Lake Road Health Centre

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This service is rated as Good **overall.**
The key questions are rated as:

Are services safe? – Requires improvement Are services effective? – Good Are services caring? – Good Are services responsive? – Good Are services well-led? – Good
We carried out an announced comprehensive inspection at Lake Road Health Centre as part of our inspection programme. This service registered with CQC in November 2018 and this was our first inspection of the service.

There was a registered manager for this location; one of the service's four clinical directors. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service at Lake Road Health Centre provide extended hours primary care appointments at evenings, weekends and on bank holidays, for patients living in the Portsmouth area and holidaymakers. Patients can access GP, nurse or paramedic appointments, made through their own GP practice or via the NHS 111 out-of-hours call centre.

The provider, Portsmouth Primary Care Alliance Limited, provides other services to the Portsmouth community under other registered locations; these other services were not part of this inspection.

We collected 37 comment cards from patients attending the service. All comments were positive, with patients expressing their appreciation about the attitude and knowledge of staff, their professionalism and the ease and speed of access to appointments.

Our key findings were :

- Staff had direct access to patient information to deliver safe and effective care.
- Patients accessed appointments and advice in a timely way.
- Staff treated patients with kindness, respect and compassion.
- The provider sought feedback from patients and this was consistently positive about the quality and timeliness of care and treatment. This reflected the responses we received from the 37 comment cards we collected.
- There were systems in place to ensure patients were cared for by competent, trained staff. Staff knew what actions to take to safeguard people from abuse.
- The leaders had the skills to deliver high-quality care and work collaboratively with others.
- A positive culture was supported encouraged within the service.
- There were clear responsibilities, roles and systems of accountability to support good governance and management.
- Information was collected routinely and used by leaders to make informed decisions about the service.
- There was a culture of reporting and learning from incidents and complaints.

The areas where the provider **must** make improvements are:

- Care and treatment must be provided in a safe way.

The areas where the provider **should** make improvements are:

- Review the adverse incident reporting policy to include guidance on incidents that require reporting to NHS England.
- Consider tailoring the clinical audit process to minimise the chance of a clinician never being audited.
- Set up recording facilities for consultations carried out off-site, for escalation purposes.

Dr Rosie Benneyworth BM BS BMedSci MRCGP
Chief Inspector of Primary Medical Services and Integrated Care

Our inspection team

Our inspection team was led by a CQC lead inspector**.**
The team included a GP specialist advisor.

Background to Lake Road Health Centre

The registered provider is located at:

Portsmouth Primary Care Alliance Ltd.

Morris Crocker Ltd.,

Station House,

North Street,

Havant

PO9 1QU

The service inspected is located at:

Lake Road Practice

Nutfield Place

Portsmouth

PO1 4JT

The provider, Portsmouth Primary Care Alliance Ltd (PPCA), is a company made up of nominated GP partners from 14 GP member practices in the Portsmouth CCG area. The partners work collaboratively as an alliance to offer integrated primary care services to 230,000 patients across Portsmouth CCG's 15 practices. All but one of the Portsmouth practices are members of the PPCA.

PPCA provides an extended access service (EAS) from Lake Road Health Centre, to the whole population apart from patients detained under the Mental Health Act. The EAS is registered with CQC to provide the following regulated activities:

Treatment of disease, disorder or injury

Maternity and midwifery services.

The provider, PPCA, is also registered with CQC to provide other primary care services, from other locations within Portsmouth. These other services were not included as part of this inspection.

The EAS operates Monday to Friday from 6.30pm to 10.30pm and weekends (including bank holidays) from 8.00am to 10.30pm. The service provides triage, acute and routine appointments as well as visits to those patients in need of an urgent home visit during these hours. The provider had recently started to accept category 3 and 4 ambulance calls (urgent and less urgent), through an agreement with another health service provider providing this service.

The service is run by four clinical directors and one non-clinical director with a small number of employed business, administration and reception staff. Most of the staff, including all the medical and clinical staff, are not directly employed by the alliance. Instead, the service uses locum or bank staff to provide its clinical and nursing care.

How we inspected this service

During this inspection we visited the Lake Road Health Centre location and spoke with staff, observed practice and reviewed documents. In advance of the inspection we reviewed information we held from stakeholder organisations, such as the local clinical commissioning group (CCG)and Healthwatch, and information provided by the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Requires improvement

Are services safe?

We rated safe as Requires improvement because:

Systems to manage medicines were not consistently safe. The risk to the public is low as the provider has mitigated these risks since inspection.

Safety systems and processes

The service had clear systems to keep people safe and safeguarded from abuse.

- The provider had evidence of safety risk assessments. It obtained assurances from the host site that premises and facilities were maintained and routinely safety checked.
- The service had appropriate safety policies, which were regularly reviewed and communicated to staff including locums. For example, the policies and procedures to safeguard children and vulnerable adults from abuse were on the provider's intranet and available to all staff including bank and locum staff. The policies outlined clearly who to go to for further guidance. Staff received safety information from the service as part of their induction and refresher training.
- The service had systems in place to assure that an adult accompanying a child had parental authority. The service had evidence that staff were up to date with safeguarding children training appropriate to their roles. Clinicians were trained to level 3 and reception and administration staff to level 1. There was a lead director for child safeguarding, and staff we spoke with knew who the lead was.
- One of the clinical directors was the lead for adult safeguarding and all staff were trained in line with the provider's policy. For example, GPs, nurse practitioners and paramedics to level 3 and receptionists to level 1.
- The service worked with other agencies to support patients and protect them from neglect and abuse. Staff provided examples of actions they had taken to protect patients from actual or suspected abuse and there was an electronic system for submitting referrals. There were flags on patient records to highlight safeguarding concerns. For example, we were told that a receptionist had concerns about a child they had observed in reception. The receptionist raised these with the GP on site who made a referral to the multi-agency safeguarding hub. The safeguarding lead followed up to ensure these concerns were logged and considered in line with its protocol.
- The provider carried out staff checks at the time of recruitment and on an ongoing basis where appropriate. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). It was the service's recruitment policy to carry out DBS checks on all appropriate staff. The provider risk assessed staff who had substantive posts in member practices and required them to provide a copy of their most recent DBS check. If these were over three years old, the provider carried out a new check.
- The service's rota system included data from recruitment checks. This meant that staff were alerted when they were due to present evidence of their professional registration or revalidation, medical indemnity, appraisal and safeguarding training.
- The service had four drivers who acted as chaperones for home visits where needed. All four drivers were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. Premises were clean and there was personal protective equipment in place.
- The provider gained assurance from the host site that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. This included systems for safely managing healthcare waste and legionella risk assessments. Staff said there had not been a fire-drill, however, there was a plan to complete one in December 2019.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety, however there were some areas that needed strengthening to minimise risks.

- There were arrangements for planning and monitoring the number and mix of staff needed. Staff reported this had improved in the past few months, with a new rota system. The provider monitored demand levels and staffed the service accordingly, to a safe minimum level of at least two reception staff and at least one GP on duty at any time. Typically, there were two reception staff during weekday evenings and two reception staff and two administration staff on duty at weekends, when administration staff were involved in care navigation. If

there was a surge in demand there was an escalation policy and the director on-call could log on and triage patients from outside the premises, under defined controls. However, these telephone consultations were not automatically recorded so could not be audited.

- There was an effective induction system for permanent and bank staff tailored to their role.
- When there were changes to services or staff the service assessed and monitored the impact on safety. For example, the provider had recently started to accept category 3 and 4 ambulance calls (urgent and less urgent), through an agreement with another health service provider. Only specific clinicians, trained by the ambulance service, were permitted to provide this service, on behalf of another health service provider.
- The provider had developed a business continuity plan. It had followed the plan once in the past year, when the extended access service had to relocate temporarily to the provider's other location. Patients were redirected appropriately, in line with the plan.
- Clinicians used their own NHS cards to access the clinical records system and removed these when they left the room to control of risk of unauthorised access. They stayed within the consulting rooms during their shifts.
- There were systems to support patients who deteriorated. Staff understood their responsibilities to manage emergencies and to recognise those in need of urgent medical attention. All staff completed basic life support training annually, and this was face to face for clinical staff. Receptionists completed training on how to recognise and respond to a sick patient as part of their on-line training. Clinicians ensured the National Early Warning Score (NEWS2) was applied when triaging patients. Staff knew how to identify and manage patients with severe infections, for example sepsis, and ensured they were seen promptly in line with their risk factors.
- The service ensured doctors had access to the equipment they needed, and each had a checklist.
- The service used the host site's emergency medicines and equipment, under a memorandum of agreement (MOA). The medical car and its medical equipment were provided under contract from a third party. The MOA stated all equipment in agreed consulting rooms was available for the service to use. In addition to the host site's system for checking the emergency equipment, the MOA stated the service would carry out its own checks and would advise the host site of any items that were used and needed replacing.
- There was a complete list of emergency medicines available in the car used by the doctor for home visits.

Information to deliver safe care and treatment

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

- The service and all Portsmouth GP practices used the same clinical records system, which was also used by social services and other community health services. This meant clinical staff had access to patient's individual care records, if they were patients from Portsmouth GP practices, so they had information to support safe and timely decision making. Staff said they asked for consent to view patients' medical history on this system. Once consent was logged they could then view and add to records and include advice for a patient's own GP. For example, the clinician could add a task on the system for the patient's own GP to see the patient for an urgent appointment. For patients not registered at a Portsmouth practice, the clinicians relied on the summary health record and provided patients with written advice and a copy to share with their GP.
- Records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service's access to the electronic clinical records system enabled information to be shared directly with other agencies, such as community mental health and social services as well as GP practices.
- Clinicians made appropriate and timely referrals in line with protocols and up to date evidence-based guidance.
- The provider's website included information on how it managed patient information, when it would be shared and patient's rights to ask for their information not to be shared.

Safe and appropriate use of medicines

The service had systems for appropriate and safe handling of medicines, however there were risks associated with their prescription stationery.

Requires improvement

Are services safe?

- The service's medicines management policy was last reviewed in August 2019 and included responsibilities for medicines and reporting errors. The service did not hold stocks of medicines so signposted patients to late opening pharmacies for any prescribed medicines.
- The service used the host site's emergency medicines under a memorandum of agreement (MOA).
- We found the emergency medicines and equipment were not maintained in line with the MOA or to best practice standards. The emergency medicines trolley on the premises did not contain two items recommended by the Drugs and Therapeutics Bulletins in 2015: an antiemetic (for the treatment of nausea and vomiting) and a pain-relief medicine. After the inspection, we were told the provider had liaised with the host site on reviewing the list of medicines required on the emergency trolley.
- The MOA stated the provider would have its own checks, and would advise the host practice of any items were used and needed replacing.
- The emergency trolley was not secured by a tamper-evident seal, and this had not been raised at handover with the host practice. This meant there was a risk emergency medicines might have been used and not replaced since the last check. It also indicated the checking processes was not carried out in line with the MOA. After the inspection, we were told the provider had liaised with the host practice on securing the emergency trolley and reviewing the list of medicines required.
- Medical staff prescribed Schedule 2 and 3 controlled drugs (medicines that have the highest level of control due to their risk of misuse and dependence) for palliative care purposes only.
- The service did not have a system to monitor prescription stationery used on the premises or to ensure it was securely stored. Prescription stationery was held in unlocked printer drawers and the provider used the prescription stationery provided by the host GP practice. There was no system to record the prescription numbers at handover. Access to areas where the printers were located (the treatment rooms and the upstairs telephone hub) was secured by keypad entry, which reduced the risk they could be accessed by unauthorised users. However, this arrangement presented a risk to staff safety. After the inspection, the provider said they had contacted the local clinical commissioning group's lead pharmacist and had started to record the number of the first and last blank prescription in the printer, for audit purposes, and they were in the process of obtaining their own prescription stationery.
- There was a system for controlling the prescription stationery used by the doctor for home visits. The driver signed for prescriptions and there was record of any used by the doctor.
- The service carried out monthly audits of at least 1% of clinical consultations. These audits included an assessment of prescribing, to ensure it was in line with best practice guidelines for safe prescribing.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. Clinicians had access to the British National Formulary via their mobile phones. Processes were in place for checking medicines and staff kept accurate records of medicines. Where there was a different approach taken from national guidance there was a clear rationale for this that protected patient safety.

Track record on safety and incidents

The service had a system for monitoring incidents and a good safety record.

- Staff were encouraged to report incidents and near misses. The provider's adverse incidents policy included guidance for staff on what to report and when to report incidents to outside agencies, such as the commissioners, MHRA and HSE. It included template forms for staff to complete and explanations on what constituted an incident and a serious adverse event. It did not provide guidance on what incidents required reporting to NHS England.
- There had been no serious adverse events within the service recorded in the last 12 months.
- The provider monitored and reviewed incidents each month and there was an average of 14 incidents a month over the past year, all of which were low risk/no harm. Incidents were categorised, for example in relation to IT/telephony, abusive or aggressive behaviour, medication error or information governance. Incidents such as serious prescribing errors or those relating to resuscitation equipment were considered serious incidents.
- The provider had made the categorisation of incidents more detailed to help identify trends and issues. This

helped it to understand risks and make safety improvements. For example, there had been a theme relating to poor IT connectivity from GPs making home visits. In response, the provider had purchased 4G-enabled laptops to improve connectivity.

Lessons learned and improvements made

The service learned and made improvements when things went wrong.

- There was a system for recording and acting on incidents. Staff understood their duty to raise concerns and report incidents and near misses. They said leaders and managers supported them when they raised concerns and there was a no blame culture.
- There were adequate systems for reviewing and investigating when things went wrong. The service learned and shared lessons, identified themes and took action to improve safety in the service. For example, a pharmacist had identified a prescribing error, and corrected it before it caused potential harm to a patient. This incident had led to a change in policy to require clinicians to consistently use established care plans based on best practice. The service also completed an audit of its GPs' prescribing skills.
- We saw that learning from an incident that occurred locally, within a member practice as opposed to this service, was shared via a staff newsletter. There was a link to the guidelines for reference.
- The service had worked with partners to improve efficiency of referrals, in response to reported incidents of inappropriate referrals from patients registered with GPs outside Portsmouth. Collaboration with the NHS 111 service led to an amended process to ensure the correct patients were referred to the Portsmouth extended hours service. This resulted in a lower number of referrals needing to be referred back to NHS111.
- The service acted on and learned from external safety events as well as patient and medicine safety alerts. The service had an effective mechanism in place to cascade alerts to all members of the team including sessional staff. The chief quality and operations officer received the alerts and cascaded relevant alerts via the internal communication system. For example, they had shared an alert relating to the lack of availability of a commonly used medicine.
- The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. They gave examples of apologies given to patients following an incident or a near miss.

Good

Are services effective?

We rated effective as Good because:

People had good outcomes because they received effective care and treatment and care was coordinated between health and social care professionals. There was regular audit of clinical practice and employed staff received regular supervision.

The provider could consider how to audit all clinicians within the principle of a 1% random audit approach.

Effective needs assessment, care and treatment

The provider had systems to keep clinicians up to date with current evidence based practice. We saw evidence that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance (relevant to their service)

- The clinicians used established, evidence-based clinical pathways where appropriate and ensured patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- There were pathways in place to support vulnerable patients, such as patients with mental health problems, who were seen by GPs only and referred to the crisis team if appropriate. For children under six-months of age, appointments were always assigned to GPs. For palliative care patients, the service offered GP home visits and liaised with the palliative care team.
- The clinical commissioning group issued information on changes or updates to evidence-based guidance, such as the National Institute for Health and Care Excellence (NICE) best practice guidelines. Updates and alerts were shared, such as a recent update relating to the disruption in supply of a particular medicine and the recommended alternatives to use.
- Because the service was linked to the Portsmouth-wide electronic clinical records system, clinicians could view patient medical history including test results. They had sufficient information to decide on the best treatment pathway.
- We saw no evidence of discrimination when making care and treatment decisions.
- Arrangements were in place to deal with repeat patients. The service monitored patients who contacted the service more than three times a month and contacted the patient's GP.
- Staff assessed and managed patients' pain where appropriate.

Monitoring care and treatment

The service was actively involved in quality improvement activity.

- The service used information about care and treatment to make improvements. The provider had systems for monitoring activity and identifying areas for improvement, such as through clinical audit, timeliness of service provision or patient feedback.
- The service undertook a clinical audit programme. In line with contractual arrangements, it randomly selected and audited at least 1% of cases and applied the Royal College of General Practice audit toolkit. Monthly results showed over 98% compliance over the past year. Any themes, positive or negative, where reported on. For example, in June 2019, the service results showed chaperones had been offered and used when requested and paramedic practitioners made appropriate decisions. If individual clinicians' performance was variable the clinical directors gave feedback on changes required to ensure improvement.
- The provider ensured they audited the performance of any new GPs, to check their competency and learning needs. Clinicians were allocated to roles that best suited their skills.
- We highlighted the approach to auditing 1% of cases at random meant there was a risk that clinicians who regularly worked very few shifts were at risk of not being audited.
- In July 2019, the service audited clinical practice in the care of dehydration in children under one year of age, following the introduction of NICE guidance. Results showed compliance with the guidance.
- The CCG had carried out a quality assurance visit in November 2019 and reported on its findings. They commented on the effective end-to-end reviews and clinical audit.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- All staff were appropriately qualified. The provider had an induction programme for all newly appointed staff.

Good

Are services effective?

- Relevant professionals (medical and nursing) were registered with the General Medical Council (GMC) and the Nursing and Midwifery Council. Health and Care Professions Council for paramedics. All professionals were up to date with revalidation.
- The provider understood and defined the training needs of different staff groups. Compliance with training was monitored and reported on each month and there were up to date records of skills, qualifications and training. The four clinical directors were 100% compliant with 12 training modules described as mandatory and over 80% compliant with all 20 modules. All but one employed staff were over 90% compliant with their mandated training. Over 82% of the service's 40 GP locums were up to date with basic life support and safeguarding level 3 for both adults and children. All but one of the eight nurse practitioners had completed adult basic life support and safeguarding level 3 for adults and children. Face to face training was booked to ensure full compliance.
- Staff were encouraged and given opportunities to develop. For example, one locum nurse described how they had been mentored by a service director for their prescribing course. Another staff member had been promoted to into a manager position.

Coordinating patient care and information sharing

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

- Patients received coordinated and person-centred care. Staff referred to, and communicated effectively with, other services when appropriate via the shared access to the patient record. The other services included GP practices, community health services and social services. Staff asked for patient consent to access their record.
- Before providing treatment, doctors had knowledge of the patient's medical history, any relevant test results and their medicines, through their electronic record. Similarly, the service's GPs included notes of their consultation and any medicines prescribed on the patient record so these details could be reviewed by the patient's registered GP. If appropriate, they referred patients back to their own GP for further care and treatment. They could add a specific task onto the record for the patient's GP to action. They followed up if this action was not completed.
- Patients who were not registered with a GP in a Portsmouth practice were given copies of the consultation record to give to their GP.
- The provider had risk assessed the treatments they offered. They had identified medicines that were not suitable for prescribing if the patient did not give their consent to share information with their GP, or they were not registered with a GP. For example, medicines liable to abuse or misuse, and those for the treatment of long-term conditions such as asthma.

Supporting patients to live healthier lives

Staff were consistent and proactive in empowering patients, and supporting them to manage their own health and maximise their independence.

- Where appropriate, staff gave people advice so they could self-care. For example, nurses gave advice when offering wound care on dietary and health care.
- Risk factors were identified, highlighted to patients and where appropriate highlighted to their normal care provider for additional support.
- Where patients' needs could not be met by the service, staff redirected them to the appropriate service for their needs.

Consent to care and treatment

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

- Staff understood the requirements of legislation and guidance when considering consent and decision making. Clinical staff completed training in the Mental Capacity Act 2005 though the adult safeguarding course.
- Staff supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The service monitored the process for seeking consent appropriately.

Good

Are services caring?

We rated caring as Good because:

People were treated with dignity, respect and compassion and were involved as partners in their care.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treated people. The service had a system to seek feedback from patients on the quality of care provided. It used a third-party company that asked patients for feedback by text or email, and responses were available for the public to view. The feedback was in the form of free-text as well ratings, for example on how likely patients were to recommend the service, timekeeping and staff professionalism. Results showed that 95.5% of patients would recommend the service. We viewed the feedback on-line and there were a range of positive comments relating to the attitude of staff. For example, comments described doctors as kind and compassionate.
- We collected 37 comment cards as part of the inspection and they were consistently positive.
- Staff understood patients' personal, cultural, social and religious needs. They displayed an understanding and non-judgmental attitude to all patients. We received feedback that the doctor was fully aware of one patient's autism and took that into account when examining them.
- The service gave patients timely support and information. All feedback we received commented on the short waiting time to be seen.

Involvement in decisions about care and treatment

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

- Patients told us through comment cards that they felt listened to and supported by staff and had sufficient time during consultations to ask questions. This feedback was also evident in the provider's routine patient survey responses. There were a variety of responses that praised the support patients had received from doctors and comments they had been listened to.
- Staff had access to telephone translation services for patients who did not have English as a first language. Receptionists knew how to access these services and we were told they were used approximately once a month. The service also had a hearing loop for patients who had difficulty hearing.
- For patients with learning disabilities or complex social needs family, carers or social workers were appropriately involved.

Privacy and Dignity

The service respected patients' privacy and dignity.

- Staff recognised the importance of people's dignity and respect.
- Patients were seen by clinicians in consulting rooms and conversations could not be heard outside the room.
- The reception desk was designed so it afforded patients some privacy when they spoke with staff.

Good

Are services responsive to people's needs?

We rated responsive as Good because:

The service was designed to meet patients' needs and provide appointments in a timely way and staff took complaints seriously and learnt from them.

Responding to and meeting people's needs

The service organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The provider was initially set up to support primary care in Portsmouth to deliver services at scale for patients registered with Portsmouth's GP practices. The provider understood the needs of their patients, recognising the local demographics, and collaborated with member GP practices, commissioners and the wider health economy to develop new services. These included home visiting services and out of hours provision, as well as the extended access service (EAS) we were inspecting.
- The facilities and premises were appropriate for the service. The provider delivered this service from one central GP practice in Portsmouth, which had good access, a large waiting room and parking. There was a memorandum of agreement for the use of these premises. The provider's management offices were in a different site.
- Reasonable adjustments had been made so that people in vulnerable circumstances could access and use services on an equal basis to others. The service offered home visiting and the length of appointments were adjusted to meet patients' specific needs.
- The service also provided cover for the Portsmouth GP practices when closed for training on one afternoon a month.

Timely access to the service

Patients were able to access care and treatment from the service within an appropriate timescale for their needs.

- Patients had timely access to initial assessment and treatment. Patients registered at the 15 Portsmouth practices had access to appointments at the service via their own GP practice or via the NHS 111 service. The service was contracted to provide triage services, face to face consultations, both routine and urgent and home visits. Timeliness of activity was monitored and overall compliance against contracted target was 98% in September 2019. Narrative behind these scores showed explanations and evidence of effective patient care.
- The extended hours service operated between 6.30pm and 10.30pm on weekdays and 8.00am to 10.30pm during weekends and bank holidays. The service monitored waiting times, delays and cancellations in line with their contract. Staffing was planned based on demand trends. Waiting times and delays were minimal and managed appropriately.
- Feedback both from our comment cards and through the service's own survey showed patients valued the prompt service they received when they were referred to the service via NHS 111.
- Patients with the most urgent needs had their care and treatment prioritised. Call handlers, who booked the appointments, used a navigation system to book appointments with the most appropriate clinician. The appointment system had some flexibility so urgent cases could be fitted in at short notice.
- Consultations and transfers to other services were undertaken in a timely way. The service's data showed that 99% of all patient contacts were communicated to their own GP by 8am the following day. This was facilitated by the shared IT system for patient records. The 1% shortfall was accounted for by out-of-area patients.
- The provider monitored activity and outcomes, which showed that in the year to October 2019, 53.3% of activity resulted in advice to patients to contact their own GP if no better, 27.7% required no follow up, 5.3% of contacts were advised to attend emergency department and 10.9% were referred to their own GP for a routine appointment.

Listening and learning from concerns and complaints

The service took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- A 'comments, concerns, compliments and complaints' guide was available in reception for patients. This included information on how to make a complaint or raise concerns. There was guidance on the complaints process, what to expect and what actions to take if, following the provider's response, the complainant remained dissatisfied.

Good

Are services responsive to people's needs?

- Staff treated patients who made complaints compassionately. Staff acknowledged that complaints were useful and they logged verbal as well as formal complaints.
- If people made a complaint through the feedback process, the service responded to say they were sorry and invited the complainant to contact them directly.
- The service had complaints policy in place. The service learned lessons from individual concerns, complaints and from analysis of trends, and they were a standing item on governance meetings agendas. The provider used complaints from all of its services to improve the overall quality of care it provided.
- We reviewed a written complaint response and there was a sincere apology, details of the investigation and an offer of a face to face meeting. The letter also included guidance on taking the complaint to the Parliamentary Health Service Ombudsman if the complainant wished to take the matter further.

Good

Are services well-led?

We rated well-led as Good because:

The leadership, governance and culture were effective and supported the delivery of high-quality person-centred care. The service had a good system for gaining patient feedback.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service. Clinical directors worked within the service and were available and visible to staff.

Vision and strategy

The service had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- The provider displayed its vision and aims on its website. Its vision was to offer 'high quality primary care with general practice at the centre of effective, meaningful health systems. Looking to work collaboratively to improve patient care and local service provision by supporting the work of primary and community care.'
- Its aims were to work collaboratively to enhance health care provision for all, to tender for and deliver services above and beyond traditional provision and enable the appropriate transfer of care from the hospital setting into the community. It aimed to offer caring, safe, responsive, well led effective services where patients were involved in decisions about their own care. The directors said the provider was committed to be an advocate for primary care.
- The provider formed from a federation of Portsmouth GP practices in 2017, set up initially to deliver an acute visiting service across the city. The provider had since added further services, including the extended access service, and has expanded the range of services offered to meet local demand for integrated primary care services in the city.
- The provider developed its strategy jointly with external partners. It worked in partnership with commissioners, NHS community services and adult social services to develop health and care services for the Portsmouth population. There was an agreed multi-speciality community provider (MCP) partnership, which set out a commitment to integrate primary, community and social care services in Portsmouth City. Two of the provider's directors sat on the MCP programme board.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them

Culture

The service had a culture of high-quality sustainable care.

- Staff said they felt respected, supported and valued. This included both permanent staff and those on bank or locum contracts. They said they were listened to and there was a fair approach for allocating shifts.
- The first annual staff survey results, from June 2019, showed 95% of staff who participated in the survey looked forward to going to work and felt supported by colleagues. Areas for development had been identified for further action, and some actions had already been implemented, such as giving feedback to staff.
- The provider was developing its 'people agenda' for staff, and as part of this had surveyed staff to develop an agreed set of values for the service.
- The service focused on the needs of patients, whilst supporting staff safety. Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Leaders and managers acted on behaviour and performance inconsistent with the company's vision and aims.
- Staff told us they could raise concerns and were encouraged to do so. They had confidence these would be addressed. The provider had responded to a concern

raised by a clinician, and had engaged an external, impartial reviewer to investigate the issues. No further action was required and reassurance was shared. The provider followed its whistleblowing policy.

- There were processes for providing staff with the development they needed. These included appraisal and career development conversations. All employed staff had received these in the past year, and there had been opportunities for career development within the service. Staff were supported to meet the requirements of professional revalidation where necessary.
- One clinical locum staff said they had been mentored by the provider for their professional development, which they appreciated. Although staff were not given protected time for professional development, staff said they valued the easy access to training and support, and there was time to complete their training during normal working hours. The provider had rewarded staff who had completed all their training and acknowledged their achievement.
- There was a strong emphasis on the safety and well-being of all staff. Staff were encouraged to report any incidents of aggression or verbal abuse and there was an alarm on their IT system to call for assistance as well as instant messaging. The health centre doors were locked at night and patients called reception for access. Working hours were monitored to ensure staff wellbeing was considered, and staff could request time off in lieu for additional hours worked.
- The service required all employed staff to complete training in equality and diversity. An external company had provided face to face training on this topic for all board members.
- Staff told us there were positive relationships between staff and an absence of hierarchy, which they valued. Staff felt they were treated equally.

Governance arrangements

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

- There was a clear governance system, to support the management of the company, joint working with partners and collaboration with other providers of health and social care and commissioners. Meetings and actions were logged and any conflicts of interest considered.
- The provider's board was made up of four clinical and one non-clinical director. The chief quality and operations officer also attends the board meetings as a non-voting member. It met monthly and the standing agenda covered operational and activity updates, future developments and the operational report incorporating training, incidents and finance. Actions were agreed, monitored and updated.
- The assurance and governance meetings were also held monthly. These ensured directors had oversight of incidents, audits results, patient feedback, complaints, risks and service developments.
- The provider had regular contract review meetings, which included reviews of activity, finance, quality and future developments.
- Leaders had established policies, procedures and activities to promote safety and assure themselves they were operating as intended. These were reviewed and updated when necessary, and available on the intranet for all staff to view.
- Staff were clear on their roles and accountabilities. For example, clinical staff did not work outside their competencies or confidence.

Managing risks, issues and performance

There were effective processes for managing risks, issues and performance however some procedures had not been audited to ensure they were implemented in line with policy or guidance.

- There was a process to identify, understand, monitor and address current and future risks including risks to patient safety. The provider maintained a risk register which was updated monthly, and showed risk scores, mitigations and actions. For example, the risk rating for staffing levels was regularly reviewed and revised based on recruitment and service development plans. The risk register included a risk that staff might not be fully ware of the organisational strategy, vision and values. Work was in progress to complete actions planned to reduce the impact of this risk, for example with a strategy day and a people's agenda.
- The service had processes to manage current and future performance. Performance of clinical staff was assessed though monthly audits of their consultations, prescribing and referral decisions. Leaders had oversight of safety alerts, incidents, and complaints.

Good

Are services well-led?

- Clinical audit had a positive impact on quality of care and outcomes for patients. There was evidence of actions taken to improve quality.
- The provider had plans in place for major incidents to maintain business continuity. They described how they had moved the service to the backup-premises at short notice one evening, in response to a facilities issue at the host site.
- The provider monitored activity levels by source, time of referral, practitioner and by type, to help plan staffing needs. For example, appointments with GPs, nurses or paramedic practitioners, and the proportion of visits to care homes. The provider also identified repeat patients, such as those with three or more contacts during a month. Any issues were escalated to relevant staff, member practices or other partners in the system.
- The agreement with the host practice included arrangements for handing-over the premises and checking the emergency medicines and equipment. On this inspection however, the process had not been followed yet this had not been identified before as an issue. This indicated the process had not been monitored and reviewed. After the inspection, the provider said they were developing a handover procedure for the start and end of shifts.
- In addition, the risk relating to the lack of clear management of prescription stationery had not been identified. After the inspection, the provider advised they had immediately set up a more secure system and had liaised with the CCG pharmacist to order their own prescription stationery.

Appropriate and accurate information

The service acted on appropriate and accurate information.

- The provider had access to a clinical records IT system that was shared across all community health and social care providers in Portsmouth. This enabled clinicians to have immediate access to patient records to inform decision making and to communicate with their registered GPs.
- Quality and operational information was used to monitor and improve performance. Performance information was reviewed monthly by the provider and by commissioners, and this included the views of patients. Management and staff were held to account based on the data.
- Quality and sustainability were discussed in relevant meetings with partners and commissioners. These meetings were informed by access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses. Any issues with potential information errors were flagged.
- The service understood their responsibility to submit data or notifications to external organisations as required.
- The provider had appointed the Data Protection Officer to support all primary care services in Portsmouth. All directors, receptionists, administration and business staff had completed training in the General Data Protection Regulation (GDPR).
- Staff had individual card-entry to access patient records system, and access was controlled and monitored.

Engagement with patients, the public, staff and external partners

The service involved patients, the public, staff and external partners to support high-quality sustainable services.

- The service encouraged and heard views and concerns from the public, patients, staff and external partners and acted on them to shape services and culture.
- Staff said they could give feedback formally or informally and was used to improve services. For example, clinicians reported they had received some referrals with insufficient information. In response, the medical director contacted the referring GPs directly to highlight and resolve the issue. Pharmacy feedback relating to a prescribing error led to an audit and the introduction of specific best-practice pathways for children.
- The staff survey, undertaken in April 2019, gave rise to a range of actions under the headings communication, clinical governance and organisational development. Some of these had been implemented already, such as actions relating to improving communication.
- The service was transparent, collaborative and open with stakeholders about concerns and performance. The provider had regular performance reviews with commissioners and engagement with the wider multi-speciality community provider (MCP) partnership
- Through the MCP, the provider had helped to improve the access pathway to the crisis mental health team.

Good

Are services well-led?

- The CCG had carried out a quality review in November 2019 and the team had been impressed by the services they had viewed. They made four recommendations, including they should review any restricted patient feedback (i.e. feedback that named clinicians and was unsuitable for publication) at contract monitoring meetings.
- The provider carried out engagement visits with member partners, and these were used to share concerns, operational issues and to promote the service.

Continuous improvement and innovation

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

- The provider was fully involved in supporting system-wide improvements to primary care services, in collaboration with partners and commissioners. Future developments were discussed, planned, piloted and reviewed.
- For example, the service had developed a new protocol with partners and the local acute trust for their emergency department to redirect patients to the primary care provision. This helped improve patient care in both the primary and secondary care settings.
- The provider's medical director was the co-chair of Portsmouth Integrated Care system board. This board was key to developing new services for the city, including prescribing processes within palliative care, musculoskeletal services and a care home team.
- Within the service, there was a focus on continuous learning and improvement. The management team gave plaudits and improvement guidance monthly to support staff learning.
- The service made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements. For example, clinicians had raised concerns about lone working when making home visits. The provider had employed drivers to take doctors on home visits, and this had improved safety.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance. The service had plans to hold a board away day early in 2020 to facilitate sharing of ideas and improvement.
- The provider was a training service for final year, specialist trainee GPs. They provided extra staff cover for this and received good feedback from the trainees.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: • The provider had not set up a safe system for managing prescription stationery. • The provider did not have a safe approach for the management of emergency medicines. This was in breach of regulation 12 (1)(2)(b)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.