# Solent Medical Services Limited

# Newtown Clinic

## Inspection report

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## Overall summary

We carried out an announced comprehensive inspection on 23 August 2018 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

**Our findings were:**

**Are services safe?**

We found that this service was providing safe care in accordance with the relevant regulations.

**Are services effective?**

We found that this service was providing effective care in accordance with the relevant regulations.

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations.

**Are services responsive?**

We found that this service was providing responsive care in accordance with the relevant regulations.

**Are services well-led?**

We found that this service was providing well-led care in accordance with the relevant regulations.

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

Newtown Clinic offers services in dermatology, ophthalmology and community well-being nursing care to patients living in Southampton and Hampshire. Patients are referred to the service either by their registered GP or by secondary care units based at the Royal South Hampshire hospital. The service only sees adults over the age of 18 years. Patients attending the ophthalmology service may attend for the purpose of reviewing and treating cataracts or glaucoma, while those attending the dermatology service may attend for the purpose of treatment for mild to moderate skin complaints or the removal of lesions.

The service is registered with the Care Quality Commission (CQC) under the Health and Social Care Act 2008 for all of the services it provides. On this inspection, we inspected the dermatology and ophthalmology services provided. Newtown Clinic is registered with CQC to provide the regulated activities of diagnostic and screening procedures and treatment of disease, disorder or injury.

At the time of our inspection a registered manager was in place. A registered manager is a person who is registered with the CQC to manage the service. Like registered

# Summary of findings

providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This is the first inspection by CQC of the Newtown Clinic, although services provided by the provider, Solent Medical Services Ltd have been inspected by CQC previously. The full comprehensive reports for the previous inspections can be found by selecting the 'all reports' link for Solent Medical Services Ltd on our website at www.cqc.org.uk.

We received 31 completed CQC comment cards from patients. Feedback was very positive about the service delivered at Newtown Clinic. We also spoke with patients on the day.

**Our key findings were:**

- Patients were positive about the service they received at Newtown Clinic.
- Clinicians regularly assessed clients according to appropriate guidance and standards.
- The provider was aware of, and complied with, the requirements of the Duty of Candour.
- Risks to patients were well-managed. For example, there were systems in place to reduce the risk and spread of infection.
- Information about how to complain was available and easy to understand.
- There were effective systems in place to check all equipment had been serviced regularly.
- Staff were up to date with current guidelines and were led by a proactive management team.
- The system for managing safety alerts was not consistently effective at the time of the inspection visit; this was addressed immediately following the visit.
- Risk assessments had been carried out and the provider had completed all actions that they were responsible for.
- There was a culture of openness and transparency throughout the service.

There were areas where the provider could make improvements and should:

- Continue to review how the service receives and actions safety alerts.
- Review policies to ensure they are reflective of the service's systems and processes for example, frequency of infection prevention and control training of non-clinical staff.
- Review how the service obtain assurances that staff receive appropriate training relevant to their role, for example, the Mental Capacity Act 2005, safeguarding and fire safety training.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Are services safe?**

We found that this service was providing safe care in accordance with the relevant regulations.

- The service had systems, processes and risk assessments in place to keep staff and patients safe.
- Staff had received or were booked to receive safeguarding training appropriate to their role.
- Staff had the information they needed to provide safe care and treatment, and shared information as appropriate with other services.
- The service had an adequate track record on safety. Safety alerts were monitored by the registered manager.
- The staffing levels were appropriate for the provision of care provided.
- We found the equipment and premises were well-maintained by the service with a planned programme of maintenance. However, there were outstanding actions from the service's recent fire risk assessment which had been referred to NHS Property Services.
- Medicines used by the service and prescription stationery were stored securely on site.
- However, we found evidence of annual fire safety training was overdue for four staff members.

**Are services effective?**

We found that this service was providing effective care in accordance with the relevant regulations.

- Staff sought consent from patients for treatment appropriately and recorded this in patient records. However, the service could not demonstrate that staff had been provided with appropriate support and guidance to use the Mental Capacity Act 2005 as needed.
- Staff had the skills, knowledge and experience to deliver effective care and treatment, but we found evidence of inconsistencies in the recording of staff training.
- Staff used current guidelines to deliver appropriate care and treatment.
- The service had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness of the care provided.

**Are services caring?**

We found that this service was providing caring services in accordance with the relevant regulations.

- We received 31 comment cards. Comments showed that patients were pleased with the care they had received at Newtown Clinic.
- The service treated patients courteously and ensured that their dignity was respected.
- The service involved patients fully in decisions about their care and treatment.
- We found the staff we spoke to were knowledgeable and enthusiastic about their work.

**Are services responsive to people's needs?**

We found that this service was providing responsive care in accordance with the relevant regulations.

- The service proactively sought patient feedback and identified and resolved any concerns that were identified.
- There was an accessible complaints system. Information was available in the waiting area of the service and on the service's website.
- The service was responsive to patients' needs and provided a choice of appointments and locations that patients could attend.

# Summary of findings

- The service had suitable facilities and was well-equipped to meet the needs of patients.
- The service was able to accommodate patients with a disability or impaired mobility. All patients were seen on the ground floor of the premises.

**Are services well-led?**

We found that this service was providing well-led care in accordance with the relevant regulations.

- The provider had a clear vision and strategy for the service and the service leaders had the knowledge, experience and skills to deliver high quality care and treatment.
- The service had access to a suite of policies, and systems and processes were in place to identify and manage risks and to support good governance. However, some processes were not always effective, in particular the monitoring of staff training and actioning of safety alerts.
- The service actively engaged with staff, patients and primary and secondary care colleagues to support and promote improvement.
- Regular staff meetings took place and these were comprehensively minuted then cascaded to all staff.
- There was a management structure in place and staff understood their responsibilities.
- The culture within the service was open and transparent.
- Staff told us they felt well supported and could raise any concerns with the provider or members of the management team.

# Newtown Clinic

**Detailed findings**

## Background to this inspection

Newtown Clinic is part of Solent Medical Services Limited, which is an NHS-staff owned company. The service aims to provide accessible community-based care for NHS patients for dermatology and ophthalmology. The service also provides community well-being nursing services which do not fall under the scope of regulated activity and which we did not inspect. Those referred to Newtown Clinic for dermatology and ophthalmology services receive comprehensive assessments and discussions regarding appropriate treatment. Minor procedures are performed onsite if appropriate, otherwise patients are referred onto secondary care providers which are provided by University Hospital Southampton NHS Foundation Trust.

Newtown Clinic is located at 24-26 Lyon Street, Southampton, Hampshire, SO14 0LX.

The service also has two satellite sites based at:

Woolston Lodge Surgery, 66a Portsmouth Road, Woolston, Southampton, SO19 9AL, and Burgess Road Surgery, 357a Burgess Road, Southampton, SO16 3BD. Neither of the sites were in use by the service on the day of inspection so we did not visit them.

The core opening hours for dermatology and ophthalmology services are Monday to Friday 8am-5pm.

The staff team at the service consists of dermatology and ophthalmology consultants, GPs with special interests in dermatology and ophthalmology, optometrists, nurses and healthcare assistants. The clinical team are supported by an administrative team and there is a comprehensive management structure led by the Head of Services, who reports to Solent Medical Services Limited's Board of Directors.

We carried out an announced comprehensive inspection at Newtown Clinic on 23 August 2018. Our inspection team was led by a CQC Lead inspector. The inspection team included a GP Specialist Advisor.

Prior to the inspection, we reviewed a range of information we hold about the service, such as any notifications received, and the information provided from the pre-inspection information request.

During our visit:

- We spoke with the Registered Manager, a member of the Board of Directors, the Head of Services, the Operations Manager, clinicians and a number of administrative staff.
- We looked at equipment and rooms used for providing dermatology and ophthalmology services.
- We reviewed records and documents.

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

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

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

# Are services safe?

## Our findings

**Safety systems and processes**

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

- The service had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Although the service did not provide treatment to patients under the age of 18 years, the service had access to a child safeguarding policy to safeguard any child that might attend the premises. Staff received safety information for the service as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We looked at staff training records and found that three clinicians had not received level three safeguarding training since June 2015. The service's own safeguarding policy required staff to receive this training every three years. Since inspection, the service has confirmed that the three clinicians were booked to receive safeguarding training in the next three months.
- When asked, staff knew how to identify and report concerns.
- The service's own policy regarding staff training stated a requirement for annual face to face fire safety training. However, we found evidence of four clinicians who had not received fire safety training since May and June 2017. One of the clinicians who had not received fire safety training was on planned extended leave. The service had not sought assurances that any form of fire safety training had been undertaken in other employment.
- Staff who acted as chaperones were trained for the role and had received a DBS check.
- The service carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks had been undertaken on all staff. (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).
- The professional revalidation of all clinical staff was monitored and recorded. The service used a database to record all renewal dates for professional revalidation.
- There was an effective system to manage infection prevention and control, but this was not fully supported by training provided. Records showed that clinicians had received training on infection prevention and control, but ten non-clinical staff had not received any training. The service's policy stated that this training should be undertaken by all staff each year. Since inspection, the service has confirmed that all but one non-clinical staff member had completed online training for infection prevention and control. The remaining staff member was on annual leave.
- There were systems for safely managing healthcare waste.
- The service ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.
- The service provided evidence of a recent Legionella risk assessment, undertaken in March 2018. The service confirmed actions had been taken to minimise the risk of legionella.

**Risks to patients**

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The service was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures. The service had a defibrillator and oxygen on site.
- 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 service assessed and monitored the impact on safety.

# Are services safe?

- There were appropriate arrangements for professional indemnity in place and we saw documents which confirmed this.

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The service had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of pathology test results for the dermatology service.
- Referral letters included all of the necessary information.

**Safe and appropriate use of medicines**
The service had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including medical gases, and emergency medicines and equipment minimised risks. One emergency medicine, adrenaline, was held on the premises. (Adrenaline is most commonly used as a first line treatment for anaphylaxis, which is a severe life threatening allergic reaction). The service had risk assessed this; risk was minimised by the proximity of a minor injuries unit which was based at the Royal South Hants hospital behind the service's premises.
- The service had carried out an appropriate risk assessment to identify medicines that it should stock. The only medicines kept on site were used in the ophthalmology service, for example eye drops. Staff received supervision and appropriate training to administer these medicines.
- The service kept prescription stationery securely and monitored its use.
- Staff prescribed or administered medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The service involved patients in reviews of their medicines.
- Written procedures were in place and reviewed regularly to ensure safe practice.

**Track record on safety**
The service had a good safety record.

- There were comprehensive risk assessments in relation to safety issues and the service responded to risk appropriately.
- Outstanding actions from the most recent fire risk assessment, completed in January 2018 recommended installation of a fire detector in the lobby area; installation of fire call points on the first floor; provision of fire extinguishers in the main entrance lobby area and repairs to the false ceilings in the cleaner's cupboard and areas of the first floor. We saw evidence that showed NHS Property Services had been informed of these outstanding actions and the service was waiting for NHS Property Services to complete them.

**Lessons learned and improvements made**
The service learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. The service had not had any significant events or incidents in the previous 12 months.
- 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 service learned and shared lessons, identified themes and took action to improve safety in the practice.
- The service did have a system in place for receiving and acting on safety alerts but not all staff were aware of it. The registered manager confirmed safety alerts were received from external organisations such as the Medicines and Healthcare Products Regulatory Agency (MHRA). However, this information was not routinely shared with Newtown Clinic as alerts previously received had not been relevant to the service. Since inspection the provider has confirmed they have a new process in place to ensure all safety alerts are cascaded to staff.
- The provider was aware of and complied with the requirements of the Duty of Candour.
- The provider encouraged a culture of openness and honesty.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment, care and treatment**

The service 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 during a pre-assessment session. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The service had systems in place to keep all clinical staff up to date with new guidance.
- Staff had access to best practice guidelines and used this information to deliver care and treatment that met clients' needs.
- Clinicians confirmed they were given the opportunity to attend national meetings and conferences to ensure they remained up to date with current guidance.
- Staff used appropriate tools to assess the level of pain in patients when appropriate.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The service confirmed that a new policy regarding sepsis had recently been ratified by the Board of Directors and would be circulated to all staff in the days following the inspection to ensure staff were aware of the signs and symptoms of sepsis and how to act if patient presented with such symptoms.

**Monitoring care and treatment**

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

- Staff were actively involved in monitoring and improving quality and outcomes.
- Audits were carried to demonstrate quality improvement and all relevant staff were involved to improve care and clients' outcomes.
- We reviewed nine audits, including an audit on patient appointments that required follow-up reviews, an audit on the referrals received by the service and patient outcomes and a surgical audit relating to the minor surgical procedures performed by the dermatology service. The results of the audits showed that the service was proactive in monitoring patient outcomes and improvements to patient care were introduced as indicated. For example, the surgical audit demonstrated that correct diagnosis rates following possible basal cell carcinomas referral was 43 cases out of 44. The outlying case was diagnosed as a squamous cell carcinoma and appropriate protocol measures were followed.

**Effective staffing**

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

- The service understood the learning needs of staff and provided protected time and training to meet them. Records of skills, qualifications and training were maintained. However, inconsistencies in staff training for infection prevention and control, safeguarding and fire safety were identified during inspection which had not been addressed by the service. Since inspection, the service has provided evidence to show all but the fire safety training had been rectified.
- Staff were encouraged and given opportunities to develop. The service was in the process of supporting three GPs in completing a diploma in dermatology. Following completion of this diploma, those GPs would become GPs with Special Interest.
- The service provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The service ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating patient care and information sharing**

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, services and organisations, were involved in assessing, planning and delivering care and treatment.

# Are services effective?

## (for example, treatment is effective)

- Patients received coordinated and person-centred care. This included when they moved between services or when they were referred. The service worked with patients to develop personal care plans that were shared with the patients' GP with the patients' consent.

**Supporting patients to live healthier lives**

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

- The service identified patients who may be in need of extra support and directed them to relevant services.
- Staff encouraged and supported patients to be involved in monitoring and managing their health with regards to dermatology and ophthalmology.
- Staff discussed changes to care or treatment with patients and their carers as necessary.

**Consent to care and treatment**

The service 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 service monitored the process for seeking consent appropriately. Evidence we gathered during inspection showed that staff were seeking and documenting patient consent accurately. The service had not identified training in the Mental Capacity Act as necessary for staff.

# Are services caring?

## Our findings

**Kindness, respect and compassion**
Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The service gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- After attending the service, patients were asked for their feedback. Patients that responded stated they were very satisfied with the care and treatment they had received.
- Of the 31 patient Care Quality Commission comment cards we received 29 were positive about the service experienced. The remaining two were neutral. This is in line with the results of other feedback received by the service.

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

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. The service also had access to a sign language interpreter for those patients identified as having a hearing impairment.
- Any referrals to other services, including to their own GP, were discussed with patients and their consent was sought to refer them on.
- All staff had completed training in equality and diversity.

**Privacy and Dignity**
The service respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting area. The service had installed a radio in the reception waiting area to reduce the possibility of conversation at the reception desk being overhead.
- Confidential information was seen to be stored securely and in line with General Data Protection Regulations (GDPR) 2018.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

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

- The service understood the needs of its patients and tailored services in response to those needs. For example, advanced booking of appointments, choice of location, and some Saturday morning sessions.
- The facilities and premises were appropriate for the services delivered.
- The service made reasonable adjustments when patients found it hard to access services. Level access was available from the rear of the premises.

**Timely access to the service**

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

- Patients had timely access to initial assessment and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately. The service had identified there was a delay in secondary care referrals being processed, so as a result the service changed how they made referrals to secondary care, and identified a named contact to address all referrals too. All referrals to secondary care were now being logged and monitored.
- Patients with the most urgent needs had their care and treatment prioritised.
- Once a patient's referral was received by the service, a relevant consultant would triage the referral and ensure an appropriate appointment was allocated and, as far as possible, met the preferences of the patient. A confirmation letter was then sent to the patient, informing them of their appointment and any pre-appointment information.

**Listening and learning from concerns and complaints**

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

- 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. Two complaints were received in the last year. We reviewed both complaints and found that they were satisfactorily handled in a timely way.
- The service responded to complaints with truthful information. A verbal apology was given and a written apology was offered.
- They kept written records of verbal interactions as well as written correspondence.
- The service learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, following a complaint regarding an appointment letter, the practice confirmed all appointment letters were now being followed up with a telephone call to confirm patients were aware of when they needed to attend the service.

# Are services well-led?

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

## Our findings

**Leadership capacity and capability**

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

- Leaders had the experience, capability and integrity to deliver the service's strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. The service had recently commenced an operational efficiency review in order to assess all areas of its systems and processes to ensure the service was working effectively. A recent outcome of this review was to create new managerial roles to support current staff, and as a result a clinic supervisor and an administration manager were now in post.
- 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 service had effective processes to develop leadership capacity and skills, including planning for the future leadership of the service.

**Vision and strategy**

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

- There was a clear vision and set of values. The service had a realistic strategy and supporting business plans to achieve priorities.
- The service developed its vision, values and strategy jointly with patients, staff and external partners.
- 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 priorities across the region. The provider planned its services to meet the needs of its identified patient population.
- The service monitored progress against delivery of the strategy.

**Culture**

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

- Staff stated they felt respected, supported and valued. They were proud to work in the service.
- The service focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent 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 were able to 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.
- Clinical staff, including nurses, were considered valued members of the service team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff were given a share of the profits made by the service each year in the form of an annual performance bonus. Every year the service also organised and funded staff social events to promote positive relationships.
- The service actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were clear 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 but were not always effective. For example, oversight of staff training or the process of dealing with safety alerts.
- The governance and management of joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on what actions they should take in respect of safeguarding and infection prevention and control.

# Are services well-led?

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

- Service leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, there were some outstanding actions that the service were waiting for external support to complete.

**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.
- The service had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions.
- Service leaders had oversight of incidents and complaints. Since inspection, service leaders have provided evidence on how they will improve oversight of national and local safety alerts compared to their previous arrangement.
- 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.
- The service had plans in place and had trained staff for major incidents.
- The service implemented developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

**Appropriate and accurate information**

The service 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 service 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 service used information technology systems to monitor and improve the quality of care.
- The service 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 service 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. The service had received positive feedback from their secondary care colleagues and they encouraged feedback from GPs regarding the service they offered to patients. We saw evidence that showed 95% of the GPs who gave feedback considered the service had had a positive impact for patients.
- The service was in the process of creating a patient participation group. Posters advertising for patients to join the patient participation group were seen in the waiting area.
- Patients regularly gave feedback about the service through patient surveys, which had led to the installation of a vending machine in the waiting area and improvements to the service's location map which is sent to patients, informing them of how to find the premises.
- The service was transparent, collaborative and open with the Board of Directors about performance.

**Continuous improvement and innovation**

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

- There was a focus on continuous learning and improvement at all levels within the service.
- Staff knew about improvement methods and had the skills to use them.
- The service 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.