidence to demonstrate that the practice operated an effective system for the handling of requests for repeat medicines. Requests were checked throughout the day every few hours and allocated to a GP for review and processing. • There was evidence to support that patients had their medicines reviewed in line with 	

Medicines management	Y/N/Partial
recommended guidelines and timeframes. We noted that a practice pharmacist also carried out medicines reviews with patients and offered medicines management support by completing prescribing audits and reviewing and discussing prescribing guidelines as well as medicines and safety alerts.	

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:	Six
Number of events that required action:	Five
<p>Explanation of any answers and additional evidence:</p> <p>We saw that learning from significant events were discussed during formal practice meetings and minutes were provided during our inspection to support this. Significant events were also discussed during the practices daily huddles where staff discussed key topics including clinical matters, significant events, unplanned admissions, daily home visit requests, safeguarding and vulnerable patients. Once a significant event was recorded, it was further reviewed at one and four months to determine if it could be closed, or if there were any further areas to action and to learn from.</p>	

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
A significant event was recorded due to delay from the hospital in sharing the results of a patients scan with the practice	<ul style="list-style-type: none"> • Necessary actions were taken immediately to ensure further appointments and referrals were made pertaining to the patient. • Incident formally recorded, discussed during practice meeting and learning shared. The incident highlighted that the scan appointment was not flagged up to the practice by the consultant in secondary care. • The practice also informed the secondary care provider and recorded the incident on Datix (a web-based incident reporting and risk management system which enables sharing with social and secondary care for wider learning and actions where needed). • To help prevent recurrence, clinicians were prompted to review previous notes in the event that this may prompt them to chase up pending results from secondary care.

	Staff were also asked to encourage patients to enquire about any results they may require from hospital or community care.
A significant event was recorded as a member of staff identified a box of vaccinations in the corridor area of the practice.	<ul style="list-style-type: none"> • The vaccinations were immediately put in to the fridge. • Incident formally recorded, discussed during practice meeting and learning shared. • The incident form highlighted that the team were unable to identify who had received the order and that the company delivering the vaccinations did not have a signature. The company could confirm the delivery time with the practice and therefore the vaccine manufacturer was contacted to determine if the vaccines could still be used. • The company advised that some of the vaccines could be used under an off-label arrangement. This was due to a break in the cold chain, where the vaccines may get warmer or colder than recommended. • Records confirmed that clinical judgement was sought from a GP at the practice to confirm if the vaccines could be used under an off-label arrangement supported by a Patient Specific Direction. We saw that formal records and authorisation was in place to support this arrangement. • We also saw that the practice provided written information for patients, parents and carers to help explain when an off-label vaccine was being offered. • To help prevent recurrence, staff were reminded of cold chain procedures and to informing a member of the nursing team should a vaccination delivery arrive.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>We saw evidence of a system in place for disseminating and actioning alerts. However, in one instance we found that the practice couldn't demonstrate that they had followed all the recommended actions following a medicines safety alert on the use of Valproate medicines in females with childbearing potential. We saw that actions such as searches and recalling patients in for an appointment had been taken in line with alert instructions and there was evidence of counselling offered in line with some of the alert requirements however there was no evidence that further steps (pertaining to the pregnancy prevention programme) had been covered as part of this process, this included evidence to demonstrate that conversations regarding contraception had taken place, for example. Although clinicians informed us that these areas had been covered with patients they had not recorded this and were therefore unable to provide evidence of these actions.</p>	

Effective

Rating: Good

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
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 were in place 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:
 Conversations with clinical staff and most of the evidence provided during our inspection confirmed that care and treatment was delivered in line with current guidelines however we found that in one instance, the practice could not provide evidence that all the necessary actions had been undertaken in response to a specific medicines safety alert. Clinical staff did assure us that the actions had been completed where required and that their record keeping had not captured these actions in full.

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) <small>(NHSBSA)</small>	0.13	0.75	0.81	Significant Variation (positive)

Older people

Population group rating: Good

Findings
<ul style="list-style-type: none"> The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. 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 changes. Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Some of the GPs at the practice had a special interest in the care of older people. Health checks were offered to patients over 75 years of age.

- The practice offered a safe and well check to patients over the age of 80 who had not contacted the practice in over a year. As a result of some work undertaken, the practice had identified and addressed the medical and social needs 16 patients who met this criterion.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice had a high prevalence of diabetic patients, at the time of our inspection the practices patient record system highlighted 1,370 patients on the diabetic register. The practice offered a nurse-led diabetes clinic and had monthly support from a diabetes specialist nurse.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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.
- The practice had a high prevalence of patients with hypertension, at the time of our inspection the practices patient record system highlighted that they had 2,033 patients on their hypertension register. We also saw that patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.5%	80.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	14.4% (200)	11.2%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	80.8%	79.5%	77.7%	No statistical variation
Exception rate (number of exceptions).	7.3% (102)	8.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on	76.1%	79.6%	80.1%	No statistical

the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)				variation
Exception rate (number of exceptions).	11.5% (160)	11.4%	13.5%	N/A

Other 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, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	73.3%	78.1%	76.0%	No statistical variation
Exception rate (number of exceptions).	5.1% (49)	4.5%	7.7%	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 (01/04/2017 to 31/03/2018) (QOF)	93.0%	91.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	14.6% (22)	12.7%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	85.4%	81.7%	82.6%	No statistical variation
Exception rate (number of exceptions).	4.1% (82)	4.3%	4.2%	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 (01/04/2017 to 31/03/2018) (QOF)	87.5%	91.2%	90.0%	No statistical variation
Exception rate (number of exceptions).	11.1% (14)	5.4%	6.7%	N/A

Any additional evidence or comments

We observed the practices process for exception reporting during our inspection. We saw the practice followed an appropriate process where for example, patients that repeatedly failed to attend their

appointment where excluded; following three attempts from the practice. Staff explained that patients who declined treatment or investigations were excluded, where this occurred the patient consented to this and the practice managed these on a case by case basis to ensure that vulnerable patients were not inappropriately excluded. There was clinical oversight of the practices exception reporting, this was supported by the GPs.

Exception data was made available during our inspection, this data showed a significant reduction in exception reporting across many areas and reflected the period of April 2018 to February 2019. For example, exception rates for Diabetes had reduced to 4.66% and exception rates for atrial fibrillation were at 5.3%. This data was unverified, unpublished data.

Families, children and young people

Population group rating: Requires Improvement

Findings

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. Members of the management team explained that their patient population presented challenges with regards to childhood immunisation uptake and that some families did not want certain vaccinations, sometimes due to cultural reasons and personal preference.
- 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.
- 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.
- Young people could access services for sexual health and contraception.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	192	211	91.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) <small>(NHS England)</small>	155	175	88.6%	Below 90% minimum (variation negative)
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) (01/04/2017 to	153	175	87.4%	Below 90% minimum (variation negative)

31/03/2018) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	154	175	88.0%	Below 90% minimum (variation negative)

Any additional evidence or comments

Conversations with the practice team during our inspection highlighted that childhood immunisations had been identified as an area for ongoing improvement in the practice and the practice had engaged with their local CCG (Clinical Commissioning Group) to encourage the booking of vaccination appointments and to understand any reasons behind missed appointments. We saw that part of this work involved the use of a patient contact form developed through the CCG to encourage the booking of vaccination appointments and to understand any reasons behind missed appointments.

In addition, conversations with staff and evidence provided during our inspection demonstrated that the team took an opportunistic approach in encouraging childhood immunisation uptake for their practice population, for example:

- Staff used every opportunity to promote the service when engaging with their families, children and young population groups.
- The practice ensured that call, recall and DNA's (failure to attend appointments) were followed up and escalated appropriately.
- The practice was focussing on educating their families, children and young population groups on the importance of childhood immunisation.
- The practice provided unverified data at the time of our inspection, this data highlighted that performance for the vaccinations of children aged one year and under was at 87% and vaccinations for children aged two years and over was also at 87%, this data represented April 2018 to February 2019. This data was unverified, unpublished data.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

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

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who	63.5%	66.2%	71.7%	No statistical variation

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) (01/04/2017 to 31/03/2018) (Public Health England)				
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	65.3%	64.8%	70.5%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	39.5%	42.7%	55.1%	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. (01/04/2017 to 31/03/2018) (PHE)	81.6%	65.9%	70.5%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	53.6%	50.8%	51.9%	No statistical variation

Any additional evidence or comments

In some areas, cancer screening rates were below the Public Health England (PHE) targets such as for cervical and bowel cancer screening. Performance in other areas however was above target, this was reflected in cancer diagnosis rates at six and 15 months, as well as the number of new cases treated from a two week wait referral.

Members of the management team explained that their patient population presented challenges with regards to uptake of specific screening programmes, such as for cervical and bowel cancer screening, and that some patients did not wish to partake sometimes due to cultural reasons and personal preference. To improve and encourage uptake staff used every opportunity to promote the service and to educate patients on cervical screening when engaging with their eligible population groups.

- We noted that written information was provided in various formats and languages to meet the needs of the practices diverse population and we saw information on display to encourage screening across other areas including for bowel cancer screening.
- The practice ensured that call, recall and DNA's (failure to attend appointments) were followed up and escalated appropriately.
- Screening appointments were made available at different times throughout the week.
- There was evidence to confirm that sample takers were trained and up to date with their training requirements.
- We saw evidence of evidence of the nurse's failsafe records to ensure that a screening result was received for every sample submitted to the lab and that inadequate sample rates were routinely audited.
- The practice provided unverified data at the time of our inspection, this data highlighted that their cervical screening uptake had reached 77%.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

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.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- 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.
- One of the practice GPs had a specialist interest in mental health care. The practice also worked with and signposted patients and carers to local specialist support services such as DISC (Dementia Information and Support for Carers).

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 (01/04/2017 to 31/03/2018) (QOF)	92.7%	92.6%	89.5%	No statistical variation
Exception rate (number of exceptions).	15.1% (39)	13.5%	12.7%	N/A
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) (QOF)	91.6%	94.1%	90.0%	No statistical variation

Exception rate (number of exceptions).	12.4% (32)	10.9%	10.5%	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 (01/04/2017 to 31/03/2018) (QOF)	74.3%	85.3%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.1% (4)	6.8%	6.6%	N/A

Any additional evidence or comments

We observed the practices process for exception reporting during our inspection. We saw the practice followed an appropriate process for exception reporting. More recent exception data was made available during our inspection, this data showed a significant reduction in exception reporting across many areas and reflected the period of April 2018 to February 2019. For example, the exception rates for Mental Health indicators overall were at 4.38%. Year-end data provided by the practice also showed that care plan reviews for patients with Dementia were at 54% and further reviews were scheduled. This was unverified, unpublished data.

Monitoring care and treatment

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

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	539.8	537.5
Overall QOF exception reporting (all domains)	7.7%	6.4%	5.8%

	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.	Y

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

The practice operated an effective audit programme to identify and embed improvements within the practice and to improve patient outcomes. For example, a completed audit cycle on antibiotic prescribing demonstrated a reduction in inappropriate prescribing specifically for the prescribing of antibiotics for ear infections. Additional audits demonstrating improvements included a prescribing audit for patients diagnosed with cardiovascular disease receiving dual antiplatelet therapy.

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. 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.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence: Employee recruitment and training files were well organised and demonstrated that staff had the skills, knowledge and experience to carry out their roles. Staff learning and development needs were continually monitored and the practice operated an effective system for checking and ensuring that staff were up to date with key training and professional registration requirements.	

Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Y
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.	Y
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
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y
Explanation of any answers and additional evidence:	

Evidence provided during our inspection highlighted that MDT (multidisciplinary team) meetings took place twice a month. Key items including palliative care, frailty, falls and admissions avoidance were covered at the meetings. We also noted that meetings were well attended by the Community Matron, district nurses, Macmillan nurse and DISC (Dementia Information and Support for Carers) team.

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
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, tackling obesity.	Y

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	95.7%	96.0%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.8% (27)	0.7%	0.8%	N/A

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.	Y
Explanation of any answers and additional evidence:	

Discussions with clinical staff demonstrated that they understood best practice guidance for obtaining consent. Written consent was also obtained for immunisations and minor surgery procedures.

Caring

Rating: Good

Kindness, respect and compassion

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

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

CQC comments cards

Total comments cards received.	Five
Number of CQC comments received which were positive about the service.	Three
Number of comments cards received which were mixed about the service.	Zero
Number of CQC comments received which were negative about the service.	Two

Source	Feedback
CQC Comment Cards	The three positive comment cards described clinicians as caring, reception and support staff were also described as friendly and helpful. One card highlighted problems accessing the service via telephone and another card described an unclean environment at the Laurie Pike practice premises.
Interviews with patients	Patients we spoke with during our inspection described staff as caring, friendly and helpful.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
17718	423	90	21.3%	0.51%

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 (01/01/2018 to 31/03/2018)	86.9%	84.4%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	79.8%	82.1%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	94.5%	93.3%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	60.3%	76.0%	83.8%	Variation (negative)

Any additional evidence or comments

- We discussed the survey results with a member of the management team during our inspection. The team was aware of the results and members expressed that patients' responses on their overall experience of the practice was most likely due to accessing the service, specifically by telephone and that patients feedback was usually positive regarding care and treatment.
- The practice had produced a patient feedback assessment report to work on areas identified for improvement. We saw that the report outlined how the team was working together to ensure patients were signposted correctly, offered appointments with the most appropriate member of the team and offered online access to patients.
- We saw an action for staff to complete online customer service training and we noted that an action was for all front-line staff to receive Modality core values, signposting and face to face customer service training at a protected learning time event. Although the report did not contain clear timeframes for completing the actions we did see evidence that some of these actions had been completed during our inspection, this included training in areas such as customer care.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y
Any additional evidence	
The practice produced a patient feedback assessment report to work on areas identified for improvement	

following the National GP patient survey and the NHS Friends and Family Test. The practice planned to conduct an in-house survey to analyse the completed actions to date, most of these related changes to improve their telephone access.

Involvement in decisions about care and treatment

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

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: The practice engaged in social prescribing programmes and signposted patients to Route to Wellbeing where patients could access local-community based services. This service provided a wide range of advice, guidance and access across areas including health, home care, victim and family support. The practice also worked closely with DISC, a service where patients and carers could access Dementia information and support.	

Source	Feedback
Interviews with patients	Patients we spoke with during our inspection said they felt involved in decisions about their care and treatment.

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 (01/01/2018 to 31/03/2018)	87.3%	90.0%	93.5%	No statistical variation

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

The practice served a diverse population and therefore interpreters were offered for all languages with extended appointments available for those requiring them.

Carers	Narrative
Percentage and number of carers identified.	<ul style="list-style-type: none"> • 338 carers • This was 2% of the practices patient register
How the practice supported carers.	<ul style="list-style-type: none"> • There was a carers pack in place which contained a range of supportive and signposting information for carers to take away. • The practice had a carers board which contained useful information for carers. • Carers were offered health checks, health screening and flu vaccinations. <p>The practice held a three-day carers event in June 2018 at The Laurie Pike Health Centre. The aim of the event was to increase awareness, identification of carers and to offer support and general health checks, health screening and depression checks to their carers. The practice carried out 31 health checks during the event. Through these checks, clinicians could address biological, psychological and social issues and support patients to make positive changes.</p> <p>In addition, a carers session called 'Making Space' was implemented at the practice every two weeks. This was developed as an over 50s carers group, the group was described as a supportive group and members often spoke with patients in the waiting area to help raise awareness on a weekly basis.</p> <p>Due to the success of the carers event in the summer of 2018 the practice held a further two-day carers event in November 2018. The aim of the event was again to increase awareness and identification of carers and to also carry out health checks for carers in addition to care plans for patients with Dementia. The event was attended and supported by the Carers hub and DISC (Dementia information and support for carers). Those who attended received various health, screening and depression checks as well as signposting information through the Route to Wellbeing service. Patients were also given the opportunity to speak with representatives from the Carers hub and DISC.</p> <p>Patients with Dementia were seen by a clinician for a comprehensive care plan review. Any carers of these patients could also have their needs assessed. In addition, the practice offered this service to Dementia patients identified as being housebound where care plans and health checks were completed with a clinician at home and information on support service was also provided.</p> <p>The practice carried out 21 health checks during the event and 13 Dementia care plans were completed which allowed identification of social, psychological and health issues and support offered through contact with DISC.</p>
How the practice supported recently bereaved patients.	<p>The practice sent condolences to support recently bereaved patients, this was done to suit the individual including contact over the telephone and by inviting them in to the practice. Patients were also signposted to support</p>

	services such as Cruse Bereavement Care.
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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.	Partial
There were arrangements to ensure confidentiality at the reception desk.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>Our observation of the branch practice at Shanklin House surgery highlighted that due to the restrictions of the building and the layout of the reception and waiting area, conversations at the reception desk could be overheard. Staff assured us that a room was available for patients to use to discuss sensitive issues however this was not signposted to clearly inform patients of this. We also found that conversations in consulting rooms could be overheard during our inspection.</p>	

Responsive

Rating: Requires Improvement

Responding to and meeting people's needs

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

	Y/N/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.	Partial
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice offered some services at both The Laurie Pike Health Centre and Shanklin House branch surgery for ease of access, such as phlebotomy, ECGs (Electrocardiogram's) and spirometry. There was also a duty GP allocated for any urgent or emergency appointments that arose each day.</p> <p>Through the practices provider organisation, the Modality Partnership, patients could also access a range of additional services through direct referral. These services included ddermatology,</p>	

rheumatology, urology, gynecology, ENT (Ear nose and throat) care, cardiology, ophthalmology and circumcision services.

Whilst the Laurie Pike Health centre was situated in a more modern purpose-built premise, the branch surgery at Shanklin House Surgery was based in a converted house built in 1904. The management team explained that Shanklin House Surgery had been a GP surgery since before the foundation of the NHS and the surgery had served many long-standing patients and their families through the generations. The surgery contained many of its original Edwardian features, and although we found that the branch surgery had purpose built rooms for consultations and treatments, in some areas the premises was dated. To help with this a more modern extension had been added to the property.

Practice Opening Times

Day	Time
Opening times:	
Monday	8am – 6.30pm Shanklin House branch surgery was open until the later time of 8.30pm for extended hours
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm The Laurie Pike Health Centre was open until the later time of 8.30pm for extended hours
Thursday	8am – 6.30pm
Friday	8am – 6.30pm
Appointments available:	
Monday	8am – 6.30pm Extended hours appointments were available at Shanklin House Surgery from 6.30pm – 8pm
Tuesday	8am – 6.30pm
Wednesday	8am – 6.30pm Extended hours appointments were available at The Laurie Pike Health Centre from 6.30pm – 8pm
Thursday	8am – 6.30pm
Friday	8am – 6.30pm

On Saturdays patients could also access appointments at Enki Medical Practice through the Modality Partnership's extended access service. These appointments ran from 9am to 1pm.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
17718	423	90	21.3%	0.51%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	93.6%	92.4%	94.8%	No statistical variation

Older people

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- The practice had a dedicated bypass phone number for care homes, district nurses, ambulance service and hospice to use to ensure prompt access to multidisciplinary working.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.

People with long-term conditions

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.
- The practice offered a range of nurse-led clinics covering long term conditions such as asthma, diabetes and COPD (Chronic obstructive pulmonary disease). The practice also had monthly support from a diabetes specialist nurse.

Families, children and young people

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

- The practice offered later appointments on a Monday, Wednesday and on Saturdays through the extended access service for school age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Pregnant patients were able to access clinics with the midwife provided by the Sandwell and West Birmingham Hospitals NHS Trust as these were held at the Laurie Pike Health Centre.
- Children under the age of five were guaranteed a same day appointment with a GP and there was also a duty GP available for emergencies each day, for all other ages.
- The practice held a weekly baby clinic for immunisations and eight-week development checks. In addition, nurses would see children requiring immunisations in any routine appointment, encouraging uptake and offering flexibility to parents and carers.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was open until 8.30pm on a Monday at Shanklin House branch surgery and until 8.30pm at The Laurie Pike Health Centre on a Wednesday.
- On Saturdays patients could also access appointments at Enki Medical Practice through the Modality Partnership's extended access service. These appointments ran from 9am to 1pm.
- The practice also offered telephone appointments to patients where consultations could be carried out over the phone.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.
- The practice offered regular health checks to their vulnerable patients. These patients were also offered longer appointments at flexible times to suit their needs.
- These patients also had access to emergency appointments if needed with the duty GP available each day.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

Although we noted many changes implemented to improve access, the practice could not demonstrate the impact of these changes at the time of our inspection. Patient feedback also highlighted a theme in problems in telephone access at the practice. This effects all population groups.

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

Timely access to the service

People were not always 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
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • The practice operated an effective system for managing home visit requests, each request was discussed during the daily huddle meetings and reviewed by a GP who contacted the patient/carer to triage and attend if appropriate. There was a formal protocol in place to support this process. • However, we noted a theme in patient feedback from the information gathered and the evidence provided by the practice during our inspection. The theme highlighted that patients were not always able to access care and treatment in a timely was due to issues in accessing the practice 	

via telephone.

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 (01/01/2018 to 31/03/2018)	30.2%	58%	70.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	47.3%	59.2%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	53.7%	63.4%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	58.4%	67.1%	74.4%	No statistical variation

Any additional evidence or comments

Staff we spoke with explained that the practice had been through a number of changes during the last year which presented challenges. For instance, the migration to a new IT system in November 2018 resulted in patients having to re-register for online access. Staff also had to take time to adapt to the new system. Furthermore, there had been some staffing changes at the practice including the retirement of one of the practices long standing GP partners.

The practices patient feedback assessment report outlined areas that the team were working on to improve access and patient satisfaction, for instance the practice was working with staff to ensure they were signposting patients correctly, offering appointments with the appropriate member of the team and offering online access to patients. The practice was increasing their advertising of online access as well as the availability of their extended hours appointments.

In addition to these areas we noted that some other changes had been made to improve access, staff explained that these changes were implemented because of patient feedback.

- The practice changed their centralised call centre system in January 2019 and bought this process in-house so that all calls were handled by the practice and staff who were more familiar with the practices patients.
- To help ease telephone access the practice recruited three additional full-time receptionists to help grow and support the team.
- Reception staff were undergoing care navigation training to ensure that patients were signposted appropriately and provided with a suitable appointment with and appropriate clinician.

Members of the management team explained how the practice had been through a journey of

transformation with regards to access and the team were focusing on educating staff and patients on how to choose well with regards to health advice and primary care appointments.

Although we noted many changes implemented to improve access, at the time of our inspection the practice was unable to demonstrate that these changes had improved access for patients. Our observations of the practices complaints for the over the past 12 months, survey results and feedback gathered from patients during the inspection highlighted a theme in problems in telephone access at the practice. The practice had plans to undertake a in house patient survey to assess what impact the changes had on patients experience of the service.

Source	Feedback
CQC Comment Cards	One card highlighted problems accessing the service via telephone and another card described an unclean environment at the Laurie Pike practice premises.
Interviews with patients	Whilst patients we spoke with during our inspection were positive about their care and treatment, all patients expressed that it could be was difficult to get an appointment however telephone access was the main issue with regards to accessing the service. Patients highlighted that when they got through to the practice via telephone there were no appointments left.
NHS Choices	The practice had received a two and a half out of five-star rating based on 121 ratings and 123 written reviews. A theme in the comments made for 2019 so far highlighted concerns regarding accessing the service via telephone. We noted that the comments had been responded to and complainants were invited to discuss their experiences further with a member of the management team.
NHS Friends and Family Test (FFT)	Results from the practices FFT for the last 12 months showed that 42% of the respondents were extremely likely to recommend the practice to friends and family members and 33% of the respondents were likely to. Four percent and 15% were unlikely and extremely unlikely to recommend the practice to friends and family members.

Listening and learning from concerns and complaints

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

Complaints	
Number of complaints received in the last year.	34
Number of complaints we examined.	Two
Number of complaints we examined that were satisfactorily handled in a timely way.	Two
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	Zero

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

There was evidence that complaints were used to drive continuous improvement.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> Information about how to make a complaint or raise concerns was available in the practice waiting area. There was a complaints policy and form in place which could be used to capture verbal and hand-written complaints. The practices complaints policy reflected NHS complaints guidelines and patients were also signposted to further support services in the event that they wished to gain additional advice or escalate their concerns further. Minutes of practice meetings demonstrated that complaints, outcomes, actions, learning and themes were discussed at various practice meetings. Our observations of the practices complaints for the over the past 12 months highlighted a theme in problems in telephone access at the practice. The practice had responded to these and made changes to improve this area, the practice also had an action plan outlining ongoing areas to further improve. 	

Examples of learning from complaints.

Complaint	Specific action taken
Complainant unhappy with incorrect information provided to patient regarding a referral for general surgery.	<ul style="list-style-type: none"> The complaint was formally managed and a written response and apology provided. The investigation of the complaint highlighted a change in policy which was missed by a GP who was new to the practice. To prevent recurrence the clinical team were reminded of which hospital to refer general surgical patients to.
Complaint made due to a lengthy waiting time for an appointment whereby a patient waited over an hour for their appointment.	<ul style="list-style-type: none"> An apology was provided, the patient was seen by a nurse and reported that they were happy with their care. Due to the appointment waiting time however an investigation of the complaint was carried out and receptionists were reminded to monitoring waiting times and ensure any issues with clinics and potential delays were communicated and acted on appropriately.

Well-led

Rating: Requires Improvement

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: Leaders were visible in the practice, staff spoke positively when discussing the professional relationships between managers and staff. An Area Manager from the practices provider organisation, the Modality Partnership, was appointed to oversee the daily management of the practice and the practice had recruited a Patient Services Manager to manage the daily running of the practice from April 2019. There was evidence of both clinical oversight and operational management of the practice. There was also evidence of succession planning in place. We saw that following staffing and restructure changes, the practice had recognised the need to grow their nursing team and two practice nurses had been recruited; these nurses were due to join the practice at the beginning of March 2019. In the meantime, we noted that the nursing team was supported by a locum nurse. In addition, the practice had appointed three full time receptionists to help support their administrative and receptionist functions.	

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: The practice had a clear set of values which outlined a commitment to working with compassion, openness, truth and honesty. The values, in summary, included taking accountability of own actions, ensuring respect for self and others and delivering excellence through innovation and dedication. Conversations with staff demonstrated that their values and approach aligned with this.	

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
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y

Explanation of any answers and additional evidence:

The practice invested in staff support and incentive schemes which enabled staff to receive free counselling through an external organisation, the scheme also offered other perks such as free coffee vouchers.

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

Source	Feedback
During our inspection we spoke with staff in a variety of roles from various areas of the practice, this included clinical staff, non-clinical staff, a locum member of the clinical team and a trainee GP.	<ul style="list-style-type: none"> Staff described the practice as a positive, friendly and open environment in which to work. Staff expressed that they were confident to raise concerns and to make suggestions at work. Feedback from a locum clinician highlighted that they felt integrated with the practice team. A trainee GP we spoke with described positive support from the practice and overall, they spoke positively about their experiences in training with the practice. Support staff and members of the management team expressed that the practice had been through some challenges over the last year due to staffing changes and an IT system migration however all staff felt supported during this time and were positive about future plans and the new recruits due to join the practice team. Management staff described a competent and hardworking team of which they expressed pride for during our inspection.

Governance arrangements

There were clear responsibilities, roles and systems of accountability in place however in areas these systems had lapsed and did not always reflect good governance.

	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>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> Although the practice benefitted from centralised functions across areas of the Modality Partnership, such as a central HR and Governance team, we found that in areas such as infection control governance to support effective risk management had lapsed. The practice operated a clear leadership structure which was supported by clear management and lines of accountability. We saw that formal governance and organisational structures were in place to support this. Staff we spoke with were aware of their roles and who to go to with a specific query in the practice, as well as which department to contact within the provider organisation, Modality Partnership, when needed. 	

Managing risks, issues and performance

There were some processes in place for managing risks, issues and performance however we found gaps in some of these areas.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Partial
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Partial
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y
Explanation of any answers and additional evidence:	
We found that the practices assurance and risk management systems were not always effective across areas relating to infection prevention control. During our inspection we also identified gaps in the record keeping of prescription stationary and the whereabouts of the prescriptions were not always clearly identifiable.	

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 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.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
Through the Modality Partnership, the practice made use of SharePoint software which was used to manage significant events and complaints. The system was also used to support learning and as a document management system for readily access to practice policies and procedures.	

Engagement with patients, the public, staff and external partners

The practice involved staff and external partners to sustain high quality and sustainable care however patient engagement had lapsed in areas.

	Y/N/Partial
Patient views were acted on to improve services and culture.	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
<p>Explanation of any answers and additional evidence: Although we noted many changes implemented to improve access, the practice planned to carry out an internal patient satisfaction survey to analyse the impact of the changes they had made so far. Therefore, the practice could demonstrate that patient views were acted on but could not demonstrate the impact of the changes they had made, at the time of our inspection.</p> <p>During our inspection management explained that although they did have an active PPG at the practice, over recent months the PPG meetings had lapsed. Staff we spoke with expressed that this was most likely due to practice and staffing changes which included a period of transition whilst recruiting a new practice manager to also undertake a patient services manager role. We saw evidence of historical PPG meetings where 14 members had met on a quarterly basis in February, May and August 2018. Conversations with the area manager highlighted plans to reinstate the PPG with the inclusion of the new practice manager due to join the practice in April 2019.</p>	

Feedback from Patient Participation Group (PPG).

Feedback
N/A

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<p>Explanation of any answers and additional evidence: Learning was shared each month at the Clinical Governance Group and every two weeks at the Operational Management Team Meeting to allow for wider sharing of learning across the Modality Partnership, as an organisation. Through the Modality Clinical Governance Group (CCG) the practice could monitor performance across a range of indicators each month via the CGG Dashboards. Indicators included specific areas of the Quality Outcomes Framework (QOF), uptake of immunisation in certain areas and prescribing performance.</p>	

Examples of continuous learning and improvement

We noted a theme in patient feedback from the information gathered and the evidence provided by the practice during our inspection. The theme highlighted issues in accessing the practice via telephone. Staff were aware of this issue and the practice had taken steps to improve this area including a change in the way they received and handled telephone calls; by bringing this system back in the practice from January 2019. We saw that this theme was an ongoing area for discussion and evaluation in practice, it was discussed during practice meetings and the practice also incorporated ongoing actions to further improve into their patient feedback assessment report where satisfaction results were analysed.

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-

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

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

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

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.
- 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.

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>

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.