

Care Quality Commission

Inspection Evidence Table

John Pounds Surgery (1-983962222)

Inspection date: 5 November 2019

Date of data download: 29 October 2019

Overall rating: Good

The overall rating has improved. At our last inspection on 10 October 2018 we rated this service as requires improvement. The practice was rated as requires improvement for effective and well-led, and for three population groups; people with long term conditions, families, children and young people and working age people. This meant the practice was rated requires improvement overall. We issued a requirement notice for Regulation 17: Good governance.

At this inspection on 5 November 2019 we rated the practice as good overall and good for all population groups. We continued to rate the practice as requires improvement for well-led services, because governance systems had not identified where there were gaps in assurance. Systems to promote learning from complaints and significant events were not embedded.

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2018/19.

Safe

Rating: Good

Safety systems and processes

The practice had 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 took account of patients accessing any online services.	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

Safeguarding	Y/N/Partial
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
<ul style="list-style-type: none"> There were flags on patient records indicating when patients were identified as having a potential safeguarding concern. Medical records clearly outlined safeguarding concerns. The GP safeguarding lead had regular meetings with health visitors and there were shared electronic records to promote shared understanding of safeguarding risks. The safeguarding adults policy had been reviewed in August 2019. It outlined the actions to take if staff had concerns. It did not include details on appropriate levels of training required by staff. The practice explained there was a more recent version with the CCG for ratification. The practice had a comprehensive child safeguarding policy, including contact details for the safeguarding lead and teams in other agencies/services. It stated the provider's training requirements for staff. For example, any team member who had contact with children (including reception staff) should be trained to level 2, and all practice nurses and GPs to level 3. Almost all reception and administration staff had completed safeguarding level 1 training. The practice had booked for all receptionists to attend level 2 training on 27 November 2019. Staff we spoke with were aware of what actions to take if they had any concerns relating to potential abuse or other safeguarding concerns. All clinical staff had completed adult and children safeguarding training, either using the on-line package or face to face training. This was to level 3 for safeguarding children and level 2 for safeguarding adults. Disclosure and Barring Service (DBS) checks had been completed for all clinical staff. The DBS policy, reviewed in August 2019, stated reception and administration roles would be risk assessed regarding the need for a DBS on a position by position basis. The practice showed us they carried out appropriate risk assessments and reviewed them when staff took on different responsibilities. There was a poster in the waiting room advising patients they could request a chaperone. The chaperone policy stated that only staff trained for the role and had been DBS checked should act as chaperones. The practice had trained two receptionists as chaperones and provided evidence of chaperone training and the completion of a DBS for them. 	

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.	Partial
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:

- The practice did not use locums. When GP cover was required, this was provided by GPs working for the same provider at their other location nearby.
- We looked at three staff personnel files and they showed evidence of safe recruitment procedures. The practice's recruitment policy did not detail to provide guidance on the checks required to be carried out on new staff at recruitment.
- Staff immunisation status was kept in staff files. After the inspection the practice manager sent a list of staff whose status was known. This showed that clinical staff (GPs, nurses and healthcare assistants) had immunity for Hepatitis B, Chickenpox and Bacillus Calmette-Guerin (BCG), as well as Diphtheria, Polio, Tetanus and measles, mumps and rubella (MMR). This was in line with the 'Green Book' immunisations against infectious disease guidance.
- The practice advised non-clinical staff to be up to date with standard NHS immunisations, for the benefit of their health and for others. The Green Book recommends these staff should be up to date with tetanus, diphtheria, polio and MMR. After the inspection, the practice manager said they would ask non-clinical staff to confirm their immunisation status in writing.

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: 29 October 2019	Y
There was a record of equipment calibration. Date of last calibration: 10 January 2019	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
There was a record of fire extinguisher checks. Date of last check: August 2019	Y
There was a log of fire drills. Date of last drill: 1 November 2019	Y
There was a record of fire alarm checks. Date of last check: 5 November 19	Y
There was a record of fire training for staff. Date of last training: 10 October 2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed.	Y

Date of completion: 26 March 2019	
Actions from fire risk assessment were identified and completed.	Y

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 1 November 2019	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 1 November 2019	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The legionella risk assessment was completed 13 September 2019 and there were no issues to address. The emergency lighting was last serviced on 10 July 2019 and was tested by the practice each month. 	

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: 19/12/2018	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.	Partial
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> There had been an external audit of infection control in treatment rooms on 19 December 2018 and the practice had achieved 98%. Recommended actions were listed and completed. An external audit of managing clinical sharp items was completed on 19 December 2018 and showed 100% compliance. All clinical and non-clinical staff were up to date with infection control training. The environment appeared visually clean and well maintained. The practice used an external contractor for cleaning services and they were satisfied with their performance. One of the two exterior clinical waste bins was found unlocked and containing clinical waste of the day of inspection. However, it was noted to be kept in a secure area behind a locked gate. The practice was alerted to raise this with their clinical waste contractor. 	

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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
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice could respond to increased demand or staff absence by allocating staff from the pool of staff that worked across the provider's two sites. Staff completed a core induction programme, appropriate for their role. The practice displayed guidance on identifying and responding to signs of sepsis. Sepsis awareness was part of the infection prevention and control training, and had been a training topic at a staff external regional training day in February 2019. Receptionists could call for assistance, via the computer system, if they needed urgent assistance from a GP. They had all received training in basic life support including anaphylaxis. 	

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • At our last inspection we found there was not a system to review test results received on GP non-working days. At this inspection we found urgent test results were reported to the duty GP for immediate follow up if they were received when the patient's GP was not working. • Electronic records were stored on a secure system, which was password and smart card protected. Any paper records were stored in locked cabinets in a room secured by coded entry. • The electronic record system was used by other health and social care providers locally, which supported the sharing of key information, including alerts. • An administrator took responsibility for summarising new patient notes. 	

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) (01/07/2018 to 30/06/2019) <small>(NHS Business Service Authority - NHSBSA)</small>	0.56	0.84	0.87	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). (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	5.7%	8.5%	8.6%	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 (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	4.74	5.22	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) <small>(NHSBSA)</small>	1.88	2.57	2.08	No statistical variation

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

Medicines management	Y/N/Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
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
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
<ul style="list-style-type: none"> At our previous inspection we found the practice did not consistently monitor the temperature of medicine fridges. Since then, the practice had set up a system to allocate specific staff to monitor, record and reset the temperature of the medicine fridges every morning and afternoon. A data logger had been installed. We saw the recording sheets had been completed for October and November 2019 showing the temperatures had been recorded each day the practice was open. There had been a significant event relating to the administration of an out-of-date vaccine. This had been reported and acted on appropriately. The investigation showed that no other patients had been affected. The practice did not store controlled drugs. The practice monitored the prescribing of controlled drugs and medical staff could describe how they would raise concerns with the CD accountable officer. The practice management was proud of their advanced medicine monitoring system and their medicine management performance. The practice's prescribing performance was better than local and national averages for all four indicators, as shown in the table above. Appropriate emergency medicines were available, in date and checked. We saw eight Patient Group Directions (PGDs) that were in date, signed, dated, valid and authorised. PGDs allow authorised registered health professionals to supply or administer specific medicines, such as vaccines, to a pre-defined group of patients, without them having to see a prescriber such as a doctor. The PGD for rotavirus vaccination had been assigned for nurses' signatures and this was being monitored. The practice's prescription storage policy was reviewed in August 2019 and there was a log to record prescriptions taken out. The repeat prescribing policy had been revised in October 2019 to include, for example, receiving requests via different routes, pharmacy collection, uncollected prescriptions and high-risk medicines that required additional monitoring. 	

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> The practice had a pharmacist who ensured there was a clear audit trail for any changes in a patient's medicines from another service. 	

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.	Partial
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
<ul style="list-style-type: none"> Clinical and non-clinical staff said they would report an incident to their manager and knew how to access the significant event policy. There had been a significant event in July 2019 relating to the administration of an out-of-date vaccine. The investigation and actions taken had not been logged onto the significant event system at the time of the inspection. The clinical staff we spoke with were aware of the incident relating to the vaccine and the change in procedure. 	

Example of significant events recorded and actions by the practice.

Event	Specific action taken
The administration of an out-of-date vaccine	The practice had identified this event promptly, apologised to the patient, investigated the cause and sought advice from the manufacturers. As a result, the practice offered and administered a repeat dose of the vaccine. The practice checked no other patients had been affected and determined the cause of the error. Following the investigation, they reviewed the system for managing medicine and vaccine stocks and amended it to ensure an allocated nurse carried out weekly stock checks.
The pharmacy identified that they had	The investigation showed the medicine had been stopped

not included a medicine in a patient's pre-packed medicine tray, for 12 months.	and there had been repeated communication to the pharmacy that had not been acted upon. There was no harm to the patient. The report highlighted a new pharmacy manager was in place and the practice staff created an evidence trail for all communications.
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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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> The practice maintained a spreadsheet of safety alerts received. The provider's business manager monitored what action was required and notified clinicians. The spreadsheet showed the practice was up to date with reviewing safety alerts, including the alert regarding sodium valproate (a medicine to treat epilepsy). The outcome column in the safety alert spreadsheet did not include a summary of the specific actions taken against each alert which would provide a clear audit trail. 		

Effective

Rating: Good

At our previous inspection in October 2018 we rated the practice as requires improvement for providing effective services. This was due to shortfalls relating to the Quality and Outcomes Framework (QOF) indicators which showed the practice scored lower than local and national averages for some patients.

At this inspection, the practice had improved most of its QOF outcomes and had implemented a QOF progress monitoring tracker. Where there were known issues with patient engagement, the practice had taken additional steps to encourage attendance. Data showed there were still areas where outcomes for patients were below national averages or targets however the practice continued to engage with patients to improve this and the practice had changed their recall process and monitoring procedures.

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
<ul style="list-style-type: none"> The practice used evidence-based templates which helped ensure they fully assessed patients' needs and developed appropriate pathways. Doctors discussed new guidance and alerts at their clinical meetings and business meetings and accessed NICE guidance on line. A review of patient notes showed care was delivered in line with best practice guidance. 	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group	0.70	0.88	0.75	No statistical variation

Prescribing	Practice performance	CCG average	England average	England comparison
Age-sex Related Prescribing Unit (STAR PU) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>				

Older people

Population group rating: Good

Findings

- The practice offered a named GP for continuity and consistency.
- GPs 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 team of nurses and healthcare assistants.
- Patients on the frailty index received home visits.
- 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 medication reviews for older patients and offered patients face to face or telephone appointments with their pharmacist.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. The practice had access to a specialist outreach nurse practitioner to visit people in their homes.
- 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, including those who were housebound.

Findings

- At our previous inspection in October 2018 we rated effective as requires improvement for this population group due to shortfalls in the QOF data and higher than local or national average exception reporting rates.
- For this inspection, exception reporting had reduced for the indicators identified in the previous inspection. However, results for the 2018-2019 QOF indicators showed high exception reporting rates for two different indicators but the practice explained the actions it had taken to manage exception reporting to support effective patient care.
- The practice had set up a system to recall patients annually for their review, based on their month of birth to improve consistency and attendance. It had also appointed a lead diabetic nurse. As a result of these actions, exception reporting for patients with diabetes, whose blood pressure reading was 140/180 mmHg had been 44.7% in the 2017-2018, had reduced to 9% in 2018-2019. This indicated a higher proportion of diabetes patients were monitored regularly. The exception reporting had also reduced for their cholesterol level indicator, from 25.7% to 15.7%.
- The exception reporting for patients with chronic obstructive pulmonary disease (COPD), for reviews that included breathlessness, had reduced from 25.2% in 2016-2017 to 16% in 2018-2019.
- However, the exception reporting for diabetes patients had increased from 20.9% to 29.5% over these time periods, for the indicator for glycated haemoglobin concentration in their blood. This is a measure of average blood sugar. The clinical team had a good understanding of why individual patients were excepted for reviews and recorded reasons for exceptions. These included patients choosing not to be treated, being unsuitable for treatment, recent diagnoses or recent registration at the practice.
- Exception reporting for reviewing patients with asthma, including an assessment of asthma control, had increased from 1.2% (3 patients) in 2017-2018, to 21.5% (59 patients) in 2018-2019. The practice explained they carried out annual health reviews for patients with asthma, and the exception report reflected their risk-based approach to the review process.

We also saw other examples of effective care for this population group, including:

- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. The GPs were supported by nurses and trained healthcare assistants to complete these reviews. Since the last inspection, a pharmacist had also been employed to undertake medicine reviews.
- The healthcare assistants carried out initial checks, and results were reviewed by a specialist nurse. The outcome of these reviews were used to assess whether the patient needed further interventions and all decisions were recorded and communicated to patients.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training. For example, there were nurse leads for diabetes and for respiratory care.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.1%	80.1%	79.3%	No statistical variation
Exception rate (number of exceptions).	29.5% (66)	20.4%	12.8%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	85.1%	80.2%	78.1%	No statistical variation
Exception rate (number of exceptions).	9.8% (22)	13.8%	9.4%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2018 to 31/03/2019) <small>(QOF)</small>	77.4%	82.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	15.2% (34)	18.3%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	78.2%	74.8%	75.9%	No statistical variation
Exception rate (number of exceptions).	21.5% (59)	11.3%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.0%	91.1%	89.6%	No statistical variation
Exception rate (number of exceptions).	16.1% (23)	17.6%	11.2%	N/A

Indicator	Practice	CCG	England	England
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		average	average	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 (01/04/2018 to 31/03/2019) (QOF)	77.7%	82.8%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.8% (18)	5.6%	4.0%	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 (01/04/2018 to 31/03/2019) (QOF)	87.5%	86.7%	91.1%	No statistical variation
Exception rate (number of exceptions).	3.4% (2)	4.8%	5.9%	N/A

Any additional evidence or comments

- The practice was aware of where exception rates were higher than the CCG average. Medical and non-clinical staff provided examples of how they had encouraged patients to attend for assessments. For example, the practice had implemented a system of reviews which meant patients were invited based on their birth month, which provided patients with assurance they would have regular reviews. They placed a flag on patients' notes and took advantage of opportunities to carry out assessments when patients attended for other reasons. If they did not engage after three invitations, GPs wrote to patients and specialist lead nurses phoned individual patients to encourage uptake. There was a good understanding of the reasons why individual patients did not engage and were excepted.
- The diabetic lead nurse, for example, worked closely with the diabetic clinic and provided outreach services to review patients in their own homes.

Families, children and young people

Population group rating: Good

Findings

- At our last inspection in October 2018 we rated this population group as requires improvement for effective because two of the four immunisation uptake rates were below the minimum levels of 90% and therefore the World Health Organisation target standard of 95%.
- At this inspection, the practice had broadly met the minimum 90% target for the four childhood immunisation uptake indicators.
- The practice contacted parents or guardians of children due to have childhood immunisations, using texts as well as letters to provide more personalised invitations.
- The practice employed a specialist paediatric nurse practitioner to support children with acute or chronic conditions. They were able to review family groups and foster higher levels of confidence amongst this patient group.
- 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 offered sexual health and contraception services.
- Staff had the appropriate skills and training to carry out reviews for this population group.

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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) (01/04/2018 to 31/03/2019) (NHS England)	45	46	97.8%	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) (01/04/2018 to 31/03/2019) (NHS England)	70	78	89.7%	Below 90% minimum
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)	70	78	89.7%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	71	78	91.0%	Met 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>

- The practice had set up a tracker so were aware of immunisation rates month by month.
- The practice had a low number of children registered. Out of 78 children aged two years, 70 had been immunised in line with the national immunisation programme. All but one child had received the primary course of immunisation for one-year olds. GPs reviewed and monitored all those who had not completed the childhood immunisations. They said they were aware of the specific children and families who did not attend for immunisations, for example, families from overseas who had moved into the catchment area.
- The practice had a system to follow up failed attendances for children's immunisations. The clinical team reinforced the benefits of immunisation at postnatal checks, had set up 'one stop shops' where the GP, paediatric lead nurse and healthcare assistants supported new mothers and advised on the immunisation programme. Practice leads for paediatrics held regular meetings with health visitors and documented failed attendances in the shared record.

Working age people (including those

Population group rating: Good

recently retired and students)

Findings

- At our last inspection in October 2018 we rated this population group as requires improvement for effective because the cervical screening rate was 59.1% (Public Health England data for 01/04/2016- 31/03/2017).
- The latest data (01/04/2017 to 31/03/2018) for this practice showed a marginal increase with a rate of 59.7%. Data from NHS Digital, which shows a quarterly snap-shot of how many women were eligible and screened on the last day of each quarter, indicated a slight increase in trend over the previous four quarters, and a screening rate of 60.7% on 31 March 2019.
- The practice's own data in November 2019 showed an increase to over 75% and an improving trend. The practice had assigned a staff member to personally contact women by phone and text. They had started to send out links to a popular social media video that promoted the screening test, to help reassure women and prompt them to book an appointment.
- To improve uptake, the practice had trained an additional nurse to carry out cervical screening since our last inspection and allocated dedicated appointment times to deliver this service. They offered early morning appointments one day a week, which were reportedly proving popular. They also ran 'awareness weeks' to focus on improving engagement.
- Women were invited for breast screening and if they did not attend for their screening test this was flagged on their notes for future discussion.
- Patients had access to appropriate health assessments and checks including NHS checks for new patients and 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.
- The practice offered on-line consultation services and promoted self-referral for physiotherapy.

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) (01/04/2017 to 31/03/2018) (Public Health England)	59.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	59.5%	65.6%	72.1%	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)	45.2%	53.6%	57.3%	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)	81.8%	59.9%	69.3%	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)	42.9%	46.6%	51.9%	No statistical variation
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People whose circumstances make them vulnerable

Population group rating: **Good**

Findings

- There was a register of patients with a learning disability. Same day appointments were offered when required.
- The practice had a learning disability lead nurse and lead GP. The practice offered patients a named GP for continuity and consistency.
- Patients were referred to services such as wellbeing service of the local learning disability healthcare service. Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- The practice had effective links with the substance misuse service in Portsmouth.

People experiencing poor mental health (including people with dementia)

Population group rating: **Good**

Findings

- 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.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- The practice was an accredited dementia friendly practice.

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 (01/04/2018 to 31/03/2019) ^(QOF)	97.1%	89.9%	89.4%	No statistical variation
Exception rate (number of exceptions).	14.6% (6)	17.2%	12.3%	N/A
The percentage of patients with	89.7%	92.7%	90.2%	No statistical variation

schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) (QOF)				
Exception rate (number of exceptions).	29.3% (12)	18.5%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	76.2%	81.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	16.0% (4)	7.9%	6.7%	N/A

Any additional evidence or comments

- The medical and clinic staff had knowledge of specific patients identified with schizophrenia, bipolar affective disorder and other psychoses. They provided continuity of care for their patients. The practice's lead nurse was trained to carry out the annual reviews of patients with a mental health diagnosis.
- There was high exception reporting for patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months. The clinical team monitored reasons why individual patients were excepted for alcohol consumption.

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)	557	No Data	539.2
Overall QOF score (as a percentage of maximum)	99.6%	No Data	96.4%
Overall QOF exception reporting (all domains)	11.2%	No Data	No Data

	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
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

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

past two years

- The practice had completed five quality and innovation initiatives in 2019. These were in A&E attendance, national cancer diagnosis, end of life audit, peer referral review and medicine management audits. The practice reviewed unplanned admissions and readmissions at MDT/virtual ward rounds.
- Other audits included a review of the Leg Club and its impact on patient outcomes and saved GP appointments. The sexual health lead nurse had carried out a contraceptive device audit to assess patient experience. The practice had also audited its triage pathways to assess if they were effective and appropriate.
- The practice discussed QOF outcomes and trends at the monthly business meeting. There was a comprehensive QOF tracker to which was updated weekly and used to identify priorities.

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
<ul style="list-style-type: none"> • The practice provided all staff with a mix of on-line and face to face training. On review of the practice's training log, we found almost all of the 28 non-clinical staff were compliant with training the practice considered to be necessary. Most of the provider's 	

staff worked at the practice and at the provider's other location. The gaps in training were primarily in hand hygiene (11 staff, with training out of date less than a month) and fire safety (four staff). The hand-hygiene update had been moved to accommodate other training and had been booked for February 2020. Some face to face fire safety training had lapsed since the trainer was no longer available, and the service planned to replace this with on-line training.

- The provider's 14 nurses and healthcare assistants worked at both its two sites. These staff were 89% compliant with training the practice considered to be necessary. Six staff had not completed training in the Mental Capacity Act 2005, however in-house training to cover this topic appropriate for all staff was booked for March 2020.
- The practice supported staff to complete training and since the last inspection had set up a system to advise them in advance when training was due to expire, with enough lead time to enable them to plan and complete training before the expiry date.
- Healthcare assistants had completed their Care Certificates.
- Clinical staff attended CCG-supported training in Portsmouth, offered to clinical staff across the city on a half-day each quarter. This programme delivered a range of courses to update staff on national and local initiatives and events. In addition, there were practice-based teaching sessions.
- Only trained GPs and nurses carried out cervical screening and immunisations. A recently employed nurse was in the process of completing their training to do these tasks at the time of the inspection.

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 (01/04/2018 to 31/03/2019) (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
<ul style="list-style-type: none"> • The practice maintained a Gold Standard Framework (GSF) register and had regular reviews of both those identified for end of life care and those with a life-limiting condition. • Coordinated care was facilitated by a single electronic patient record system used by health professionals across Portsmouth. All staff said this had significantly improved information 	

sharing between the practice and other providers.

- We saw discussions from multidisciplinary meetings were entered into patient records.

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, tackling obesity.	Y
<ul style="list-style-type: none"> • The practice offered social prescribing, for example, access to the nearby activities centre to participate in wellbeing activities and gym exercise. Referral reasons included to reduce blood pressure, reduce anxiety, to lose weight or to improve overall health. • The Leg Club, offered as a weekly drop in session for referred patients to maintain healthy skin, provided a social support network as well as opportunities for health education. None of the patients who had attended this club had experienced further skin break down. • The PCN was recruiting social prescribers to work across practices. 	

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	89.9%	94.4%	95.0%	Variation (negative)
Exception rate (number of exceptions).	0.6% (5)	0.8%	0.8%	N/A

Any additional evidence or comments

- At our previous inspection the practice had a lower achievement indicator than the local CCG and England averages in relation to recording smoking status (measured for the period 1/4/2016 - 31/3/2017). At this inspection, the practice continued to have lower than local and national averages.
- The GPs told us the high exception reporting for recording smoking in patients with schizophrenia, bipolar affective disorder and other psychoses related to some patients who did not engage in the review process.
- Patient records showed all templates prompted this data to be completed, and records we reviewed showed smoking was recorded.

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
The practice monitored the process for seeking consent appropriately.	Y
<ul style="list-style-type: none"> • The practice was completing a self-audit in relation to the Mental Capacity Act 2005 issued by the CCG. 	

Caring

Rating: Good

Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Staff displayed understanding and a non-judgemental attitude towards 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.	10
Number of CQC comments received which were positive about the service.	6
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	1

Source	Feedback
Comment cards	Comment cards were positive about the care and attitude of the GPs and receptionists. There was mixed feedback about access to appointments with three responses expressed disappointment that phone system had changed and they sometimes experienced delays. The one card with a negative comment contained non-specific feedback.
NHS UK website	There were two comments posted since the last inspection. These were negative about the call answering service and there were negative comments about reception and GP attitudes. The practice responded to individual feedback and invited those who were anonymous to contact the practice manager using a number provided.
Family and Friends test results	The results from the last Friends and Family test, compiled between April 2019 and August 2019, showed 91% were likely or extremely likely to recommend the service to family and friends. This was from 112 responses. There were three responses of extremely unlikely to recommend and one unlikely.

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4328.0	431.0	97.0	22.5%	2.24%

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 (01/01/2019 to 31/03/2019)	94.0%	87.0%	88.9%	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 (01/01/2019 to 31/03/2019)	94.5%	84.2%	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 (01/01/2019 to 31/03/2019)	97.6%	95.9%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	87.3%	75.5%	82.9%	No statistical variation

Any additional evidence or comments

The practice told us it was proud of the positive feedback received from the survey, and how they compared against other practices in the Portsmouth CCG.

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

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: <ul style="list-style-type: none"> • Easy read and pictorial materials were available. • Staff were aware of local support services to signpost patients to and receptionists were trained as care navigators. This meant they could direct patients to services more appropriate to their specific needs. 	

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 (01/01/2019 to 31/03/2019)	96.2%	91.9%	93.4%	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

- Staff could recall when they had used interpreters. One receptionist also spoke languages relevant to some of the patients from minority groups and the practice had told us this was helpful.
- Information on the practice website could be translated into over 100 different languages using integrated software.

Carers	Narrative
Percentage and number of carers identified.	The practice had identified 177 patients who were also carers, representing 2.7% of the patient population. This had increased by over 100% since the last inspection.
How the practice supported carers (including young carers).	Carers were identified through consultation, at new patient registration and at flu clinics. The practice had carer packs to offer patients and their relatives. The practice did not have a dedicated list for young carers specifically.
How the practice supported recently bereaved patients.	The named GP contacted recently bereaved patients and offered support. They provided information on where to access additional support in the community.

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.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
<ul style="list-style-type: none"> • We observed staff offered a patient a private room to breast feed their child. 	

Responsive

Rating: Good

Responding to and meeting people's needs

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

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
<ul style="list-style-type: none"> This practice had a relatively small waiting room, however there were some hard toys on a low table for waiting children and staff said they could offer parents a private room to wait in if this was required. The practice accessed translation services for patients for whom English was not their primary language. Staff confirmed they used translation services frequently. All patient areas were on the ground floor and there was a lowered section of the reception counter to support communication, for example with children and people in wheelchairs. The practice had an accessible information policy and practice. It did not own a hearing loop but had access to a portable one from the adjacent healthy living centre. This had not been risk assessed. 	

Practice Opening Times	
Day	Time
Opening times:	
Monday	8.30am – 6.00pm
Tuesday	8.30am – 6.00pm
Wednesday	8.30am – 6.00pm
Thursday	8.30am – 6.00pm
Friday	8.30am – 6.00pm
Appointments available:	
Monday	8.30am – 6.00pm
Tuesday	8.30am – 6.00pm

Wednesday	8.30am – 6.00pm
Thursday	8.30am – 6.00pm
Friday	8.30am – 6.00pm
<ul style="list-style-type: none"> The practice had implemented a new telephone system in 2019. Staff in the 'hub', based in the provider's other location, triaged all calls for both locations in the mornings. This was a GP-led triage system. If there were over five calls waiting, the system diverted calls to staff at John Pounds Surgery with the aim of reducing waiting times. Afternoon calls were received directly by John Pounds receptionist staff. In reception, staff could monitor call information, via a live display that showed, for example, the number of calls waiting, average call waiting time and the total number of calls taken. The practice was part of a group that supported extended hours appointments and there was information about this on the practice website. The practice provided same-day appointments for medically urgent problems with the duty-doctor or nurse practitioner. It offered appointments within 48 hours for those patients who did not require an emergency appointment, either face-to-face or by telephone. The practice could also offer patients appointments at the provider's other practice nearby, including Saturday morning appointments. Patients could book a routine appointment up to one month in advance. Pre-bookable appointments could be booked up to two weeks in advance and could be booked on the telephone and online. 	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
4328.0	431.0	97.0	22.5%	2.24%

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 (01/01/2019 to 31/03/2019)	97.6%	93.7%	94.5%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> The practice was building up data that would show call waiting times. Anecdotal evidence from practice managers and their provisional analysis of the data was the new telephone system was improving access times.

Older people

Population group rating: Good

Findings

- All patients had a named GP who supported them in whatever setting they lived.
- The specialist outreach nurse practitioner carried out annual reviews of patients who were housebound.
- The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues. This included for flu vaccinations.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- The leg club supported patients' social inclusion as well as helping them maintain healthy skin. This was a weekly drop-in service for referred patients, whose skin had healed but might be at risk of further breakdown without ongoing support and education.

People with long-term conditions

Population group rating: Good

Findings

- The nursing team and healthcare assistants supported patients with multiple conditions with diagnostic tests and reviews. Staff were being trained to carry out reviews in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services. This included links to district nursing teams.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services. The practice maintained a list of those patients with a life-limiting illness but not on the gold standard framework, and reviewed these patients regularly.

Families, children and young people

Population group rating: Good

Findings

- The provider employed a specialist nurse practitioner who led on acute and chronic care for children, postnatal checks and immunisations. The practice offered children longer appointments (20 minutes) at clinics held at the provider's other site.
- Parents or guardians with concerns about a child were offered a same day appointment when necessary.
- There were systems to identify and follow up vulnerable children and young people, including those, who had a high number of accident and emergency (A&E) attendances.

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- There was an online appointment booking service to enable patients to access the appointments schedule in their own time.
- The practice offered digital services and telephone appointments to help working age people access healthcare at times when it was convenient.
- The practice offered bookable appointments from 7am on Thursdays and also on Saturday

mornings at the provider's other location.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- There were registers for people living with different conditions, including those with a learning disability. This helped the practice plan their care and set up specific clinics.
- The practice had appointed a nurse lead for learning disabilities. They held annual health checks for patients with a learning disability, scheduling hour-long appointments at appropriate times of the day to promote access.
- These included medicine reviews to reduce over-medication.
- The lead nurse liaised with the local learning disability centre, for health and social care support.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice offered person centred care and a named GP for continuity of care and consistency.
- Patients had access to Talking Change through self-referral.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- This was an accredited dementia friendly practice and staff were aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

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

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely	Y

necessary.	
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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 (01/01/2019 to 31/03/2019)	77.4%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	79.0%	56.6%	67.4%	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 (01/01/2019 to 31/03/2019)	74.2%	55.4%	64.7%	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 (01/01/2019 to 31/03/2019)	81.4%	64.0%	73.6%	No statistical variation

Any additional evidence or comments
<ul style="list-style-type: none"> There had been a relatively high response rate to the GP survey and the practice told us it was proud of the positive responses received. The results for January 2019 to March 2019 indicated patients rated this surgery above others in Portsmouth for ease of making an appointment.

Source	Feedback
NHS Choices	The practice responded to feedback on NHS Choices. Within the past year, there had been three feedback comments. One related to a problem accessing the practice by phone, and the practice responded with a full explanation.
CQC feedback cards	One comment was that appointments were 'hard to come by'.

Listening and learning from concerns and complaints

Complaints were listened to and responded to and used to improve the quality of care, however the system for managing complaints was not always in line with

national guidance.

Complaints	
Number of complaints received in the last year.	2
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Partial
There was evidence that complaints were used to drive continuous improvement.	Y
<ul style="list-style-type: none"> • There was a poster in the waiting room inviting patients to make a complaint if they wished to. The receptionists had access to forms where they could record verbal complaints. • People could also complete a complaints form via the practice website. • We saw that complaints were used to improve services. • There was no information describing the complaints process available for patients in the waiting room, or on the website. When we asked for it, the practice was able to provide a copy of their complaints leaflet that contained information about their complaints procedures. They told us they made these leaflets available in reception after the inspection. • The guidance for patients who were dissatisfied with the complaint response did not include accurate information on how to access the Parliamentary Health Service Ombudsman (PHSO). • The practice maintained a complaints tracker to log and monitor actions taken in relation to complaints. However, it did not include the date when the complaint was closed to help monitor the timeliness of complaint responses. • The practice had a complaints policy dated 26 August 2019 that outlined the process and timescales for responding to complaints. • We saw a complaint response that provided an apology and reflected the nature of the complaint. It did not include reference to the patient's right to take the issue to the PHSO if they were not satisfied with the practice's response. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
Patient's relative complained they had been put on a register, they were not aware, and this had impacted decisions made by other services.	The practice investigated the causes and liaised with other parties involved, apologised in person, and the complaint was resolved and closed. The practice has changed the way it managed registers as a result.
	The practice investigated the complaint and identified an

<p>Complaint on NHS choices that their phone call was not answered all afternoon.</p>	<p>error made by the phone contractor. The practice tracked all those who had made a call that afternoon and phoned to apologise and check for implications. The phone system was changed so the practice could check in real time that calls were answered.</p> <p>The practice response was posted on NHS Choices, and included their gratitude for highlighting the issue.</p>
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Well-led

Rating: Requires improvement

At our previous inspection in October 2018 we rated the practice as requires improvement for providing well-led services due to:

- Shortfalls in monitoring medicines which required refrigeration,
- Shortfalls in the checking of test results for GPs on non-working days.
- Not reviewing actions taken following the receipt of safety alerts
- It did not have a patient participation group (PPG).

At this inspection we found improvements have been made to address the issues identified at the previous inspection. However, we have continued to rate the practice as requires improvement for providing well-led services as we found further evidence to demonstrate that governance systems were not operating effectively.

Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. The management had identified challenges and areas to address, however it was not clear how these were managed efficiently.

	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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
<ul style="list-style-type: none">• The practice had appointed a business manager within the past year, to provide additional management support and develop monitoring systems.• The practice manager and administration support staff understood their roles. The business tracker was used to log and monitor actions from the monthly business meetings. This tracker listed 44 'active' subjects, most of which were allocated to three staff members. It was not clear there was an effective mechanism to manage these.• Staff at the practice said they felt supported and knew how to access advice from the practice managers at either of the two provider sites.	

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	Y

external partners.	
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
<ul style="list-style-type: none"> The practice's ethos and vision statement was: '<i>We know you well so we care for you better</i>'. All staff recognised this statement and stated that personalised care was their priority. This was explained within the service's statement of purpose. The practice's long-term strategy was in development and discussion with the commissioners, and regularly reviewed. 	

Culture

The practice had a culture which promoted 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
<ul style="list-style-type: none"> Staff reported good support from colleagues and the partners, particularly when they needed it and wanted to raise concerns or make suggestions. They were confident they could raise issues with partners and management, and staff said there was good collaboration. There was a whistleblowing policy and this made reference to the NHS whistleblowing helpline, 'speakup.direct'. 	

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

Source	Feedback
Staff member	They said they considered there was an open-door policy and as a team they 'all looked after each other'
	They said they were asked to suggest areas for improvement, for example

	brainstorming gaps in service provision. This had contributed to the development of a carers' pack.
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Governance arrangements

There were overall governance arrangements to support systems management, but these were not consistently effective.

	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
<ul style="list-style-type: none"> The practice reviewed their risk management spreadsheet at the weekly business meetings and the bimonthly provider-wide business meetings. There were monthly meetings for nursing staff. The practice liaised with third parties, such as the telephone contractors and housekeeping service, when there were issues. The provider did not have a consistent approach for proactively identifying when its systems and processes required improvement. For example, the governance arrangements had not identified that: <ul style="list-style-type: none"> Patients did not have ready access to a complaints process, from leaflets or via the website. The complaints tracker did not provide a record of when the complaint had been resolved or closed. The significant events were not documented promptly or in detail to reflect the investigation, learning points and actions taken. Meetings were not consistently minuted, with identified actions and review updates. Recruitment procedures did not include providing assurances that all appropriate staff checks had been completed including immunisation checks. Practice policies were not consistently reviewed and updated to reflect current guidance and provide a clear resource for staff. The provider had a plan to review, rewrite and update its policies, however the timescales for this process were not stated. When staff attended face to face training this was not captured in the training log. The outcome column in the safety alert spreadsheet did not include specific actions taken against each alert which would provide a clear audit trail. 	

Managing risks, issues and performance

The practice had processes for managing risks, issues and performance, but these were not consistently effective.

	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
<ul style="list-style-type: none"> The practice management recognised they had been limited in what they had completed due to staff shortages and planned to implement a clinical audit programme in 2020, coordinated through the PCN, and to include additional audit cycles. The provider's business action tracker listed subjects to address, and some information on updates, but these subjects were not prioritised. The 44 'active' actions in the list (listed between August 2019 and October 2019) were not associated with any risk assessment, time or cost implications. For example, the tracker showed in August 2019 that 90 policies required reviewing. Seven had been completed by 30 September 2019 but the tracker did not include a further update on the subject in October 2019. The practice had a business continuity plan that outlined contingency plans in the event of unexpected failures within the building or facilities. This included actions to be taken should there be a loss of computer systems, including the digital consultation system, and a list of key contact details. The practice maintained emergency medicines and equipment, and this was regularly checked. 	

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
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
<ul style="list-style-type: none"> The practice created registers and used data to improve outcomes for patients. The provider had implemented a system to collect data on telephone calls. This provided information that was used to review and improve the call handling arrangements. The provider had established a Quality and Outcome Framework (QOF) register and used this to identify progress and trends in its QOF achievement performance. The provider had submitted a statutory notification to the CQC to advise of arrangements when the registered manager was on extended leave. 	

If the practice offered online services:

	Y/N/Partial
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Any unusual access was identified and followed up.	Y

Engagement with patients, the public, staff and external partners

The practice 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
<ul style="list-style-type: none"> There was no Patient Participation Group (PPG) at the time of the last inspection. When we visited in November 2019, the PPG was described as 'embryonic' and we were told efforts were being made to foster engagement amongst the patient population. Membership of the PPG was promoted in the waiting room. The PPG lead, a member of the public, said they tried various initiatives, but they had not yet been effective, so they were promoting meetings at both of the provider's two sites. The practice worked closely with the local clinical commissioning group to deliver services to meet the local population needs. The practice was part of a newly formed Primary Care Network (PCN) and the practices involved were working collectively to plan future developments and services. The practice management team liaised closely with the commissioners on local challenges to service provision. 	

Feedback from Patient Participation Group.

Feedback
<ul style="list-style-type: none"> The feedback was positive regarding the enthusiasm and commitment of the practice to develop and support a PPG at this practice. There was an established PPG at the provider's other location, and the PPG leaders covered both sites. The provider had arrangements to alternate PPG meetings across the two sites. The PPG representative said the practice was open and supported improved engagement of

patients through the group.

- Feedback was there was currently little interest from patients in participating in a group, but that attempts to encourage interest were ongoing. Their initial aim was to explore 'quick wins' to demonstrate the benefits of the PPG to the patient community.

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation, but these were not used consistently.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
<ul style="list-style-type: none"> • The leg club was a key development the service was proud to have implemented. They aimed to extend this approach to benefit other groups of patients. • There was a commitment to learning and improvement, 	

Examples of continuous learning and improvement

- The leg club was set up to support people maintain healthy skin once their leg ulcers had healed. This proved to be effective and the practice had received funding to maintain it. The club started in March 2019 and had 14 members. Since joining the leg club, no patients had suffered further skin break-down. Patients attending the dressings clinics hold their own record card and this helped them manage their own appointments. Analysis showed the club had reduced GP appointments. For example, in the eight months prior to setting up the club, there had been 342 appointments (81 with a GP) and after setting up the club, the number of appointments had reduced to 106 (38 with a GP).

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

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

Glossary of terms used in the data.

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