Portsdown Group Practice

Quality Report

Portsdown Group Practice
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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 service	Good
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Portsdown Group Practice, Cosham Park Avenue Surgery 15 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

Our key findings across all the areas we inspected were as follows:

Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed, with the exception of those relating to Legionella.

Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.

Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

Summary of findings

There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice.

The practice had a duty GP each day who answered the phones and was joined by two further GPs between 9.00am and 9:30am. The GPs triaged the calls dealing over the phone, giving general advice, booking urgent appointments or directing patients to the nurse practitioner.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

Ensure risk assessments related to the Control of Substances Hazardous to Health (COSHH) are carried out effectively and all cleaning procedures are robust enough to ensure control of infections in the practice.

The practice should :

Review the policy, recording and analysis in relation to comments and complaints.

Review disposal of sharps boxes and security of external waste bins.

Discuss clinical audits fully with relevant staff members.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where improvements should be made.

Entry and exit to and from the reception and waiting areas were designed to accommodate patients with disabilities. There was a clean and tidy waiting area.

Staff we spoke with were trained in and aware of their responsibilities for safeguarding of vulnerable adults and children. There were systems and processes in place to raise concerns and there was a culture of reporting and learning from incidents within the practice.

The practice had suitable arrangements in place for dealing with emergency situations and we saw policies in relation to reacting to any interruption to the service provided.

Vaccines, medicines and prescriptions kept on the premises were stored suitably and securely. There were suitable systems for the receipt, storage, record and administration of vaccines.

Systems were in place for reporting, recording and monitoring significant events.

We were told that the cleaning of the practice was divided between a small company and a self-employed person who came in and cleaned some parts of the building. The practice was not clear if there were any cleaning schedules or colour coded systems.

There were various household cleaning products however there was no evidence of any records relating to Control of Substances Hazardous to Health (COSHH) for them. This is the law that requires employers to control substances that are hazardous to health. A COSHH assessment concentrates on the hazards and risks from substances in the workplace.

We saw a very basic cleaning rota which did not fully specify times scales for cleaning areas and equipment to maintain an appropriate level of cleanliness.

Privacy curtains in consulting rooms were made of fabric the practice manager was unsure of when the curtains had been laundered and there were no records to show whether this had occurred or not.

Clinical waste was removed on a daily basis. When the sharps bins were at recommended capacity they were placed in one of the

rooms. These were stacked in a corner of the room. The full sharps bins were then placed in the bins outside the night before collection. All full clinical waste bags were placed in the clinical waste bin at the side of the building which was locked.

Appropriate checks were made on all staff before they started to work. Staff files were comprehensive and complete.

Are services effective? — Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance was referenced and used routinely. Multidisciplinary working was also evidenced. Patient's needs were assessed and care planned and delivered in line with current legislation which included assessments of a patient's mental capacity. Staff were proactive in promoting good health and referrals were made to other agencies to ensure patients received the treatment they needed in a timely manner. Staff had annual appraisals and told us that their training needs were supported by senior staff.

Are services caring? — Good

The practice is rated as good for caring.

Patients told us that they were well informed about their care and treatment. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

All the patients we spoke with, and the comments we received were complimentary of the care and service staff provided.

Are services responsive to people's needs? — Good

The practice is rated as good for responsive.

The practice understood the needs of their patient population and this was reflected in the practice environment and systems used to meet some of the needs of their patients.

Patients told us they could always get an emergency appointment the same day and waiting time for routine appointments was satisfactory.

The practice obtained and acted on patients' feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

Summary of findings

Are services well-led?	Good

The practice is rated as good for well-led.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received induction, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with greater needs.

The practice also provided care to several care homes. One home was visited on a weekly basis by a GP. The GP regularly attended this home and the patients were well known to the GP, who felt that this made the GP more responsive to their needs. The GP had provided the management staff at the home with their personal mobile number and was happy to be called, even out of hours to deal with issues.

All older patients had a named GP. One of the GPs at the practice had a diploma in geriatric medicine and felt that the practice was well suited and managed the complex needs of the aging population.

The practice also interacted with the voluntary sector, community geriatricians and older patients mental health services.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

Patients in this population group received safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice ran chronic obstructive pulmonary disease, asthma, diabetes and coronary heart disease clinics. The practice scored highly on the Quality and Outcomes Framework consistently and achieved full points in the last financial year. One of the GPs was especially proud of the diabetes service which had won an award from the Health Service Journal for the setting up of the service. All diabetic patients apart from those who were pregnant, had severe kidney disease or ulcers were managed in the practice. All patients were seen by a GP with a special interest in diabetes at least annually.

Summary of findings

Families, children and young people The practice is rated as good for the population group of families, children and young people. The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. They worked with other health and social care providers to provide safe care. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an appropriate way and recognised as individuals. We were provided with good examples of joint working with midwives and health visitors. The practice offered the full, recommended schedule of vaccinations for children. Recent uptake data showed 95.94% of the five year immunisations and 96% for the two year immunisations.	**Good**
Working age people (including those recently retired and students) The practice is rated as good for the population group of working age people (including those recently retired and students). There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this population group. The practice offered a variety of appointments (evening and weekend) and were currently taking part in the extension to extended hours and weekend working. The practice offered late evening surgery for pre booked appointments on Mondays from 6.30pm to 8.30pm. The practice offered online booking for ease of access.	**Good**
People whose circumstances may make them vulnerable The practice is rated as good for the population group whose circumstances may make them vulnerable. There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection. The practice offered annual learning disability checks and were proactive in telephoning the patient to have this done. Regular visits to local care homes with a dedicated GP for continuity of care, which was important for older/vulnerable patients.	**Good**

Summary of findings

The GPs had undertaken training to identify domestic abuse.

The practice promoted awareness of children who were on the child protection register, and had regular discussions and monitored relevant alerts on patient records.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia).

The practice ensured that good quality care was provided for patients with mental health illnesses. The practice had a nominated lead who linked with other health professionals and community teams to ensure a safe, effective and co-ordinated service. The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia. Data showed that this practice was in line with the national average score for dementia diagnosis in older patients.

Patients with mental health problems and learning disabilities had annual reviews. The practice either phoned these patients beforehand or text messaged them to remind them to attend. This had been effective as a recent learning disability annual review had picked up a new case of diabetes.

Summary of findings

What people who use the service say

During our visit we spoke with eight patients and two representatives from the friends of the practice. We reviewed 38 comments cards from patients who had visited the practice in the previous two weeks. The majority of feedback we received was positive. Although there were negative comments relating to the time patients had to wait for appointments to see their chosen GP and that GPs appeared to be rushed in consultations.

Patients were we spoke to were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed, that the appointment system was adequate and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Data showed that the practice was above the national average for the proportion of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP; the GP was good or very good at treating them with care and concern. The practice was also above average for the percentage of patients who described their overall experience of their GP practice's fairly good or very good.

Areas for improvement

Action the service MUST take to improve

Ensure that there are effective operation systems to assess risk and detect and control the spread of health care associated infection. In addition risk assessments related to the Control of Substances Hazardous to Health (COSHH) are carried out effectively.

Action the service SHOULD take to improve

Review the policy, recording and analysis in relation to comments and complaints.

Review disposal of sharps boxes and security of external waste bins.

Ensure that results of clinical audits are always discussed within the practice.

Outstanding practice

The practice had a duty GP each day who answered the phones and was joined by two further GPs between 9.00am and 9:30am. The GPs triaged the calls dealing over the phone, giving general advice, booking urgent appointments or directing patients to the nurse practitioner.

If the calls were such that GPs could not answer them the receptionist would place the patient on a triage list and a GP would call the patient back usually within 30 minutes. The duty GP completed the call backs from 8.00am until 1.00pm. There was a duty GP in the afternoon who was available to triage urgent matters until 6.30pm, after this time the calls were diverted to the out of hour's service.

Portsdown Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP, and a practice manager advisor.

Background to Portsdown Group Practice

Cosham Park Avenue Surgery, Cosham Park Avenue, Portsmouth, Hampshire, PO6 3BG is part of the Portsdown Group Practice. The group practice has been established in the Portsmouth area for many years and operates from five sites covering Portsmouth and the surrounding area. The five surgeries are located in Crookhorn Lane (Waterlooville) to the North, Cosham Park Avenue and Allaway Avenue (Paulsgrove) in the middle, Kingston Crescent, North End and Somers Town, both of which serve the Southern part of the area.

This inspection was conducted at Cosham Park Avenue Surgery only. This practice has a patient list of about 12,000 and is contracted by the Portsmouth area Clinical Commissioning Group under a Personal Medical Services (PMS) contract.

Portsdown Group practice has a total of 23 GPs and four Nurse Practitioners. Each clinician has his or her "home" practice where they are based, which allows the group to give continuity of care wherever possible. Although patients may be offered an appointment at a practice other than their usual practice, the group were confident that the level of care received would be of the same high standard throughout the group practice. All patient records were computerised which meant that the same information was available in each site. The practice rarely relied on locums, instead using their own GPs to cover for sickness and leave where required.

Cosham Park Surgery on the day of our inspection had a total of five partner GPs, three male and two female, and three salaried GPs, one male and two female, working a full time equivalent (FTE) total of 5.67. There were two nurse practitioners with a FTE of 1.24, nine nurses with a FTE of 2.89 and two healthcare assistants with a FTE of 1.

The group offered a variety of extended hours, routine and same day appointments across the five sites which we were told meant that patients were able to see a GP somewhere within the practice group six days per week.

The practice had opted out of out of hour's working and this service was provided by another provider Hampshire Doctors.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. Such as from local NHS England, Healthwatch and the clinical commissioning group. We asked the practice to send us information about them, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 15 January 2015.

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of 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?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice manager monitored governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and systems changes were made where appropriate.

Adverse events and safety issues were discussed and documented regularly each month. All four GPs, nurse, health care assistant and practice manager attended these meetings and we were able to see minutes of recent meetings.

Safety alerts were cascaded to all GPs and relevant members of the primary health care team by the practice manager. These included Medicines and Healthcare Products Regulatory Agency (MHRA) alerts, prescribing guidance, and recall notices. Any medication concerns were dealt with by the prescribing lead GP for the group. The prescribing lead GP worked closely with the clinical commissioning group primary care pharmacist. An example of a recent safety alert around the drug domperidone was discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners' meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points.

The practice significant event analysis file was reviewed. This contained two documented events for the year 2014. These had been dealt with appropriately and minuted in the practice meeting.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in level three training in the subject. The practice was arranging safeguarding vulnerable adult training for staff.

Staff we spoke with were clear about their responsibilities to report any concerns they may have. Staff gave examples of safeguarding, when they would have had concerns and how they would deal with those concerns. Any case of concern was discussed during the clinical meetings. Staff were able to give examples of when they had raised concerns about child safeguarding.

If any child protection concerns were raised on an accident and emergency discharge documentation the practice would contact the health visitor immediately if appropriate to the age of the child, and a GP would see the child that day. A recent example was given when this had occurred and the practice had subsequently made a formal referral to social services that day.

Staff were also aware of the practice "whistleblowing" policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Staff told that this service was offered to patients and but chaperone duties were usually performed by the nurse or healthcare assistant.

Medicines management

We checked medicines stored in the treatment room and medicine refrigerators and found they were stored securely. Practice staff monitored the refrigerator storage temperatures and told us of the actions they would take if the temperatures went outside the recommended ranges.

Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank computer generated prescription forms were stored in accordance with national guidance.

Cleanliness and infection control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of

Are services safe?

infection. We saw an infection control folder with a 2013 risk assessment and were told that the infection control lead for the Portsmouth area had visited the practice within the last 12 months and conducted an audit of infection control. There had been some recommendations made and an action plan was put into place and completed.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with well sited information and clean privacy curtains, sharps boxes and foot operated waste bins. We spoke with one of the nurses who clearly described the procedures in place to maintain a clean and safe working environment.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a good supply of bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was segregation of waste.

We were told that the cleaning of the practice was divided between a small company and a self-employed person who came in and cleaned some parts of the building. The practice was not clear if there were any cleaning schedules or colour coded systems.

There were various household cleaning products with no evidence of any records relating to Control of Substances Hazardous to Health (COSHH) for them. This is the law that requires employers to control substances that are hazardous to health. A COSHH assessment concentrates on the hazards and risks from substances in the workplace.

We saw a very basic cleaning rota which did not fully specify times scales for cleaning areas and equipment to maintain an appropriate level of cleanliness.

Privacy curtains in consulting rooms were made of fabric the practice manager was unsure of when the curtains had been laundered and there were no records to show whether this had occurred or not.

Clinical waste was removed on a daily basis. When the sharps bins were at recommended capacity they were placed in one of the rooms. These were stacked in a corner of the room. The full sharps bins were then placed in the bins outside the night before collection. All full clinical waste bags were placed in the clinical waste bin at the side of the building which was locked.

Equipment

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment by a contactor were seen. Continual risk assessing took place in the different areas of the surgery and we saw evidence of the assessments in the health and safety file. The last health and safety policy review had taken place in January 2015.

Staffing and recruitment

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included appropriate evidence of satisfactory conduct in previous employment, and where required criminal record checks, using the Disclosure and Barring Service.

The staff told us that they had worked at the practice for a number of years. The practice manager and GPs told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave during practice opening hours.

Monitoring safety and responding to risk

The practice conducted regular fire drills to ensure fire safety was high. There was a continual risk assessment of areas of the practice and evidence of the assessments was found in the Health and Safety file.

Fire risk assessments were found. Equipment testing and fire extinguisher testing were up to date. Equipment was checked regularly and when sourcing new equipment, required standards were checked.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurse to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise.

Requires improvement

Are services safe?

We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service.

Staff had taken part in annual emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular weekly meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people. The practice also used local Portsmouth authorised guidelines and reviewed details for the following clinical areas: chest pain, cancer, liver conditions and cardiology.

All new patients were offered new patient checks and NHS checks as appropriate. Chronic disease management appointments were offered, as well as GP appointments when required.

All new patients were seen by the practice nurse. If the patient had complex needs or was on certain specific medicines then they were also seen by a GP. We saw a recent example of a patient who was on warfarin and who needed referral on to the local anticoagulation services.

The practice was actively screening new patients for alcohol related harm. If patients were identified as being high risk they would receive advice and written information from the nurse or would be signposted to the GP. The GP gave an example of a patient who had been seen with erectile dysfunction who was also screened for alcohol problems.

The practice participated in clinical audits. They were currently conducting an audit of blood glucose testing and gliptins following their recent prescribing meeting. Gliptins are a group of medicines effective at lowering blood glucose. The audits were shared and sometimes discussed in the clinical meetings. We were given examples of clinical audits, for example an audit of coeliac disease and an audit of the tele health service. One of the GPs had recently conducted audits of annual tissue transglutaminase antibody (TTG) testing in patients with coeliac disease, selective serotonin reuptake inhibitors (SSRI) prescribing in adolescents and cardiovascular (CV)risk in patients with psoriasis, a skin condition. We saw evidence that these had been performed in the GPs appraisal document but they was no evidence that they had been discussed at practice level.

One GP provided minor surgery services and joint injections. We were told that the GP audited this every six months. The results of these audits were not available on the day of the inspection. The GP contacted the patients one week after the procedure to check that there were no adverse effects and followed them up two to three months later.

We were given data relating to a tonsillitis/sore throat audit. This showed a first and second cycle of data collection, comparisons and actions taken by the practice to a conclusion. We saw similar data and process for a metformin, a medicine use to treat diabetes, audit.

Management, monitoring and improving outcomes for people

The practice managed patients with long-term conditions such as diabetes and asthma and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes.

The practice used the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities and they had a complete register available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.

The practice ran chronic obstructive pulmonary disease, asthma, diabetes and coronary heart disease clinics. The practice scored highly on QOF consistently and achieved full points in the last financial year. One of the GPs was especially proud of the diabetes service which had won an award from a health journal for the setting up of the service. All diabetic patients apart from those who were pregnant, had severe kidney disease or ulcers were managed in the practice. All patients were seen by a GP with a special interest in diabetes at least annually.

There were also three nurses with a special interest in diabetes working across all sites in the group. The practice was able to initiate injectable treatments including insulin

Good

Are services effective?

(for example, treatment is effective)

which meant that patients did not need to travel to the hospital for this. Follow-up was tailored to the patient's need. The practice were auditing their use of gliptins and blood glucose monitoring against the National Institute for Health and Care Excellence (NICE) standards. A GP said that the practice was also following a local clinical commissioning group implemented commissioning for quality and innovation (CQUIN) for care pathways.

Effective staffing

Staff we spoke with all told us that they felt well supported by their colleagues and the GPs. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

All GPs participated in the appraisal and revalidation processes. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

The GPs were aware of mandatory training areas and were up to date with such things as basic life support, child and vulnerable adult safeguarding and Mental Capacity Act training.

The practice took part in joint learning with other Portsmouth practices for all staff (clinical and non-clinical) through monthly training meetings on Wednesday afternoons. Recent topics have been: Fire safety, basic life support and safeguarding.

Working with colleagues and other services

There were primary health care team meetings monthly to discuss complex patients. A GP said that these are attended by a GP, district nurse, Macmillan nurses, a community matron and health visitors. A patient list was circulated to all GPs beforehand so that those unable to attend could feed-in useful information or raise concerns. These meetings were minuted and outcomes were cascaded to non-attending staff. The minutes of these meetings were seen and were in good order. This meeting was especially useful for patients nearing the end of their lives as it allowed for very good co-ordination of their care.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of older patients.

All out of hours (OOH) and accident and emergency correspondence for the preceding 24 hours was looked at every morning by the duty doctor. If follow-up was advised then the patient was contacted that morning. Any general post went to the doctor it was addressed to for action. The practice operated a buddy system to look at each other's results and correspondence when someone was on leave. Any urgent results were put for the attention of the duty doctor. The patient concerned and the result were put on the computerised triage list and a paper copy was also given to ensure it was not missed.

Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding addition information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

The practice lead on information governance explained that staff were given training where confidentiality was discussed. Staff we spoke with were able to explain the training they had received about information sharing. For example when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

A medical secretary was responsible for choose and book referrals and updating care pathways. Summarising of medical records was carried out by designated administration staff who followed a protocol.

When required information was shared in a responsible and comprehensive way. For example such as care plans for vulnerable patients were shared with ambulance and out of hour's services.

Good

Are services effective?

(for example, treatment is effective)

The practice uses a computer system which is shared with the out of hour's provider. The practice faxed over any information that the out of hour's provider needed if they considered that the service needed to be aware of any clinical issues. This included end of life care plans for terminally ill patients. The practice were involved in a virtual ward service which helped to coordinate the care of complex patients in the community.

Consent to care and treatment

The practice nurses demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and a patient we spoke with confirmed that they understood about giving consent and did not feel pressured into agreeing to treatment.

Young people were able to access the practice and have their confidentiality maintained. GPs told us that there were no age barriers. They would make an assessment based on Gillick competency test- used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions

The nurse practitioner was aware of the issues surrounding consent including Gillick competence and gave an example of these issues prior to her nurse practitioner role when she had given immunisations to unaccompanied adolescents.

A GP said that they obtained written consent when performing minor surgery and joint injections. GPs said that they had a number patients with dementia in whom the mental capacity act was relevant, they were aware of the deprivation of liberty safeguarding (DOLs) provisions and that patients needed to be referred to the coroner if they died whilst under a DOLs order. We were given an example of a patient with dementia who had been driving. In this situation a successful outcome was achieved through careful support and interagency working.

When the GP or the nurses deemed the patient did not have capacity to consent then they discussed the matter with the next of kin, carer as well as fellow professionals.

Health promotion and prevention

The practice ensured that where applicable people received appropriate support and advice for health promotion. Information available to patients was effective we saw notices relevant to the demographics of the patients. An example seen was leaflets signposting young people to sexual health services outside the local community.

The practice website gave details of clinics and advice available, for example family planning, healthy living and smoking cessation and support. The website also had links to NHS information videos such as infections and viruses, first aid and information for older patients.

The practice website and waiting areas had information on health promotion and self-management of conditions. Such as, sexual health, heart disease sign and symptoms and advice on coughs and colds.

Patients with mental health problems and learning disabilities had annual reviews. The practice either phoned these patients beforehand or text messaged them to remind them to attend.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients told us that they were always treated with dignity and respect and that their privacy was always a priority. One patient told us that they had been a patient at the practice for several years and had seen many changes for the better. The patient said that the staff were always polite and that the GPs listened to them and treated them with respect and compassion.

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly to the waiting areas. The practice had set aside an area for patients to use if they required further privacy to discuss any matter.

Phone calls were answered professionally and with a friendly greeting, confidentiality was maintained as at no time did we hear mentioned names or diagnosis or treatment. The incoming calls were answered in a secure area away from the main reception and this ensured confidentiality.

The practice communicated with the Out of Hours service and made them aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

The patients we spoke with and the comment cards completed were in the majority complimentary of the staff at the practice and the service received. Although there were negative comments relating to the time patients had to wait for appointments to see their chosen GP and that some GPs appeared to be rushed in consultations.

Patients told us that they felt listened to and involved in the decisions about the care and treatment. Patients expressed their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment. Patients told us that the GPs took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

Patients who were receiving end of life or palliative care were discussed at monthly meetings, which involved other health professionals such as district nurses.

In the practice waiting room there were posters on the wall signposting patients to a variety of support organisations. GPs said that they used web information sheets and signposting to local services in order to offer patient and carer support.

The practice website signposted patients to health advice and support groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice provided care to several care homes. One in particular was visited on a weekly basis by a GP.

Patients with mental health problems and learning disabilities had annual reviews. The practice either phoned these patients beforehand or text messaged them to remind them to attend. This had been effective as a recent learning disability annual review had picked up a new case of diabetes.

The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia.

There was an appropriate system of receiving and responding to concerns and feedback from patients who found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs of this population group.

The practice obtained and acted on patients' feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care. Some of the changes that the practice had agreed to make as a result of the patient requests and surveys included, a change to the contact telephone number of the practice to make it easier for patients to make contact, and changes to the times blood tests results could be obtained.

Tackling inequity and promoting equality

There was wheelchair access to the practice with a lowered door bell and wide front door. There was access to all the ground floor rooms. The practice did not have a lift to the upstairs consulting room, but if the patient mentioned to the receptionist that they were unable to manage the stairs, every effort was made to accommodate the patient on the ground floor.

The practice had a hearing loop installed in reception for the hard of hearing.

Staff told us that there was some diversity of ethnicity within their patient population. They were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Appointments were made by telephoning the surgery or by calling into the surgery. Routine appointments could be made in advance up to a maximum of one month.

Patients could also make an appointment up to four weeks in advance online. Patients had to register in order to use this service and the practice was finding that this was becoming an increasingly popular method of making appointments.

Patients that had a genuinely urgent medical problem that needed attention on the same day, were asked to explain this to the receptionist and the patient would be seen that same day. This was confirmed by patients we spoke with who told us that they had phoned the practice that morning spoken to the duty GP on the phone and had been called in to see a nurse practitioner or GP.

The practice had a duty GP each day who answered the phones and was joined by two further GPs between 9.00am and 9:30am. The GPs triaged the calls dealing over the phone, giving general advice, booking urgent appointments or directing patients to the nurse practitioner.

If the calls were such that GPs could not answer them the receptionist would place the patient on a triage list and a GP would call the patient back usually within 30 minutes. The duty GP completed the call backs from 8.00am until 1.00pm. There was a duty GP in the afternoon who was available to triage urgent matters until 6.30pm, after this time the calls were diverted to the out of hour's service.

The practice offered an early morning surgery from 7.00am to 8.00am on Fridays and a late evening surgery on Mondays between 6.30pm and 8.30pm for pre booked appointments with a GP. The Portsdown group offered Saturday appointments between 8.00am and 2.00pm alternating between the Kingston practice and Cosham practice.

Patients could contact the practice from 8.00am until 5.30pm to make routine appointments or until 6.30 pm for urgent calls to speak with the duty GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

If a GP thought that the patient was too unwell to visit the practice, a GP would visit the patient at home.

The practice was closed on a Wednesday afternoon each month for training and on these occasions patients were directed to the out of hour's service.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handles all complaints in the practice. We were told that complaints were discussed at the monthly practice/organisational meeting. One of the GPs was previously the lead GP for complaint management however, due to forthcoming retirement this role has passed to another GP. The lead GP said that in addition to answering the complaint it was practice to write to each GP involved to highlight learning points from the case for future learning. The example documentation seen was from 2011, which was prior to when GPs had to register with the Care Quality Commission. When minutes from recent practice meetings in the past 12 months were examined, they contained no evidence of any discussion of complaints. The practice manager and business partner stated that there was no formal discussion of complaints and that this was done in house on an informal basis.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed.

Patients were informed of the procedures of how to make comments and complaints on the practice website. We saw a comments and complaints box located in the waiting area and notices displayed for patients' information.

Patients told us that they felt that they were able to make comments and complaints if required but those patients we spoke to told us that they had not needed to make any comments or complaints.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and strategy

The practice had a clear vision to place patients' needs at the heart of everything it did. Observing and speaking with staff and patients we found the practice demonstrated a commitment to compassion, dignity, respect and equality. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice and all the GPs met regularly to support each other and discuss the care of patients.

Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at governance meetings and action plans were produced to maintain or improve outcomes.

We saw good working relationships amongst staff and an ethos of team working. Partner GPs, Nurse practitioners and the practice nurses had areas of responsibility, such as, prescribing procedures or safeguarding, it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice had a system in place for completing clinical audit cycles. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance.

Leadership, openness and transparency

The GPs and practice manager told us that they advocated and encouraged an open and transparent approach in managing the practice and leading the staff teams. The GPs promoted shared responsibility in the working arrangements and commitment to the practice. For example, the individual areas of responsibility included dermatology, clinical commissioning, safeguarding and hospital admissions.

Staff we spoke with told us that they felt there was an open door culture, that the GPs and acting practice manager were visible and approachable. They also said that there was a good sense of team work within the practice and communication worked well. The patient satisfaction survey further illustrated the practice ethos of a caring and quality service provided for patients.

There was an open culture among colleagues in which they talked daily and sought each other's advice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice had gathered feedback from patients through: patient surveys and comment cards

The practice had an active patient feedback group called 'The Friends of Portsdown Group Practice' which was started in April 2005. The group concentrated on running charity events to raise money for the practice; and to date they had raised in excess of £75,000. The money raised was used to purchase additional equipment which benefited patients. To date some of the equipment purchased included four portable ECG machines; four 24 hr. BP Monitors; four pieces of spirometry equipment (used to assess patients with respiratory problems) numerous sets of weighing scales.

The practice signed up to the Patient Reference Group Enhanced Service in 2011 to encourage good communication with its patients and to find ways to improve the services it provided.

The Patient Reference group was now in its fourth year of existence and continued to work towards its original purpose of ensuring that patients were involved in decisions about the range and quality of services provided by their practice.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

The group practice had worked with a patient group to produce a practice survey for the wider practice population. A patient survey had been undertaken in early 2014 and steps taken towards completion of the identified action. The patient survey undertaken earlier in the year showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit. Some of the changes that the practice had agreed to make as a result of the patient requests and surveys included, a change to the contact telephone number of the practice to make it easier for patients to make contact, and changes to the times blood tests results can be obtained. Patients can now phone at any time.

The practice had a patient reference group and friends of the practice group and the practice worked with them to help improve the care services. Patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning and improvement

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly. The practice acted on feedback from patients, the public and staff.

The partners had taken up a suggestion from receptionist to undertake their triage calls in the administration area as a “call centre” style environment. This shows that the partners were receptive to staff ideas and involved them in decision making and the vision for the practice in the future. The practice had regular “away days” and staff barbecues to improve team working and morale.

The senior partner and registered manager both said that the practice had a culture of innovation demonstrated through its commitment to clinical research in the community. They said that the practice was involved with and lead on a number of innovation research studies including tele health for patients with COPD. The culture of innovation was also demonstrated by the practices ability to perform diagnostic ultrasound in-house. This was able to be delivered because of the leadership and culture of the practice.

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 were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Regulation 15(1)(a) and 15(2) Health & Social Care Act 2008.(Regulated Activities)Regulations 2014 (part3) How the regulation was not being met: There were various cleaning products however there was no evidence of any records relating to Control of Substances Hazardous to Health (COSHH) for them. This meant that the cleaning procedures were not robust enough. This is the law that requires employers to control substances that are hazardous to health. A COSHH assessment concentrates on the hazards and risks from substances in the workplace. The regulation. • Premises and equipment must be kept clean and cleaning must be done in line with current legislation and guidance. • Premises and equipment should be visibly clean and free from odours that are offensive or unpleasant. • Providers should: Use appropriate cleaning methods and agents. Operate a cleaning schedule appropriate to the care and treatment being delivered from the premises or by the equipment. Monitor the level of cleanliness. Take action without delay when any shortfalls are identified. Make sure that staff with responsibility for cleaning have appropriate training.

This section is primarily information for the provider

Requirement notices

• Domestic, clinical and hazardous waste and materials must be managed in line with current legislation and guidance.