Alexandra Road Surgery

Inspection report

Alexandra Road
Lowestoft
Suffolk
NR32 1PL
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http://www.alexandracrestviewsurgeries.co.uk/

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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	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Overall summary

This practice is rated as Requires Improvement overall. (Previous rating August 2015 – Good)

The key questions at this inspection are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

We carried out an announced comprehensive inspection at Alexandra Road Surgery on 11 October 2018. We carried out this inspection as part of our inspection programme.

At this inspection we found:

- The practice had 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.
- We found out of date items on the emergency trolley and in clinical rooms. These were removed immediately.
- 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.
- There were clear plans in place that were being acted on to improve the Quality Outcomes Framework, where some outcomes were lower than local and national averages.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The practice hosted a number of groups to support patients including an art therapy group for patients experiencing poor mental health and a social prescribing group.
- Patients found the newly changed appointment system easy to use and reported that access care when they needed it was becoming easier to get.
- There was a focus on continuous learning and improvement at all levels of the organisation.
- The practice had hosted a multidisciplinary event in conjunction with the local council, local GP practices, wellbeing, children's services, housing, counselling organisations and social services. The event was attended by over 400 patients and free health checks were offered on the day. Feedback from patients and the providers that attended was positive, with many services wishing to hold the event again.

We saw areas of outstanding practice:

- The practice had hosted an event for patients on high doses of opiates. This was in response to information from the Clinical Commissioning Group that there was an initiative to reduce opiate prescribing. The practice invited all patients on high dose opiates to the event and gave a presentation about opiates and associated risks. This event was hosted by the practice manager, practice pharmacist, GP and physiotherapist. At the end of the event, several patients volunteered to trial reducing their opiates and after consultation with the GP, pharmacist and physiotherapist began a reduction programme. The event was shared with, and adopted by, many local practices as good practice and utilised as a tool to reduce opiate prescribing.

The areas where the provider **must** make improvements are:

- Ensure care and treatment is delivered in a safe way to patients.

The areas where the provider **should** make improvements are:

- Continue to review, monitor and improve outcomes for patients, particularly those with diabetes and mental health conditions.
- Continue to drive improvement and uptake for cervical screening.

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	Requires improvement
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)	Requires improvement

Our inspection team

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

Background to Alexandra Road Surgery

- The name of the registered provider is Alexandra Road Surgery.
- The practice is registered to provide diagnostic and screening procedures, family planning, surgical procedures, maternity and midwifery services and treatment of disease, disorder or injury.
- The practice has a general medical services (GMS) contract with the Great Yarmouth and Waveney Clinical Commissioning Group (CCG).
- There are approximately 15,800 patients registered at the practice.
- The website for the practice is http://www.alexandracrestviewsurgeries.co.uk/
- The practice has two GP partners (both male), two salaried GPs (one male, one female), long term locum GPs, a pharmacist, an emergency care practitioner, five managerial staff, three nurse practitioners, six practice nurses, two healthcare assistants, two phlebotomists, and a team of administrative staff.
- The practice is a teaching practice for medical, nursing and paramedic students. At the time of our inspection, there was a GP registrar at the practice.
- The practice is open from 8am to 6.30pm Monday to Friday and offers extended appointments on Monday, Thursday and Friday evenings.
- When the practice was closed patients were directed to the out of hours service provided by Integrated Care 24 via the NHS 111 service.
- The most recent data available from Public Health England showed the practice has a lower than average number of patients aged between 24 to 44. The practice has a higher than average number of patients aged between 65 and 84. Income deprivation affecting children is 33%, which is higher than the CCG average of 23% and the national average of 20%. Income deprivation affecting older people is 24%, which is also higher than the CCG average of 19% and national average of 20%. Life expectancy for patients at the practice is 78 years for males and 82 years for females which is comparable to the national average.

Requires improvement

Are services safe?

We rated the practice as requires improvement for providing safe services.

We rated the practice as requires improvement for providing safe services because:

- We found out of date items on the emergency trolley and in clinical rooms, including medicines. These were removed immediately.

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 to the lead GP and to external agencies. Learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (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.
- There was a system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order. This included electrical and calibration testing.
- Arrangements for managing waste and clinical specimens kept people safe.

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.
- The practice had difficulty in recruiting GPs and as a result had reviewed the skill mix within the practice. They had successfully recruited nurses, an emergency care practitioner and a pharmacist to meet patient demand.
- 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. However, we found out of date medicines in the practice. These were removed immediately.
- 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.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. For example, the practice had put files on the computer system that contained information about specific conditions. These folders included prescribing guidelines, referral details and local support groups.
- Clinicians made timely referrals in line with protocols. The clinicians completed peer reviews of all referrals to ensure they were appropriate and discussed these in clinical meetings.

Appropriate and safe use of medicines

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

- The practice was in line with local and national averages for prescribing data.
- The systems for managing and storing medicines, including vaccines and medical gases. However, we found the system for managing emergency medicines and equipment did not minimise risks. We found out of

Requires improvement

Are services safe?

date medicines and equipment on the emergency trolley and in clinical rooms. The practice removed these immediately and stated they would review the system for checking these. After the inspection, we received evidence of a new system to review the emergency trolley and clinical rooms. This included a second check every month by the lead nurse.

- 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.
- 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

- There were risk assessments in relation to safety issues. Action plans were completed and monitored.
- 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. Staff we spoke to were able to identify examples of where they had raised concerns.
- 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.

Requires improvement

Are services effective?

We rated the practice and two of the population groups as requires improvement for providing effective services. The population groups were people with long term conditions and people experiencing poor mental health (including people with dementia). The other population groups were rated as good for providing effective services.

We rated the practice as requires improvement for providing effective services because:

- Data for 2017/18 relating to outcomes for diabetes and mental health were lower than local and national averages. Outcomes relating to cervical screening were lower than local and national averages. There was a programme of clinical audit in place, however at the time of inspection most audits were single cycle audits and did not show quality improvement.

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.
- There was a blood pressure and weight machine available in reception to encourage patients to monitor their health.
- 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.
- The practice called and reviewed all patients that had unplanned admissions to hospital to ensure their care plan was updated and the reason for admission fully explored to avoid this happening again.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions. We rated this population group as requires improvement because:

- Diabetes care had reduced to 66% overall for data reviewed for 2017/18. The practice had reviewed this and had completed an audit to review care processes for patients with diabetes. The outcome of this audit was to call patients who were not meeting best practice standard outcomes for a review and to improve documentation and coding in records. The practice also ensured the shared computer system had up to date guidance including local protocols, insulin guidance, chronic disease checklist, and a resource information sheet which had information on to refer patients to local support groups and national charities. The practice was also part of a research project called GLOW (Glucose Lowering through Weight Management). The practice shared some aspects of care with other services and found patients did not always attend the practice as a result of this. To improve uptake, the practice completed opportunistic checks if patients attended the practice for another reason and sent letters to patients who did not respond to two invites. The practice also called patients. However, this had not yet resulted in improved uptake for patients.
- 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 for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People

with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- 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)
- Outcomes for other long term conditions including COPD, atrial fibrillation, heart failure and chronic kidney disease were in line with or above local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were in line with the target percentage of 90%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- The practice had employed a sexual health specialist nurse. At the time of our inspection the nurse had completed implant insertion and removals and had completed coil fitting. The nurse had also provided an educational session during a quarterly training meeting.

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

- The practice's uptake for cervical screening was 66%, which was below the 80% coverage target for the national screening programme, but in line with local and national averages. The practice had hired more nursing staff to increase this and had completed regular audits on the number of inadequate outcomes. This was fed back to all nursing staff.
- The practice's uptake for breast and bowel cancer screening was in line with the national average. The practice wanted to further improve their screening rates and did so by inviting Macmillan nurses to give information to patients.
- 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. The practice had completed 385 health checks in 2017/18.

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 regular meetings with the multidisciplinary team to ensure coordinated care for these patients. They also had a dedicated line for healthcare professionals to use if they had concerns about a patient at the end of life.
- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia). We rated this population group as requires improvement because:

- 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.
- All staff were trained in dementia awareness.
- The practice offered annual health checks to patients with a learning disability. The practice had 125 patients registered with a learning disability and had completed 70 health checks.
- We found that unverified data for 2017/18 showed mental health outcomes had reduced to 59% overall. However, we also found that exception reporting had reduced from 34% to 15%. This was due to a review of exception reporting completed by the practice to ensure only appropriate patients were exception reported. The practice was also keen to improve the access to group therapy and hosted a weekly art group for patients with mental health diagnoses. The practice shared some

aspects of care with other services and found patients did not always attend the practice as a result of this. To improve uptake, the practice completed opportunistic checks if patients attended the practice for another reason and sent letters to patients who did not respond to two invites. The practice also called patients. However, this had not yet resulted in improved uptake for patients.

Monitoring care and treatment

The practice 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.

- We reviewed the QOF outcomes for 2017/18 and found there had been a decrease in the overall achievement to 86%. We spoke with the practice about this, who were aware and had reviewed this. The practice had reviewed their exception reporting processes and had decreased exception reporting to 9% in 2017/18 from 16% in 2016/17 in clinical domains. They had also identified some coding issues, particularly around diabetes where there was shared care with the hospital. The practice had recently employed new nursing staff and had given clinicians lead roles for conditions.
- The practice used information about care and treatment to make improvements.
- The practice was actively involved in quality improvement activity. We reviewed several audits which covered a wide range of clinical conditions. Though many of these were single cycle audits, there was a very clear plan in place to repeat these and monitor any improvements. Where appropriate, clinicians took part in local and national improvement initiatives.
- The practice was involved in research. The current research they were involved in included GLOW (Glucose Lowering through Weight Management), IPCAs (Improving Primary Care after Stroke) and Adult Autism to held further treatments available for these patients.
- The CCG regularly updated the practice on their performance in several indicators via a dashboard. The practice had improved their performance from 19th to 5th over the past year. This included areas such as referrals, pathology requests and radiology requests.

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. Staff had a system in place to follow up all samples taken to ensure they were received and results acted upon.
- 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 and reported there was a positive culture for training.
- 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, midwives 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. There was a dedicated phone life for health professionals to use if they had concerns about a patient at the end of life.

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 12 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. The practice also had blood pressure machines and weighing scales available in reception for patients to utilise to monitor their health.
- 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.
- The practice referred patients to local support groups where necessary and staff had undertaken training to improve the way they delivered advice on health and diet.

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. Staff showed awareness and knowledge of how to assess consent of children.
- 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.
- The practices GP patient survey results were in line with local and national averages for questions relating to kindness, respect and compassion. This was reflected in the comment cards and conversations we had with patients on the day of inspection.

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.
- Non- clinical staff were trained to be 'care navigators' and signposted patients to the most appropriate service.
- The practice proactively identified carers and supported them by regularly checking patients were still carers, sending them a carers pack and offering them a flu jab. The practice had identified 4% of the practice population as carers.
- The practice GP patient survey results were in line with local and national averages for questions relating to involvement in decisions about care and treatment. This was reflected in the comment cards and conversations we had with patients on the day of inspection.

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.

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 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. For example, the practice offered home visits and lunch time appointments.
- 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.
- Reception staff had completed 'care navigation training' in order to signpost patients to local support services.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had hosted a multidisciplinary event in conjunction with the local council, local GP practices, wellbeing, children's services, housing, counselling organisations and social services. The event was attended by over 400 patients and free health checks were offered on the day. Feedback from patients and the providers that attended was positive, with many services wishing to hold the event again.

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 practice employed a nurse who completed weekly home visits for all housebound patients in order to regularly review their needs and limit any unplanned admissions.
- The practice supports a local care home and offered visits twice per week to review patients.

People with long-term conditions:

- Some 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.
- Patients who did not attend for their annual review after three letters were flagged to their GP who decided whether to call them. All patients requiring an annual review were sent for blood tests prior to the appointment and it was organised so that if a GP appointment was also required, this was booked in directly after.
- 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:

- 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.
- Time was allocated for the healthcare assistant to complete documentation for Child Health Services and there was weekly communication to discuss who had not attended an appointment. The healthcare assistant followed these patients up.

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

- 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, evening appointments.
- The practice were active on social media and used it as a method of communication for this patient population group.

People whose circumstances make them vulnerable:

Good

Are services responsive to people's needs?

- 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 practice hosted and referred to a 'solutions' group. This group held 45 minute appointments for patients and discussed issues with employment, debt, mental health and other social issues such as housing. Feedback regarding this service was positive.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held a weekly art therapy group for patients experiencing poor mental health. This was well attended.

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.
- The practice offered weekly home visits to housebound patients with the nurse in order to regularly assess and meet their care needs.
- Patients we spoke to reported that the appointment system was easy to use and had improved with the new system in place.
- The practices GP patient survey results were in line or below local and national averages for questions relating to access to care and treatment. The practice had changed their appointments system to an on the day system which allowed for greater appointment availability. We found that there were appointments available on the day of our inspection. The practice had a system whereby there was a telephone hub at the Alexandra Road Surgery which dealt with all incoming calls. The practice planned to review the new system.

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 also from analysis of trends. It acted as a result to improve the quality of care.
- The practice recorded verbal complaints in order to fully assess the range of feedback from patients.

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, including recruitment. They understood the challenges and were addressing them with action plans that had been implemented.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. Staff reported they felt able to address leaders with concerns and that these concerns would be acted upon.
- 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 and regularly updated their plans.

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 and many staff had worked for the practice for a number of years.
- The practice focused on the needs of patients and adapted services to meet these needs. For example, the practice hosted many services to assist patients such as a social prescribing group.
- 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 and received feedback regarding any issues raised.
- 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. For example, staff were able to attend groups hosted by the practice, such as the art therapy group.
- 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.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. However, we found out of date medicines and equipment on the emergency trolley and in clinical rooms. The practice reviewed and improved their system and provided evidence of this after the inspection.

Managing risks, issues and performance

Good

Are services well-led?

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 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.
- 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. For example, the CCG regularly updated the practice on their performance in several indicators via a dashboard. The practice had improved their performance from 19th to 5th over the past year.
- 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 which was consulted with when changes to the practice were planned.
- 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 at all levels. Where possible, the practice upskilled staff. For example, the practice had supported nurses to complete prescribing courses and receptionists to complete health care assistant courses.
- 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.
- The practice was actively involved in research and teaching students. They had recently started to take on nursing and paramedic students.

Please refer to the evidence tables for further information.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **There were out of date medicines and equipment on the emergency trolley and in clinical rooms.**