Adelaide Health Centre

Inspection report

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

Ratings

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

Overall summary

This practice is rated as Good overall. (Previous rating June 2016 – Good)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Adelaide Health Centre on 16 and 17 October 2018 as part of our inspection programme.

At this inspection we found:

•The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.

•The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.

•Staff involved and treated patients with compassion, kindness, dignity and respect.

•Patients found the appointment system easy to use and reported that they were able to access care when they needed it.

•There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

•Continue to review all health and safety risk assessments across all sites so that outstanding actions are completed.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser, a second CQC inspector and a CQC assistant inspector.

Background to Adelaide Health Centre

This report relates to the regulatory activities being carried out at Adelaide Health Centre which is situated in William Macleod Way, Millbrook, Hampshire SO16 4XE. The practice is operated by Solent NHS Trust and has three sites in the Southampton area known locally as the Solent GP Surgery. We visited all three sites during our inspection. The practice has a website which is located at www.solent.nhs.uk

The other sites are located at:

Nicholstown Surgery, Fanshawe Wing, Level B, Royal South Hants Hospital, Brinton Terrace Southampton, Hampshire, SO14 0YG.

Portswood Solent Surgery, 7 Belmont Road, Portswood, Southampton, Hampshire, SO17 2GD

Solent NHS Trust provides a Homeless Health Care Team at the Two Saints Day Centre, 30 Cranbury Avenue, Southampton SO14 0LT. Patients can self-refer between Monday to Friday 9am-4pm and can also be seen at Patrick House Hostel on Monday and Wednesday mornings. We visited the Two Saints Day centre as part of this inspection.

Adelaide Health Centre is registered for the following Regulated Activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures and Treatment of disease, disorder or injury.

Local authorities, NHS trusts, voluntary organisations, charities, limited companies and limited liability partnerships require a nominated individual. This practice has a nominated individual who has been nominated by the Solent NHS Trust. A nominated individual must be employed as a director, manager or secretary of the organisation with responsibility for supervising the management of the regulated activity. The provider must be sure of that individual's ability to fulfil the responsibility of their role.

The deprivation decile rating for the practice area is six (with one being the most deprived and 10 being the least deprived). The practice provides a primary medical service to approximately 17,586 patients of a diverse age group across the three sites. The 2011 census data showed that the majority of the local population identified themselves as being White British.

Adelaide Health Centre, is led by a senior management team consisting of a Primary Care Manager, Clinical Lead GP and a Matron. At each of the sites there are Site Managers and Lead GPs. The Adelaide Health Centre

team consists of 12 salaried GPs including two long term locums, six Advanced Nurse Practitioners, two trainee Advanced Nurse Practitioners, four practice nurses and five Health Care assistants. Clinical staff are also supported by 15 receptionists (three supervisors) seven back office administrators, a clinical pharmacist, a medicines manager and a lead practitioner.

Patients using the practice also have access to health visitors, counsellors, carer support workers, district nurses, and midwives. Other health care professionals visited the practice on a regular basis.

The Adelaide Health Centre practice premises, phone lines and reception desk are open seven days a week between 8am to 8pm, including bank holidays. Appointments are offered between those times. Outside of these times patients are directed to contact the out of hour's service and the NHS 111 number. This is in line with local contract arrangements.

The practice offers a range of appointment types including face to face same day appointments, telephone consultations and advance appointments (two to three weeks in advance) as well as online services such as repeat prescriptions.

Good

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes.

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

•The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff.

•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 vulnerable children and 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 who acted as chaperones and had been trained for their role. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)

•Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.

•The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis. We checked staff files and saw written evidence which confirmed this. Managers had systems in place which reminded them to check that clinical staff maintained their registrations with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC).

•There was an effective system to manage infection prevention and control. We saw evidence which confirmed this at each location.

•The practice had arrangements to ensure that facilities and equipment were safe and in good working order. Equipment had been calibrated at each location.

•Arrangements for managing waste and clinical specimens kept people safe. Clinical waste was stored appropriately. We checked that external clinical waste bins were kept locked and stored securely.

Each of the three locations had an identified GP lead and site manager who provided oversight of day-to-day operations. In addition to weekly meetings and regular reviews of individual incidents, there were audits which covered infection control and health and safety. The outcomes were discussed at team level and within the primary care governance meeting which brought together the GP leads and site managers from each surgery. This provided the opportunity to ensure learning was shared across the teams, assurance that policies and protocols were being followed and that the service was continually improving its performance. For example, hand hygiene audits had been completed at each location over the summer of 2018.

Risks to patients.

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

•Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.

•There was an effective induction system for temporary staff tailored to their role.

•The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.

•Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

•When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment.

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

•The care records we saw showed that information needed to deliver safe care and treatment was available to staff.

Good

Are services safe?

•The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.

•The provider used a shared drive computer system which ensured secure sharing of information appropriately across all sites.

•Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines.

The practice had reliable systems for appropriate and safe handling of medicines.

•The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks. The practice had appropriate emergency bags at each of their locations. These were all identically colour coded for ease of access. We found that online checks had been completed on a weekly basis to ensure all necessary equipment and medicine was in the bags at each location.

•Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.

•There were effective protocols for verifying the identity of patients during remote or online consultations such as eConsult an online tool for GP consultation. Staff checked patient identity using information stored in patient records.

•Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.

Track record on safety.

The practice had a good track record on safety. However, we identified areas of concern at the Portswood branch.

•The practice had the support of a risk management team at their Trust headquarters to help identify and manage risk.

•There were risk assessments in relation to health and safety issues at Adelaide Health Centre, Nicholstown branch and the homeless healthcare branch.

•At the Portswood branch we found that a fire risk assessment completed in September 2016 still had one uncompleted action. This was to ensure there were written instructions for staff at the branch on actions to take in the event of a fire. For example, checking rooms for staff and patients during an evacuation. The provider was able to provide written instuctions for staff after the inspection.

•At the Portswood branch we found that there was no evidence that a health and safety risk assessment had been completed. For example, checking for unsafe flooring or trip hazards. The provider has since confirmed that Health & Safety assessments have been completed out at the Portswood branch.

•The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made.

The practice learned and made improvements when things went wrong.

•Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.

•There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice.

•The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and all the population groups as good for providing effective services overall.

Effective needs assessment, care and treatment.
The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

•Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.

•We saw no evidence of discrimination when making care and treatment decisions.

•The practice used a centralised telephone system located at the Nicholstown site. Clinicians were available within surgery hours to triage patient calls and direct them to the most appropriate support.

•Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:
•Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.

•The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

•Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

•The majority of older patients, including residents of a local care home were registered at the Portswood branch. Carers' packs were available at all sites. Portswood had a dedicated home visit clinic, enabling the surgery team protected time to support house bound patients.

People with long-term conditions:
•Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.

•Staff who were responsible for reviews of patients with long term conditions had received specific training.

•GPs followed up patients who had received treatment in hospital or through out of hours services.

•The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension).

•Each site had a diabetic lead GP and there were regular clinics to review patients whose diabetes was poorly controlled. The practice also provided warfarin management and phlebotomy clinics to assist patients with monitoring their conditions and run an annual 'flu vaccination clinic' to protect those whose diagnoses make them vulnerable to influenza.

•The practice had a Pharmacist whom provides medication reviews. This was useful for those with long-term conditions and older people; two groups prone to polypharmacy.

Families, children and young people:
•Childhood immunisation uptake rates were in line with the target percentage of 90% or above. For all patients there were regular childhood immunisation clinics and the practice had instigated a process for following up all non-attendances.

•The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

•8% of the patient list were children aged under 5 years and under 18s account for 22% of the list size. The practice had embedded safeguarding procedures, such as regular meetings with the link Health Visitor to ensure communication flows.

•Children could be brought in to see an Advanced Nurse Practitioner for minor injuries and illnesses after the school day ended. The practice also offered advice over the telephone.

Good

Are services effective?

Working age people (including those recently retired and students):

•Practice level data which has not been verified, showed that uptake for cervical screening was 85%, which was above the 80% coverage target for the national screening programme.

•The practice's uptake for breast and bowel cancer screening was comparable to the national average.

•The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.

•Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

•On the day appointments are dealt with by a telephone triage system therefore patients do not always need to attend the surgery. Patients also had the ability to contact the practice online via eConsult. Text reminders were sent to patients about appointments.

People whose circumstances make them vulnerable:

•End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.

•The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

•The practice provided longer, 30-minute appointments for patients with a learning disability.

•The homeless healthcare team of the practice provided care and treatment to a transient population of approximately 500 patients. This included regular health checks and blood tests for a wide range of potential health conditions relevant to homeless patients.

•The practice provided support to patients who were carers; identifying them and read-coding "carer" in their record. Identification of carers enables the practice to offer the opportunity of referral for additional support including signposting to other local organisations.

People experiencing poor mental health (including people with dementia):

•The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.

•When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.

•Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.

•The practice offered annual health checks to patients with a learning disability.

•The practice had a higher prevalence of people with mental health needs; 1.4% compared with 0.8% nationally. Patients who were experiencing mental health problems were able to telephone for an on the day appointment.

•The practice had the Southampton Clinical Commissioning Group contract to provide the Special Allocations Service at the Nicholstown branch; many of the patients on the scheme experienced some mental health issues. The practice provided assessments for them when they first register and longer appointments (30 minutes) where possible.

•The practice had piloted a Mental Health Multi-Disciplinary Team at the Nicholstown branch which included representatives from the local Community Mental Health Team.

•The Portswood branch site was Dementia friendly.

Monitoring care and treatment.

The practice had a comprehensive programme of quality improvement activity and routinely reviewed review the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

•The practice used information about care and treatment to make improvements.

Good

Are services effective?

•The practice was actively involved in quality improvement activity. Where appropriate, clinicians took part in local and national improvement initiatives.

Effective staffing.

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

•Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.

•Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

•The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

•The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.

•There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment.

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

•We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.

•The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.

•Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

•The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives.

Staff were consistent and proactive in helping patients to live healthier lives.

•The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last months of their lives, patients at risk of developing a long-term condition and carers.

•Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.

•Staff discussed changes to care or treatment with patients and their carers as necessary.

•The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment.

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

•Clinicians understood the requirements of legislation and guidance when considering consent and decision making.

•Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

•The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Good

Are services caring?

We rated the practice as good for caring. Kindness, respect and compassion Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.

Involvement in decisions about care and treatment Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them.
- The practice had considered the needs of non-English speakers according to local population groups. For example, at the Nicholstown branch an audit had been completed on the number of different languages spoken by numbers of patients. This had informed the signage at the practice. The audit had identified over 40 different languages and the Nicholstown branch were able to use various language lines and interpretors to meet most of these.

Privacy and dignity The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs.
The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

•The practice understood the needs of its population and tailored services in response to those needs.

•Telephone and web GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

•The facilities and premises were appropriate for the services delivered.

•The practice made reasonable adjustments when patients found it hard to access services.

•The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.

•Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:
•The practice maintained a community wellbeing team which supported older people to continue living in their own homes.

•The practice offered home visits, same day appointments and triage prioritisation for older people.

•All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.

•The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.

•There was a medicines delivery service for housebound patients.

People with long-term conditions:
•The practice offered electronic prescription services, patient education events and 15-minute appointments.

•The practice had carried out audits on areas relevant to patients with long term conditions such as diabetes, asthma and heart conditions. The practice provided diabetes care plans.

•Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.

•The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:
•The practice offered same day appointments for children or pregnant women and held regular health visitor meetings.

•The practice offered contraception reviews and paediatric examinations. Regular health visitor meetings were held at the practice.

•We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

•All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

Working age people (including those recently retired and students):
•The practice offered cancer screening, online consulting and online appointment booking.

•The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, opening from 8am to 8pm every day of the year, seven days a week, including all bank holidays and Christmas Day.

Good

Are services responsive to people's needs?

People whose circumstances make them vulnerable:

•The practice had an easy to read pre-appointment questionnaire for patients with learning disabilities and other easy to read material.

•The practice supported patients who lived in refuges including those for women and the homeless.

•The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

•People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.

•The homeless healthcare team had appropriate facilities to support homeless patients. These included a Belfast sink which was a deep rectangular sink at floor level, made of glazed white porcelain. This was used to wash and treat homeless patient's feet, which were a common area of concern.

•The homeless healthcare team worked closely with the neighbouring day care centre and had a holistic approach to supporting homeless patients. This included help with benefits claims, mental health issues, counselling and referral to other support teams.

•We spoke with homeless patients who told us they were extremely satisfied with the service they received at the homeless healthcare team. They described the friendly, compassionate and professional staff at the branch.

People experiencing poor mental health (including people with dementia):

•The practice provided the special allocations service which supported violent and aggressive patients in the community. The practice had appropriate security systems in place to support this provision

•The practice held regular multi-disciplinary team meetings with the local mental health team. One of the staff at the practice was a mental health nurse practitioner.

•Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

•The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to care and treatment.

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

•Patients had timely access to initial assessment, test results, diagnosis and treatment.

•Waiting times, delays and cancellations were minimal and managed appropriately.

•Patients with the most urgent needs had their care and treatment prioritised.

•Patients reported that the appointment system was easy to use.

Listening and learning from concerns and complaints.

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

•Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.

•The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Good

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability.

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

•Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.

•Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.

•The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy.

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

•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.

•The practice monitored progress against delivery of the strategy.

Culture.

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

•Staff stated they felt respected, supported and valued. They were proud to work in the practice.

•The practice focused on the needs of patients.

•Leaders and managers acted on behaviour and performance consistent with the vision and values.

•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.

•There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.

•There was a strong emphasis on the safety and well-being of all staff.

•The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.

•There were positive relationships between staff and teams.

Governance arrangements.

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

•Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.

•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.

•Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance.

There were clear and effective processes for managing risks, issues and performance.

•There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety at three of the four locations. We identified potential risks at the Portswood branch due to the absence of written fire instructions and a health and

Good

Are services well-led?

safety risk assessment for the premises. The provider confirmed that written fire instructions and health and safety risk assessments had been completed after the inspection.

•The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.

•Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. For example, the practice had conducted audits of patients prescribed spironolactone. This medicine removes excess fluid from the body and can be used to treat congestive heart failure, cirrhosis of the liver, and kidney disease. It also can be used in combination with other drugs to treat elevated blood pressure, and for treating diuretic-induced low potassium (hypokalaemia). The audit was over two cycles 88% of patients were checked and in the second cycle 93% of patients were checked. The safety improvement was reviewing patients with high potassium to minimise risk and ensure care was appropriate.

•The practice had plans in place and had trained staff for major incidents.

•The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information.

The practice acted on appropriate and accurate information.

•Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.

•Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.

•The practice used performance information which was reported and monitored and management and staff were held to account.

•The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.

•The practice used information technology systems to monitor and improve the quality of care.

•The practice submitted data or notifications to external organisations as required.

•There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners.

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

•A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was an active patient participation group.

•The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation.

There were systems and processes for learning, continuous improvement and innovation.

•There was a focus on continuous learning and improvement.

•Staff knew about improvement methods and had the skills to use them.

•The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.

•Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.