Care Quality Commission

Inspection Evidence Table

Portsdown Group Practice (1-537930417)

Inspection date: 20 January 2020

Date of data download: 02 January 2020

Overall rating: Good

The overall rating of good has stayed the same. At our last inspection on 4-5 December 2018 we rated the service as good overall but requires improvement for safe. We identified areas the provider must improve at the practice.

At this inspection in January 2020, we found the practice had made improvements in these areas and we rated safe as good.
We carried over the good ratings for the four other key questions.

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

Safe Rating: Good

We rated safe as requires improvement because although the practice had made improvements in the areas identified at the previous inspection in December 2018, we found there were gaps in systems for supporting patients prescribed high risk medicines.

The practice had a range of safety systems and processes in place to develop a strong safety culture. The practice had implemented a rota system which meant that health care assistants (HCAs) were not at risk of working at a site without a trained clinician on site. In addition, the practice had addressed areas identified at the last inspection that should have been improved, relating to medicines, prescription management, clinical waste management, equipment storage and safety incidents.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y

Explanation of any answers and additional evidence:

- The practice had appointed overall clinical and non-clinical safeguarding leads as well as safeguarding leads at each site. Information on safeguarding was displayed at sites for reference.
- The practice had established the level of safeguarding training required by different staff groups. This was included in the practice safeguarding policies for adults and for children. Staff were required to undertake safeguarding children training every 12 months, and training in safeguarding adults every 24 months.
- Data showed all 53 clinical staff had completed safeguarding adults training level 3 and safeguarding children level 3. All but three staff had also completed training in the Prevent Duty, a course relating to safeguarding vulnerable people from being exploited and drawn into terrorism.
- The 75 administration staff were compliant with level 1 training in safeguarding adults and safeguarding children. The practice had recently introduced a requirement for administration staff to complete training at level 2 for these topics. This was a level above that recommended by the Intercollegiate Guidelines on safeguarding. The practice management wanted staff to have more than the minimum level required, and staff had been tasked with completing this by the end of January 2020. At the time of the inspection, almost 60% had completed the module.
- The practice required all staff to complete chaperone training. All but five staff were up to date with this training. The practice had carried out a risk assessment relating to carrying out disclosure and barring service checks for non-clinical staff.
- The policies for safeguarding adults and for safeguarding children had both been reviewed in November 2019.
- The business intelligence team carried out quarterly searches for key prompts indicative of a potential safeguarding risk. All searches were reviewed by a GP partner in advance of the quarterly safeguarding meetings.
- Safeguarding risks and intelligence were shared with partners. External safeguarding representatives were invited to the practice's quarterly safeguarding meetings, for example from the local authority, community health services and mental health services, and minutes were shared.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y

Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y

Safety systems and records	**Y/N/Partial**
There was a record of portable appliance testing (PAT) or visual inspection by a competent person. Date of last inspection/test: 20 March 2019 at Cosham Park Surgery, 2 January 2019 at Crookham Lane Surgery; 18 December 2019 at Kingston Crescent Surgery; 3 January 2019 at Hayward Road Surgery and 4 January 2020 at Paulsgrove Surgery	Y
There was a record of equipment calibration. Date of last calibration: September 2019	Y
There were risk assessments for any storage of hazardous substances (COSHH) for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: June 2019	Y
There was a log of fire drills. Date of last drill: Between 10 January 2020 and 21 January 2020 for the six different sites.	Y
There was a record of fire alarm checks. Date of last check: Weekly	Y
There was a record of fire training for staff. Date of last training: staff completed on-line training	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: Internal risk assessments were carried out for two sites on 26 February 2019 and for the other four sites they were completed on 14, 19 and 26 February 2020. External fire risk assessments had been completed on various dates in February 2018.	Y
Actions from fire risk assessment were identified and completed.	Y

Explanation of any answers and additional evidence:

- At our previous inspection we found external clinical waste bins were unlocked at two sites and locked but not secured at two sites. The practice subsequently issued reminders to staff to lock external clinical waste bins after use and the estates and facilities lead carried out spot checks. When we visited the four sites as part of this inspection, we found all external clinical waste bins were locked and secured. They also displayed signs asking: ‘Have you locked me?’ as reminders to staff.
- The practice had appointed a safety manager to carry out routine and responsive maintenance at the six sites. They were trained to undertake PAT checks and had been appointed the lead for

COSHH.

- All but three of the workforce were up to date with fire safety training; an annual requirement for staff. Every two years the practice offered practical, interactive training sessions, particularly for fire wardens. The last course was in May 2019.
- Actions identified in the fire risk assessment were in progress.
- The practice had installed a new, integrated fire system at Paulsgrove Surgery and Hayward Road Surgery since our last inspection.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: These had been completed between 1 November 2019 and 5 November 2019.	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: These had been carried out on 5 July 2019, 24 July 2019, 7 August 2019 and 17 September across the six sites. The risk assessments were reviewed and updated in January and February 2020.	Y

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: See below	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

- The practice had appointed clinical and non-clinical leads for infection prevention and control. They had weekly meetings and reported to the monthly operations meetings.
- The clinical infection prevention and control lead attended quarterly link meetings with the infection control lead at the local NHS community trust.
- All clinical staff had completed annual training in the specific infection control module for clinicians. All but two administration staff were up to date with the non-clinical infection control training.
- There were clear schedules for daily, weekly and monthly cleaning tasks. Staff signed for completed tasks and there was a full record of sign-sheets in the online cleaning folder.
- Clinical staff, responsible for cleaning, had protected time for these duties.

- An annual audit of infection control had been completed for all six sites by the facilities lead between June and August 2019. The audit report showed the actions required had been completed. Actions included reminders to the cleaning contractor (for example to clean waste bins more effectively) or to nursing staff. New foot-pedal waste bins had been installed in treatment rooms by the estates department.
- The clinical commissioning group had carried out an annual infection control audit of two surgeries in October 2019 and they planned to audit the further four sites in January 2020.
- Improvements implemented since the last audits included replacement basins and replacement easy-clean flooring.
- We observed the premises to be clean, with sufficient personal protective equipment available. Store rooms were tidy and contained colour-coded cleaning equipment, to minimise risks of cross infection.
- We found a sharps bin located in the patient toilet in the reception of Kingston Crescent Surgery. Labelling showed this had been assembled in November 2018 and not replaced. The bin had been overlooked by practice staff and contained very little waste. It was removed at the time of the inspection.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practice was equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

- At our previous inspection we identified an HCA who had assisted an unwell patient outside of their scope of competence. The practice acted in response to this finding and changed the roster policy and procedure to prevent this happening again. The roster process was set up so that HCAs could only work with a clinician on site and the monthly rotas were approved by the clinical executive team prior to issue, as a safety check. We spoke with an HCA who confirmed they never worked without a trained clinician on site and this was well recognised amongst their staff group. If for any reason there was no clinician at a branch site, the HCA moved to work from another surgery.

- The practice had a system for managing leave for clinical staff, and the clinical partners provided internal cover. The practice had not needed to use locums since Summer 2019. Overall, staff said there were sufficient staff within the practice.
- The practice had modified its staff recruitment and induction programmes. New staff were required to complete online training during their induction period and there were clear protocols for different roles.
- Staff had access to a GP partners based both at the main sites and at the contact centre, who provided support with any queries or patient safety issues.
- All staff, apart from one administration staff, had completed annual training in adult basic life support within the past year. All clinical staff were up to date with child basic life support. In addition, sepsis training for clinical staff and sepsis awareness for non-clinical staff had been added to the practice's list of mandated courses. Staff were required to complete this by February 2020. At the time of the inspection almost all clinical staff had already completed training on this topic.
- There had been a 'Think Sepsis' training day in March 2019 and sepsis guidance was displayed in each treatment room.

Information to deliver safe care and treatment

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

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and there was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y
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Appropriate and safe use of medicines

The practice had addressed the issues with medicine management identified at the previous inspection, and there were safe systems for storing medicines and managing prescriptions.

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2018 to 30/09/2019) (NHS Business Service Authority - NHSBSA)	0.97	0.83	0.87	No statistical variation
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2018 to 30/09/2019) (NHSBSA)	9.1%	8.3%	8.5%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/04/2019 to 30/09/2019) (NHSBSA)	5.10	5.18	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/04/2019 to 30/09/2019) (NHSBSA)	2.63	2.59	2.08	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	P
The practice monitored the prescribing of controlled drugs. (For example, investigation of	Y

Medicines management	Y/N/Partial
unusual prescribing, quantities, dose, formulations and strength).	
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

- Before our inspection, the practice had identified that it needed to strengthen its procedure for monitoring patients on high risk medicines such as Lithium, who were monitored under the 'shared care' arrangement with the local NHS hospital. A new process was in development with the hospital for managing patients on Lithium and this was due to be implemented in March 2020. There are known risks associated with Lithium which is prescribed to treat manic episodes of bipolar disorder. Patients need their dosages and their kidney and thyroid function regularly monitored.
- There was a system for monitoring patients prescribed Methotrexate. Methotrexate is a high-risk medicine that increases risks to liver and kidney function. Patients had their blood tests checked before their GP prescribed Methotrexate.
- On our previous inspection we found the provider had not stocked emergency medicine to treat seizures across all six sites and there was no risk assessment to determine what emergency medicines were required. On this inspection, we found there had been a full risk assessment of emergency medicines, which took account of treatments provided at different surgeries. The practice had combined the policy, procedure and risk assessment into one document to aid reference. Medicine to treat seizures was included in the emergency medicines list. The practice did not stock opiates (or Naloxone, to treat opioid overdoses), in line with their risk assessment. Atropine (a medicine to treat an abnormal heart rhythm) was only stocked at Kingston Road Surgery, as this was the only surgery where minor surgery was performed.
- At our previous inspection we reported out-of-date equipment in one store room. The practice said this stock was not used. Since then, the practice had implemented a review of its stock control procedures and created a dedicated stock room at each site. Administration staff had been allocated the task of checking stock, with clinical input and oversight. We found there was a systematic approach to stock management and all items we checked were within date.
- Previously, we found the practice had not recorded the serial numbers of prescriptions issued to individual prescribers. On this inspection, we found the practice had implemented a policy and procedure relating to prescription stationery and recorded the serial numbers of scripts as they were put into printers. Prescription stationery was collected from printers and kept securely when GPs finished their sessions.
- Previously, we found not all Patient Group Directions (PGDs) had been signed appropriately. PGDs permit authorised, trained staff to administer prescription-only medicines to groups of

Medicines management	Y/N/Partial
patients, without individual prescriptions. On this inspection we found PGDs were in date, signed by a senior member of staff and they included a list of authorised prescribers. New PGDs were printed and signed by nurses at meetings. Copies were available on the intranet for reference. • Clinical staff had completed training in antimicrobial stewardship, provided by the community NHS infection prevention and control lead. The practice demonstrated a downward trend in the number of antibiotics prescribed, demonstrating good prescribing practice, and audited antibiotic prescribing against National institute for Health and Care Excellence (NICE) guidelines. • Where health care assistants administered medicines, there were Patient Specific Directions, or written instructions from a prescriber for a specific patient. • The practice ensured their non-medical prescribers prescribed within their medical competence, had regular supervision and access to the duty GP for advice and support. • The practice had a process for managing repeat prescription requests, with appropriate clinical review and authorisation. • Clinicians and pharmacists carried out structured medicine reviews for patients with long term conditions and the practice business intelligence team monitored activity and performance.	

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	113
Explanation of any answers and additional evidence: • On our previous inspection we found a safety incident had not been recorded as a significant event. We also found learning from significant events was shared with clinicians but incidents involving administration staff were not consistently shared with all administration staff to encourage learning. Since this was identified, the practice had promoted reporting of significant events across all staff, and the topic was a standing item on meeting agendas. Reporting had increased by 24%. Staff were asked to report events with both positive and negative impact. • Significant events were a standing item on all meeting agendas. For example, meetings of the executive team, management team, nursing team, partnership, surgery team leaders. Every significant event was discussed at the monthly partner meetings. Minutes showed there were detailed discussions regarding individual events where there were learning opportunities, for example at the monthly target meetings.	

- Clinical staff said events were reviewed in detail and there was a strong focus on learning and improving. For example, a practice safety champion attended city-wide meetings.
- We saw that patients received apologies and explanations following significant events.
- The practice had reviewed the categorisation of significant events and planned to update the significant event policy and analysis reporting form in February 2020. This was to make it easier for staff to complete the forms, provide more prompts on what to include and to identify trends more readily.

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

Event	Specific action taken
GP incorrectly advised parent of child's allergic reaction to a routine immunisation.	GP realised error, explained to parents and advised them to continue with the course. The learning was shared with clinical staff and parents were then given further information relating to possible reactions.
An urgent task issued to the duty doctor was not logged as completed by the end of the day.	The event analysis showed the patient received the necessary care. The process for managing urgent requests for medicines was changed

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

Explanation of any answers and additional evidence:

- All safety alerts were received into the operations mailbox. The operations team forwarded the alerts for action and/or for information. The business intelligence team monitored actions completed.
- We saw examples of actions taken on recent alerts. For example, one relating to a drug alert. The pharmacist carried out a search and found it was not relevant to any practice patients.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.

- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

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