Care Quality Commission

Inspection Evidence Table

ADELAIDE GP SURGERY (Y02838)

Inspection date: 16 – 17 Oct 2018

Date of data download: 04 October 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Please Note: CQC was not able to automatically match data for this location to our own internal records. Data is for the ODS code noted above has been used to populate this Evidence Table. Sources are noted for each data item.

Safe

Safety systems and processes

Safeguarding	Y/N
There was a lead member of staff for safeguarding processes and procedures.	Y
Safety and safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Policies were in place covering adult and child safeguarding.	Y
Policies were updated and reviewed and accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example level three for GPs, including locum GPs)	Y
Information about patients at risk was shared with other agencies in a timely way.	Y
Systems were in place to highlight vulnerable patients on record. There was a risk register of specific patients	Y
Disclosure and Barring Service checks were undertaken where required	Y

Recruitment Systems	Y/N
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff who require medical indemnity insurance had it in place	Y
Explanation of any answers:	

We saw evidence which confirmed appropriate recruitment systems were in place. An occupational health department of the host Trust provided support.

Regular checks were made with NMC and GMC registrations. Managers had systems in place which reminded them to ensure checks were made.

Safety Records	Y/N
There was a record of portable appliance testing or visual inspection by a competent person Date of last inspection/Test:	Y OCT 2018
There was a record of equipment calibration Date of last calibration:	Y FEB 2018
Risk assessments were in place for any storage of hazardous substances e.g. liquid nitrogen, storage of chemicals	N/A
Fire procedure in place	Y
Fire extinguisher checks	Y
Fire drills and logs	Y
Fire alarm checks	Y
Fire training for staff	Y
Fire marshals	Y
Fire risk assessment Date of completion	Y JAN 2018
Actions were identified and completed.	Y
Additional observations: Portswood branch had acted upon two out of three of the management recommendations arising from a September 2016 fire risk assessment. The incomplete action was to have written fire instructions at the branch on action to take in the event of a fire. For example, check rooms, evacuate, contact fire service, muster at an assembly point. The provider was able to supply written fire instructions after the inspection. Hazard warning signage had been put in place at all locations, for example for oxygen cylinders.	
Health and safety	Y (N at Portswood

Premises/security risk assessment? Date of last assessment:	) JAN 2018
Health and safety risk assessment and actions Date of last assessment:	Y (N at Portswood) Weekly risk assessments
Additional comments: NHS Facilities Management team provided services for the Adelaide Health Centre. This included premises risk assessments. We saw that twice weekly legionella checks had been completed. Professional contractors provided a similar service at Nicholstown branch and the homeless healthcare branch. Portswood branch was unable to provide evidence of a health and safety risk assessment of the premises. For example, we did not see checks on trailing cables, unsafe doors or windows, trip hazards. After the inspection the provider confirmed that assessments had been completed for the Portswood branch.	

Infection control	**Y/N**
Risk assessment and policy in place Date of last infection control audit: The practice acted on any issues identified Detail: Staff had been trained to contact the Solent NHS Trust infection prevention control (IPC) team for advice when purchasing any new equipment to ensure best practice was adhered to when cleaning it or using it. A new type of needle had been issued by NHSE this year for flu vaccinations. Practice staff had checked with their IPC team on the safe use of this new equipment. At the Portswood branch the infection prevention control audit had identified the need to clean the hand gel dispensers as they had become clogged. This had been completed.	Y SEPT 2018
The arrangements for managing waste and clinical specimens kept people safe?	Y
Explanation of any answers: A professional contractor provided waste disposal services to each location. We saw that	

appropriate clinical waste arrangements were in place. External clinical waste bins were locked and stored securely.

Professional contractors provided cleaning services to each location. We found each premise to be clean and tidy. Cleaning schedules were in place which had been dated and signed by cleaning staff. We found locked cleaning cupboards organised in line with best practice from COSSH (control of substances hazardous to health) with colour codes for different areas of the practice.

Any additional evidence
Hand hygiene audits had been completed bi annually, in May and August 2018. Staff had achieved 100%. All locations had appropriate hand washing facilities.

Risks to patients

Question	Y/N
There was an effective approach to managing staff absences and busy periods.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans were developed in line with national guidance.	Y
Staff knew how to respond to emergency situations.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
In addition, there was a process in the practice for urgent clinician review of such patients.	Y
The practice had equipment available to enable assessment of patients with presumed sepsis.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y

Explanation of any answers:

Computer based templates on the practice intranet system provided staff with clear guidance on sepsis.

Business continuity plans had been reviewed in April 2017 and were next due for review in April 2020. Paper copies were available at each location, together with electronic copies.

Information to deliver safe care and treatment

Question	Y/N
Individual care records, including clinical data, were written and managed in line with current guidance and relevant legislation.	Y

Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
The practice had a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers:

A follow up system was in place which checked referrals had been actioned and their status. A dedicated back office reviewed the status of all referrals on a weekly basis and took appropriate action.

Appropriate and safe use of medicines

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) NHS Business Service Authority - NHSBSA)	-	0.82	-	No comparison available
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/07/2017 to 30/06/2018) (NHSBSA)	-	9.8%	-	No comparison available

Medicines Management	Y/N
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
Prescriptions (pads and computer prescription paper) were kept securely and monitored.	Y
There was a process for the management of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Y
The practice monitored the prescribing of controlled drugs. (For example audits for unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were systems for the safe ordering, checks on receipt, storage, administration, balance checks and disposal of these medicines in line with national guidance.	N/A
Up to date local prescribing guidelines were in use.	Y
Clinical staff were able to access a local microbiologist for advice.	Y
For remote or online prescribing there were effective protocols in place for identifying and verifying the patient in line with General Medical Council guidance.	Y
The practice held appropriate emergency medicines and risk assessments were in place to determine the range of medicines held.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen on site.	Y
The practice had a defibrillator.	Y

Both were checked regularly and this was recorded.	Y
Medicines that required refrigeration were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective in use.	Y

Explanation of any answers:

There were four resuscitation and emergency equipment bags located at the Adelaide practice. We found these were organised in a colour coded system which was easy to follow. Clear pouches containing relevant equipment and emergency medicines had a colour coded surround with clear text labels. For example, items required to treat a cardiac arrest were in a green pouch, items required for breathing difficulties were in a blue pouch. This made it easier for clinical staff to treat patients during a fast-paced emergency.

Each site had an emergency bag available which was identical in appearance and content to the bags at Adelaide health centre. Staff showed us the online checks they completed to verify the contents each week and how expired emergency medicines or equipment was replenished.

Track record on safety and lessons learned and improvements made

Significant events	Y/N
There was a system for recording and acting on significant events	Y
Staff understood how to report incidents both internally and externally	Y
There was evidence of learning and dissemination of information	Y
Number of events recorded in last 12 months.	84
Number of events that required action	84

The practice benefits from the Risk and Incident Management system (Ulysses) of Solent NHS Trust. Staff report all level of incidents via this system which provides increased visibility and granularity for professional lead and the Trust in relation to incident management, tracking and the feedback loop. Each incident is reviewed and this is recorded on the Ulysses system. Incidents where a change in process or learning is identified are then discussed at practice meetings, for actions and learning to be disseminated.

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

Event	Specific action taken
A child was seen by an Advanced Nurse Practitioner with a cough and sore throat. The child was discharged. The child's parent called an ambulance and the child was admitted to the paediatrics ward, for asthma. Their condition became worse and they were admitted to the high dependency unit, staying in hospital for a week in total. The parent complained as they felt their child was barely looked at.	The practice investigated this matter. The Advanced Nurse Practitioner reflected on their care and treatment and notes were reviewed. A new protocol was introduced regarding treatment of potential asthma and breathing difficulties and their escalation. The practice manager spoke with the complainant who was satisfied with the outcome.
A patient was admitted to Southampton General Hospital with acute appendicitis. The patient had spoken to an Advanced Nurse Practitioner twice in the previous week. They had refused to attend the practice for an appointment instead insisting they required a home visit.	The practice investigated this. They found that the patient had contacted the practice on two occasions with intermittent abdominal pain. The patient was telephone triaged on both occasions. The patient was admitted to hospital with ongoing abdominal pain, which required surgery. It transpired that the patient had a perforated appendix. The practice reviewed its protocol about home visits and the triaging of abdominal pain.
A complaint was made by a patient whose name had been confused with another patient with an identical name. A member of staff had selected the wrong patient on the computer as both patients also had the same dates of birth. The error was not identified immediately.	The practice investigated this and found two patients with identical names and dates of birth. Only the addresses were different. One patient's notes had been transferred to the wrong practice as a result of this confusion. The practice contacted both patients to inform them of the error. GP surgery realised the mistake and subsequently contacted Adelaide Surgery to advise. There was no harm to either patient as a result of this error. The patients were satisfied with the outcome.

Safety Alerts	Y/N
There was a system for recording and acting on safety alerts	Y
Staff understand how to deal with alerts	Y

Comments on systems in place:

The practice had a dedicated risk team based at Solent NHS Trust Headquarters in Highpoint, Thornhill. The risk team was responsible for receiving, collating and disseminating the alerts including those received from MHRA (Medicines and Health Regulatory Authority). Managers at the practice showed us an example of a recent alert received regarding the use of a machine to monitor blood clotting and how to correctly interpret readings from it.

Any additional evidence

Effective

Effective needs assessment, care and treatment

Prescribing				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2017 to 30/06/2018) (NHSBSA)	-	0.78	-	No comparison available

People with long-term conditions

Diabetes Indicators				
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	63.2%	74.9%	79.5%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	20.9% (33)	16.0%	12.4%	
Indicator	**Practice performance**	**CCG average**	**England average**	**England comparison**
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF)	83.1%	75.9%	78.1%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	10.1% (16)	11.0%	9.3%	

Indicator	Practice performance	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF)	72.1%	80.1%	80.1%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	13.9% (22)	13.3%	13.3%	

Other long term conditions				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2016 to 31/03/2017) (QOF)	79.4%	74.2%	76.4%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	1.8% (5)	10.2%	7.7%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	92.5%	85.0%	90.4%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	9.5% (7)	10.7%	11.4%	

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2016 to 31/03/2017) (QOF)	78.6%	80.6%	83.4%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	3.0% (9)	4.2%	4.0%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2016 to 31/03/2017) (QOF)	94.4%	89.5%	88.4%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	5.3% (1)	9.2%	8.2%	

Any additional evidence or comments

The practice was able to supply Quality Outcome Framework results for 2017-2018 which showed that; the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months figures were was 85% with an exception rate of 10.53% which was below the CCG and national average. This showed an improvement in the previous years figures.

Families, children and young people

Child Immunisation				
Indicator	**Numerator**	**Denominator**	**Practice %**	**Comparison to WHO target**
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (to) NHS England)England)	94	96	97.9%	Met 95% WHO based target
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (to) (NHS England)England)	80	86	93.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (to) (NHS England)England)	80	86	93.0%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (to) (NHS England)	80	86	93.0%	Met 90% minimum (no variation)
Any additional evidence or comments				

Working age people (including those recently retired and students)

Cancer Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	-	67.8%	-	No comparison available
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) **(PHE)**	-	69.4%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)**(PHE)**	-	54.5%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. **(PHE)**	40.0%	65.8%	71.2%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	64.7%	52.2%	51.6%	No comparison available

Any additional evidence or comments: The practice was able to supply figures for 2017-2018 which showed that the percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64**)** was 85% which was above the required national target of 80%.

The practice had identified that screening was an area for improvement and had implemented a programme to improve the uptake of national cancer screening. For example, they had sent out letters to patients who had not attended breast screening or responded to the bowel screening invitation. This was to increase awareness of the importance of the screening and early diagnosis.

People experiencing poor mental health (including people with dementia)

Mental Health Indicators				
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	90.0%	90.9%	90.3%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	21.1% (8)	12.6%	12.5%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	94.4%	91.3%	90.7%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	5.3% (2)	13.6%	10.3%	
Indicator	**Practice**	**CCG average**	**England average**	**England comparison**
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	100.0%	84.9%	83.7%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	25.0% (1)	7.5%	6.8%	
Any additional evidence or comments The practice was able to supply Quality Outcome Framework results for 2017-2018 which showed that; The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months was 100% with an exception rate of 3.28% with 98 patients recorded on the dementia register.				

Monitoring care and treatment

Indicator	Practice	CCG	England

		average	average
Overall QOF score (out of maximum 559)	531	Data Unavailable	539
Overall QOF exception reporting	6.5%	Data Unavailable	5.7%

Coordinating care and treatment

Indicator	Y/N
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2016 to 31/03/2017) (QOF)	Y

Helping patients to live healthier lives

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF)	95.7%	93.9%	95.3%	No comparison available
QOF Exceptions	**Practice Exception rate (number of exceptions)**	**CCG Exception rate**	**England Exception rate**	
	1.4% (9)	0.8%	0.8%	

Consent to care and treatment

Description of how the practice monitors that consent is sought appropriately
E consult patient's consents are obtained as they send in a request for GP assistance. Consent forms were seen for minor surgery, injections and long-acting reversible contraceptives all were appropriately completed, logged and regularly audited.

Any additional evidence

Caring

Kindness, respect and compassion

CQC comments cards	
Total comments cards received	12
Number of CQC comments received which were positive about the service	7
Number of comments cards received which were mixed about the service	5
Number of CQC comments received which were negative about the service	0

Examples of feedback received:

Source	Feedback
For example, comments cards, NHS Choices	We received 12 CQC comment cards at Adelaide Health Centre. Seven of these were positive and five provided mixed reviews about the practice. The positive comments described a well led and caring service with friendly approachable and professional staff. The mixed reviews stated they were pleased with the service but on occasion reported that they had to wait longer than expected for an appointment in the waiting room, or wait to obtain an appointment date on the telephone. We received five CQC comment cards at the Portswood branch. All five were positive about the care and treatment received at the practice. Again, there were some negative comments about the time it took to obtain an appointment. We received two CQC comment cards at Nicholstown branch. One of these was positive about the care received but both were negative about the time it took to obtain an appointment. We received 0 CQC comment cards had been provided to the homeless healthcare Team.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology has changed in 2018. This means that we cannot be sure whether the change in scores was due to the change in methodology, or was due to a genuine change in patient experience.

Practice	Surveys sent out	Surveys	Survey	% of practice

population size		returned	Response rate%	population
			%	

Indicator	Practice	CCG average	England average	England comparison
Any additional evidence or comments				

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

Date of exercise	Summary of results
Between June and October 2018. Carried out by Healthwatch Southampton.	A full report of the survey was completed by Health watch Southampton. A total of 62 patients were surveyed at Adelaide Health Centre. The majority of patients gave positive comments that the practice was clean, efficient and helpful with friendly staff. There were good opening hours. Negative comments were that some patients found the receptionists to be rude and that there were delays in getting appointments. The practice was responding to this feedback by extra training for staff and brining in a call centre to deal with appointments more efficiently.

Any additional evidence

Involvement in decisions about care and treatment

Examples of feedback received:

Source	Feedback
Interviews with patients.	During the inspection we spoke with six patients at the Adelaide Health Centre and Portswood branch. These said that their GP or nurse involved them in decisions about their care and that they were pleased with the service. There were some negative responses regarding booking appointments and the time that it took to get through on the phone. Patients told us that they had to wait a month to get a routine appointment and longer if they wanted to see a GP of choice. There were no patients available to speak with at Nicholstown branch.

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
Any additional evidence or comments				

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

Carers	Narrative
Percentage and number of carers identified	269 patients had been identified as carers out of a patient population of 17,700. This represented 1.5%.
How the practice supports carers	The practice provided a carer's information pack, annual health checks for carers, signposting to relevant support services such as respite care.
How the practice supports recently bereaved patients	The practice GP contacted the family of bereaved patients and arranged a face to face meeting according to their wishes. Appropriate support was offered and signposting to relevant services. The practice sent out a bereavement card with details of relevant services and updated practice staff of the bereavement.

Any additional evidence

Privacy and dignity

Question	Y/N
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y

	Narrative
Arrangements to ensure confidentiality at the reception desk	The reception desk at Adelaide Health Centre was set back from the waiting area, which was a very large spacious seating area. Signs indicated that a private room could be made available if patients wished to do so. The reception desk at the Portswood branch had a glass screen with a speaking hatch for patients. Signs indicated that a private room could be made available if patients wished to do so. The reception desk at the Nicholstown branch had a glass screen and was set back from the waiting area. We saw a patient utilising the wheelchair level reception desk area which facilitated communication. Patients told us they were aware they could request a private room if necessary.

Question	Y/N
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y

Examples of specific feedback received:

Source	Feedback
Patient interviews	We spoke with four patients at Adelaide Health Centre all of whom told us they were treated with privacy and dignity. Patients described courtesy and compassion by the staff. Patients at the Portswood branch told us that the staff were caring and treated them with dignity and respect. Treatment was good and patients were listened to by staff.

Responsive

Responding to and meeting people's needs

Practice Opening Times - Adelaide	
Day	**Time**
Monday	0800 - 2000
Tuesday	0800 - 2000
Wednesday	0800 - 2000
Thursday	0800 - 2000
Friday	0800 - 2000
Saturday	0800 - 2000
Sunday	0800 - 2000

Practice Opening Times – Nicholstown and Portswood	
Day	**Time**
Monday	0800 – 1830
Tuesday	0800 – 1830
Wednesday	0800 – 1830
Thursday	0800 – 1830
Friday	0800 – 1830

GP appointments were available between 0900 – 1200 and 1400 – 1700 (until 1900 at Adelaide)
Adelaide Health Centre provided the hours shown as part of their contractual arrangements and not as part of an extended hours contract. Outside of these hours patients were advised to ring the NHS 111 service. The other branches were open between Monday to Friday for appointments between 8.30am to 6pm.

Home visits	Y/N
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention	Y
If yes, describe how this was done	
A triage process was completed by a duty team present at each of the three locations. Each of the three duty teams consisted of one GP and one advanced nurse practitioner.	

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
Not available			%	Not available

Indicator	Practice	CCG average	England average	England comparison

Any additional evidence or comments:
The practice was aware that 57% of patients found it easy to get through to the practice on the telephone. They were aware that there had been a number of “silent calls” that meant that sometimes these interfered with patients making proper calls to the practice. The practice was working with their technical teams to address this.

52% are satisfied with the general practice appointment times available. Local (CCG) average: 62%National average: 66%.

The practice was aware of these figures and had brought in a centralised call centre to improve appointments. We were told by the practice and numbers of complaints in this area had dropped and patient feedback was improving.

Timely access to the service

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison

Any additional evidence or comments:

Data for this practice was difficult to obtain as the 2018 patient survey results were reported under Solent GP Surgery and not the registered location name. The overall results were positive for example, 88% of respondents say the healthcare professional they saw or spoke to was good at giving them enough time during their last general practice appointment. Local (CCG) average: 83%National average: 87%.

85% of respondents say the healthcare professional they saw or spoke to was good at treating them with care and concern during their last general practice appointment. Local (CCG) average: 84%, National average: 87%.

Examples of feedback received from patients:

Source	Feedback
For example, NHS Choices	NHS Choices results showed that in the Family and Friends test 98% of patients would recommend this practice. Reviews placed on the NHS Choices were mixed but included other NHS services located at the practice. Patients reviewing the GP practice were generally happy with care.

Listening and learning from complaints received

Complaints	Y/N
Number of complaints received in the last year.	11
Number of complaints we examined	11
Number of complaints we examined that were satisfactorily handled in a timely way	11
Number of complaints referred to the Parliamentary and Health Service Ombudsman	0
Additional comments:	

Example of how quality has improved in response to complaints
A complaint was made following a DVLA request about a patient's fitness to drive a motor vehicle. A delay had arisen which meant that the patient received the decision from the DVLA before the patient's GP could discuss their findings with them. The practice investigated this and reviewed their protocol. The matter was discussed with the patient who was satisfied with the outcome. The protocol speeded up the process of handling DVLA requests and provided patients with an opportunity to discuss their GP's findings with them prior to receiving the DVLA's decision.

Any additional evidence
Solent GP surgery had the Special Allocation Service (SAS) contract for Southampton, which operated from the Nicholstown branch and had a very challenging patient cohort. The theme from this group of incidents was in relation to verbal abuse directed towards staff. There was a process for staff to follow if they felt unsafe, which enabled support from security and if appropriate the police. The practice had provided training to staff in managing challenging behaviour. This had been a topic at an internal training day in September 2018.

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice
The practice produced a CQC News bulletin and we saw that the 5th Edition provided a message from the Chief Executive, thanking staff for their involvement in the CQC inspection and supporting staff. The bulletin also talked about duty of Candour, being open and honest. The bulletin also promoted the staff to be open and honest and to share any areas of concern under the freedom to speak up supported by guardians.

Any additional evidence

Vision and strategy

Practice Vision and values
There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities. Staff were aware of and understood the vision, values and strategy and their role in achieving them. The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care
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. Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

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

Source	Feedback
Member of Staff	High turnover of staff which places pressure on those staff left working. Everybody is friendly and work together to get the work done.
Member of Staff	Management are open and listen to staff. They then try to sort out things. We now have a call centre which has taken some of the work load away. There are now less complaints regarding the telephones.

Any additional evidence

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.	
Practice specific policies	Chaperone Policy and Safeguarding Policy. Practice staff had access to a safeguarding team employed by Solent NHS Trust for advice and guidance. The practice also had a dedicated member of staff responsible for maintaining an up to date list of safeguarded children and vulnerable adults. Practice policy was to complete a Disclosure and Barring Service (DBS) check for every member of staff, and an enhanced DBS check for clinical staff. This was in line with best practice. Clinical staff acted as chaperones and had been trained for their role.
Other examples	

	Y/N
Staff were able to describe the governance arrangements	Y
Staff were clear on their roles and responsibilities	Y

Any additional evidence

Managing risks, issues and performance

Major incident planning	Y/N
Major incident plan in place	Y
Staff trained in preparation for major incident	Y

Examples of actions taken to address risks identified within the practice

Risk	Example of risk management activities
Infection Control	Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. The practice had a lead nurse for infection prevention control who provided support to all their locations. We saw evidence of infection prevention control audits at each location. Identified actions had been completed. For example, at the Nicholstown branch work was in progress on the day of the inspection to box off some exposed pipework underneath sinks in treatment rooms. This reduced the potential risk to patients of infection from dirt gathering amongst these pipes, or the risk of scalding.

Any additional evidence
We identified potential risks at the Portswood branch due to the absence of written fire instructions and a health and safety risk assessment for the premises. The provider has since confirmed that

Health and Safety assessments and written fire instructions have been completed for the Portswood branch.

Appropriate and accurate information

Question	Y/N
Staff whose responsibilities include making statutory notifications understood what this entails.	Y

Any additional evidence

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

Feedback
The Patient Participation Group for the Adelaide practice had had a combined first meeting with representatives from each site and 33 people attended on 11 October 2018. We saw that a newsletter had been completed and circulated. The covered areas such as the new call centre, the feedback of frustrations of patients around the telephone system and time taken to answer them this was being addressed. We were able to speak with five members of the group. They generally were happy with the practice and the way it was being led. Complaints were listened to by the practice and responded to in a timely manner. Electronic prescriptions were an example of change. Previously patients had to collect the prescription from the practice, take it to pharmacy and wait for it to be made up. With the new system the prescription is sent to the pharmacy and patients receive a text message to tell the it is ready for collection. There were a few teething problems but these appear to have been sorted and the system is much quicker. The group told us that they wanted to do more to help and felt that the meeting held in the community was less intimidating and informal which helped them feel at ease. The group were concerned that the Nicholstown minority communities may be under represented in the group.

Any additional evidence

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

Audit area	Improvement
Audit of Cervical Smears	There were 27 inadequate smears out of a total of 514 taken. The cytology laboratory advised that the lubricant being used was likely to be the cause of the inadequate smears. The lubricant now being used was compatible, only a small amount was being used and a repeat search was being made at the end of year to review progress.

Metformin and renal function	The aim of the audit was to identify how many patients at the Portswood branch were being prescribed Metformin safely and how to reduce the risk of acute kidney injury. October 2016 – 96% patients with a glomerular filtration rate >45 on metformin. April 2017, – 98% patients with a glomerular filtration rate >45 on metformin. No patients prescribed metformin with a glomerular filtration rate <30 An Acute Kidney injury template was set up on the practice computer system and patients recalled and information leaflet for patients.

Any additional evidence

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as comparable, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as comparable to other practices.

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

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	Z ≤-3
2	Variation (positive)	-3 < Z ≤ -2
3	Comparable to other practices	-2 < Z < 2
4	Variation (negative)	2 ≤ Z < 3
5	Significant variation (negative)	Z ≥3
6	No data	Null

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link: http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices

Glossary of terms used in the data.

- **COPD**: Chronic Obstructive Pulmonary Disease
- **PHE**: Public Health England
- **QOF**: Quality and Outcomes Framework (see https://qof.digital.nhs.uk/).
- **RCP**: Royal College of Physicians.
- **STAR-PU**: Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.(See NHS Choices for more details).