

Dr N Sivanesan & Partners (known as Brereton Surgery)

Quality 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 service		Good	
Are services safe?		Good	
Are services effective?		Good	
Are services caring?		Good	
Are services responsive to people's needs?		Good	
Are services well-led?		Requires improvement	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr N Sivanesan & Partners (known as Brereton Surgery) on 18 August 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients told us on the day of the inspection they were able to get appointments, both routine and emergency, although they may have to wait to see a GP of their choice.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events. However, there were inconsistencies in the level of detail recorded for significant events.
- Risks to patients were not always assessed and well managed, because the immunisation status of staff was not recorded, a system was not in place for checking the nurses' continued registration with their professional body, lack of assessments into risks such as fire, slips, trips and falls, non-servicing of the fire alarm, emergency lighting and stair lift.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- The practice did not have a clear leadership structure in place, as the GPs did not have designated clinical or managerial roles. However, staff told us they felt respected, valued and supported, particularly by the partners in the practice.
- The practice sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas the provider must make improvements are:

- Introduce a formalised system to act upon medicines and equipment alerts issued by external agencies.
- Introduce a system to check the continued registration of the nurses with the appropriate professional body.
- Carry out risk assessments into risks such as slips, trips and falls.
- Introduce effective systems for identifying, recording and managing risks, issues and implementing mitigating actions.
- Ensure that all equipment, including the fire alarm, emergency lighting and stair lift are serviced in line with the manufacturers' instructions.
- Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

- Develop a clear leadership structure, including designated roles and responsibilities for staff.

In addition the provider should:

- Ensure that the records of significant events and the minutes of meeting contain the details of the discussion and lessons learnt.
- Formalise the structure of meetings held at the practice through set agendas and detailed minutes.
- Review and record the immunisation status of staff to establish if staff and patients are protected from the risk of health care acquired infections.
- Record information regarding any physical or mental health conditions that applicants may have.
- Record which staff attend fire drills and how long it takes to evacuate the building.
- Consider keeping a copy of the business continuity plan off site.
- Continue to develop the role of the patient participation group.
- Consider a documented business plan to support the practice vision and future strategy.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

Good



- There was an effective system in place for reporting and recording significant events. However, there were inconsistencies in the level of detail recorded for significant events.
- The practice did not have a formal process in place to act upon and follow up on alerts that may affect patient safety, although evidence seen supported that appropriate action had been taken.
- Risks to patients were not always assessed and well managed, because the immunisation status of staff was not recorded, a system was not in place for checking the nurses' continued registration with their professional body, lack of assessments into risks such as fire, slips, trips and falls, non-servicing of the fire alarm, emergency lighting and stair lift.
- When things went wrong patients received reasonable support and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had systems, processes and practices in place to keep patients safeguarded from the risk of abuse.

Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes was comparable with the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the National GP Patient Survey published in July 2016 showed patients rated the practice in line with other practices.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services.
- Text reminders about appointments were sent to patients. Patients who did not attend for appointments were contacted by telephone either by a clinician or the office manager for a wellbeing check.
- Patients told us on the day of the inspection they were able to get appointments, both routine and emergency, although they may have to wait to see a GP of their choice.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised.

Good



Are services well-led?

The practice is rated as requires improvement for well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients.
- The practice did not have a clear leadership structure in place. The GPs did not have designated clinical or managerial roles. For example, responsibility for managing significant events, Medicines and Healthcare products Regulatory Agency (MHRA) alerts or Quality and Outcome (QoF) leads. Although regular clinical meetings were held, there was no set agenda and the minutes of meetings lacked detail and clarity.
- The practice did not have effective arrangements for identifying, recording and managing risks, and implementing mitigating actions. For example, the immunisation status of staff was not recorded; a system was not in place for checking the nurses' continued registration with their professional body, lack of assessments into risks such as fire, slips, trips and falls, non-servicing of the fire alarm, emergency lighting and stair lift.

Requires improvement



Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents.
- The practice sought feedback from staff and patients, which it acted on. There was a patient participation group in place. Both the practice and the group members recognised that this group needed to develop further to become more proactive and work together to improve the service and to promote and improve the quality of the care.
- There was a focus on continuous learning and improvement at all levels. This included the development of the staff team skills and knowledge.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice participated in the hospital admission avoidance scheme. The care of these patients was proactively managed using care plans and there was a follow up procedure in place for discharge from hospital.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- The GPs and the nursing team were involved in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice maintained registers of patients with long term conditions. Patients were offered a structured annual review to check their health and medicines needs were being met.
- Performance in four of the five diabetes related indicators was comparable to the national average. For example: The percentage of patients with diabetes, on the register, in whom a specific blood test was recorded was 77%, the same as the national average.
- Longer appointments and home visits were available when needed.
- For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children who were at risk, for example families with children in need or on children protection plans.

Good



Summary of findings

- Appointments were available outside of school hours and the premises were suitable for children and babies. Same day emergency appointments were available for children.
- There were screening and vaccination programmes in place and the practice's immunisation rates
- Data from the Quality and Outcomes Framework (QOF) for 2014/2015 showed that 77% of women aged 25-64 had received a cervical screening test in the preceding five years. This was below the national average of 82%.
- The practice offered routine contraception services including implant and coil insertion.

Working age people (including those recently retired and students)

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice offered on the day and pre-bookable appointments, as well as telephone consultation.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

Good



People whose circumstances may make them vulnerable

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The staff knew how to recognise signs of abuse in vulnerable adults and children. The staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Good



People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

Good



Summary of findings

- Ninety four percent of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%.
- Performance for mental health related indicators was comparable to or above the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 95% compared to the national average of 88%.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

Results from the national GP patient survey published in July 2016 showed patient satisfaction rates for consultations with GPs and nurses were comparable to the Clinical Commissioning Group (CCG) and national averages. Two hundred and thirty six survey forms were distributed and 102 were returned. This gave a return rate of 43%. For example:

- 91% of patients said the GP was good at listening to them compared to the CCG average of 85% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 86% of patients said the last GP they spoke to was good or very good at treating them with care and concern compared to CCG average of 82% and the national average of 85%.
- 84% of patients said the last nurse they spoke to was good or very good at treating them with care and concern compared to the CCG and national averages of 91%.

The results from the national GP patient survey showed patients expressed higher than average satisfaction rates compared with the CCG to questions about their involvement in planning and making decisions about their care and treatment, with the exception of nurses involving patients in decisions. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 80% of patients said the last GP they saw was good or very good at involving them in decisions about their care compared to the CCG average of 77% and national average of 82%.
- 77% of patients said the last nurse they saw was good or very good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

As part of our inspection we asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. All of the 38 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 11 patients, including two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Patients told us on the day of the inspection they were able to get appointments, both routine and emergency, although they may have to wait to see a GP of their choice.

Areas for improvement

Action the service MUST take to improve

Introduce a formalised system to act upon medicines and equipment alerts issued by external agencies.

Introduce a system to check the continued registration of the nurses with the appropriate professional body.

Carry out risk assessments into risks such as slips, trips and falls.

Introduce effective systems for identifying, recording and managing risks, issues and implementing mitigating actions.

Ensure that all equipment, including the fire alarm, emergency lighting and stair lift are serviced in line with the manufacturer's instructions.

Ensure there are formal governance arrangements in place including systems for assessing and monitoring risks and the quality of the service provision.

Summary of findings

Develop a clear leadership structure, including designated roles and responsibilities for staff.

Action the service SHOULD take to improve

Ensure that the records of significant events and the minutes of meeting contain the details of the discussion and lessons learnt.

Formalise the structure of meetings held at the practice through set agendas and detailed minutes.

Review and record the immunisation status of staff to establish if staff and patients are protected from the risk of health care acquired infections.

Record information regarding any physical or mental health conditions that applicants may have.

Record which staff attend fire drills and how long it takes to evacuate the building.

Consider keeping a copy of the business continuity plan off site.

Continue to develop the role of the patient participation group.

Consider a documented business plan to support the practice vision and future strategy.

Dr N Sivanesan & Partners (known as Brereton Surgery)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist adviser and an expert by experience.

Background to Dr N Sivanesan & Partners (known as Brereton Surgery)

Dr N Sivanesan & Partners, known locally as Brereton Surgery, is registered with the Care Quality Commission (CQC) as a GP partnership provider in Rugeley, Staffordshire. The practice holds a Personal Medical Services (PMS) contract with NHS England. A PMS contract is a locally agreed contract between NHS England and the general practice and offers variation in the range of service which may be provided by the practice. At the time of our inspection the practice had 4,273 patients.

We found there had been changes to the practice registration. A new GP had joined the partnership and the practice had not formally notified the Care Quality Commission of this change or amended their registration to reflect this change.

The practice staffing comprises of:

- Three GP partners (two male and one female).
- One female nurse prescriber, two female practice nurses and a female phlebotomist (who takes blood samples).

- A practice manager, office manager and administration manager and three reception staff.

The practice is open between 8am and 6.30pm Monday to Friday. The practice offers routine pre-bookable and on the day appointments. Pre-bookable 15 minute appointments are bookable up to four weeks in advance. Ten minute on the day appointments are either GP specific or added to the pool list to be seen by the next available GP. The practice also offers appointments with a nurse practitioner, practice nurses and a phlebotomist (person who takes blood samples). The practice does not offer any extended hours appointments.

Patients requiring a GP outside of normal working hours are advised to call the practice, where the call is automatically diverted to the out of hours service, which is Staffordshire Doctors Urgent Care.

Why we carried out this inspection

We carried out a comprehensive inspection of the services under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the service under the Care Act 2014.

Detailed findings

How we carried out this inspection

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?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

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

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

Before inspecting the practice we reviewed information we held and asked key stakeholders to share what they knew about the practice. We also reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 18 August 2016.

We spoke with a range of staff including the GPs, the nurse practitioner, a practice nurse, the phlebotomist (person who takes blood samples), the practice manager, the office manager, the clinical administrator and two members of reception staff. We spoke with patients, two members of the patient participation group who were also patients, looked at comment cards and reviewed survey information.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records and incident reports and the minutes of meetings where these were discussed. We saw there were inconsistencies in the level of detail recorded for significant events. Significant events were discussed at clinical meetings as they arose. The meetings were minuted so the information could be shared with all staff. However, the minutes did not contain the details of the discussion and lessons learnt.

The practice did not have a formal process in place to act upon and follow up on alerts that may affect patient safety, for example from the Medicines and Healthcare products Regulatory Agency (MHRA). Alerts were shared by email with clinical staff, although the practice did not have an accountable / lead clinician who ensured that alerts had been acted on appropriately. However, we saw evidence that demonstrated appropriate action had been taken in response to alerts, but the practice did not always record the actions they had taken. We spoke with the practice about this during the inspection.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from the risk of abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly

outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding, who had allocated time within their working week to dedicate to this role. Staff demonstrated they understood their responsibilities and all had received the appropriate level of training in safeguarding children and vulnerable adults relevant to their role.

- The practice held registers for children at risk, and children with protection plans were identified on the electronic patient record. The safeguarding lead met with the health visitor each week to discuss patients. Minutes of these meetings were not kept although information was recorded directly into the patient's notes.
- A notice in the waiting room and in the consultation/ treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS)
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The nurse practitioner was the infection control clinical lead. There was an infection control protocol in place. Infection prevention and control training was available on the on line training system although staff had not completed this. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The practice had not recorded the immunisation status of staff to establish if staff and patients were protected from the risk of health care acquired infections.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. Blank prescription forms and pads were securely stored and systems were in place to monitor their use. The nurse practitioner had recently qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They had received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

Are services safe?

- We reviewed three personnel files and found the majority of the appropriate recruitment checks had been undertaken prior to employment. The appropriate checks through the Disclosure and Barring Service had been completed for all staff. However, the practice did not have a system in place for checking the nurses' continued registration with the appropriate professional body, or record information regarding any physical or mental health conditions that applicants may have.

Monitoring risks to patients

There were measures in place to reduce risks within the practice. However, we saw these could be strengthened to greater assess the effectiveness of the existing arrangements.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice had not completed assessments into risks such as slips, trips and falls. A fire risk assessment had been completed. Although the practice tested the fire alarm on a weekly basis, the fire alarm system and

emergency lighting were not serviced on a regular basis. A fire drill had been carried out. However the records did not detail which staff attended and how long it took to evacuate the building. The stair lift had also not been serviced.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. All staff groups covered holidays and sickness.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training. There were emergency medicines
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. However, a copy of the business continuity plan was not kept off site.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. The staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 96.2% of the total number of points available (which was 2.7% above the local Clinical Commissioning Group (CCG) average and 1.5% above the national average), with 10.7% clinical exception rate (which was 0.5% above the CCG average and 1.5% above the national average). (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance in the five diabetes related indicators were comparable to the national average. For example: The percentage of patients with diabetes, on the register, in whom a specific blood test was recorded, was 77%, which was the same as the national average. However, the exception reporting for this indicator was 22%, which was higher than the national average of 12%.
- Performance for mental health related indicators was comparable to the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the

record, in the preceding 12 months was 95% compared to the national average of 88%. The exception reporting rate for mental health indicators was below the CCG and national averages.

- The percentage of patients with asthma, on the register, who had an asthma review in the preceding 12 months, was 70%, compared to the national average of 75%.
- 94% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was above the national average of 84%.

There was evidence of quality improvement including clinical audit.

- We looked at two completed audits undertaken in the previous 12 months where the improvements made were implemented and monitored. One of these audits related to the prescribing of soluble paracetamol and the associated cardiovascular risk. The first audit identified eight patients who were prescribed this medicine, four of which were found to have an increased cardiovascular risk, and two were elderly. As a consequence, three patients were no longer prescribed soluble paracetamol and one patient was prescribed non soluble paracetamol. The second audit cycle identified no patients who were prescribed soluble paracetamol had an increased cardiovascular risk.
- The practice used the services of the Acute Visiting Service (AVS) to carry out urgent home visits requested after 2pm. This had resulted in a reduction in attendance at accident and emergency and in unplanned admissions. The data related to patient attendance at A&E departments showed that the number of patients attending A&E as an emergency was lower than the CCG and national average. For example, the number of emergency admissions for 19 ambulatory care sensitive conditions (ACSCs) in 2014/15 per 1,000 population was 14, when compared with the CCG and national averages of 15. ACSCs are conditions where effective community care and case management can help prevent the need for hospital admission.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.

Are services effective?

(for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. The practice nurse administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. They could demonstrate how they stayed up to date with changes to the immunisation programmes, for example attending immunisation updates.
- The learning needs of staff were identified through a system of appraisals, discussions and meetings. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. Staff had protected learning time, either in house or at training events organised by the CCG. All staff had received an appraisal within the last 12 months.
- The practice supported clinical staff to extend their skills and knowledge in order to improve outcomes for patients. The nurse practitioner had been supported to undertake additional training to enable them to prescribe medicines within their area of competence.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice participated in the hospital admission avoidance scheme and had identified 68 patients who were at high risk of admission. These patients were identified on the electronic patient record. The care of these patients was proactively managed using care plans. The nurse practitioner reviewed the care plans with patients on an annual basis, or following any unplanned admission to hospital.

Staff worked together and with other health and social care services to understand and meet the range and complexity

of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice had seven patients who had been identified with palliative care needs and held three monthly meetings attended by the GPs and the palliative care nurse and community nurses.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- Clinical staff received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP, advance nurse practitioner or practice nurses assessed the patient's capacity and, recorded the outcome of the assessment.
- Written consent was obtained for minor surgery and insertion of intrauterine devices.

Supporting patients to live healthier lives

Patients who were in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition (disease prevention) and those requiring advice on their diet, smoking and alcohol cessation. The practice nurses offered smoking cessation advice.

The practice's uptake for the cervical screening programme was 77%, which was comparable to the national average of 82%. (Exception reporting for cervical screening was 6%, which was comparable to the CCG and national averages). The practice offered family planning and routine contraception services including implant/coil insertion. Chlamydia screening kits were available at the practice.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data from 2015, published by Public Health England, showed that the number of patients who engaged with national screening programmes was above the local and national averages:

Are services effective?

(for example, treatment is effective)

- 75% of eligible females aged 50-70 had attended screening to detect breast cancer in the last 36 months. This was above the CCG average of 73% and national average of 72%.
- 60% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer in the last 30 months. This was above the CCG average of 57% and national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to the CCG average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 70% to 100% and five year olds from 96% to 100%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private area to discuss their needs.

As part of our inspection we also asked for Care Quality Commission (CQC) comment cards to be completed by patients prior to our inspection. All of the 38 patient CQC comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with 11 patients, including two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published in July 2016 showed patient satisfaction rates for consultations with GPs and nurses were comparable to the Clinical Commissioning Group (CCG) and national averages. Two hundred and thirty six survey forms were distributed and 102 were returned. This gave a return rate of 43%. Results showed:

- 91% of patients said the GP was good at listening to them compared to the CCG average of 85% and the national average of 89%.
- 89% of patients said the GP gave them enough time compared to the CCG average of 84% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.

- 86% of patients said the last GP they spoke to was good or very good at treating them with care and concern compared to CCG average of 82% and the national average of 85%.
- 84% of patients said the last nurse they spoke to was good or very good at treating them with care and concern compared to the CCG and national averages of 91%.
- 85% of patients said they found the receptionists at the practice helpful compared to the CCG average and national averages of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We saw that care plans were personalised.

The results from the national GP patient survey showed patients expressed higher than average satisfaction rates compared with the CCG to questions about their involvement in planning and making decisions about their care and treatment, with the exception of nurses involving patients in decisions. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82% and the national average of 86%.
- 80% of patients said the last GP they saw was good or very good at involving them in decisions about their care compared to the CCG average of 77% and national average of 82%.
- 77% of patients said the last nurse they saw was good or very good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw information in the reception area informing patients this service was available.
- Information leaflets were available in easy read format.

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 60 patients as carers (1.4% of the practice list). Carers were asked to

identify themselves when they registered at the practice and were offered the annual influenza vaccination. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement their usual GP contacted them to offer support and an appointment if required. Information about bereavement services was available in the patient waiting area and patients could be referred to an emotional and wellbeing service for counselling.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was actively engaged with the local Clinical Commissioning Group (CCG) and therefore involved in shaping local services. The GPs, nurse practitioner and practice nurses attended the monthly protected learning time events organised by the CCG.

- There were longer appointments available for patients with a learning disability or those who needed them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation.
- Text reminders about appointments were sent to patients. Patients who did not attend for appointments were contacted by telephone either by a clinician or the office manager for a wellbeing check.
- Patients were able to receive travel vaccinations available on the NHS or were referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice was working towards becoming a dementia friendly practice, and all staff were due to receive training to become Dementia Friends.
- The practice offered a range of enhanced services including minor surgery, joint injections and spirometry (a test to see how well a patient can breathe).
- Midwife and health visitor clinics were held at the practice.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. GP appointments were available from 9am, with the last appointment being at 5.30pm. Appointments could be booked in person, over the telephone and on line. The practice had amended the appointment system to include pre bookable appointments as well as on the day appointments. Pre-bookable 15 minute appointments were available up to four weeks in advance (approximately one third of the daily appointments). The remainder of appointments were ten minute on the day appointments, with either a specific GP or added to the pool list to be seen by the next available GP. The GPs told us they thought the

current arrangement offered patients more choice of appointments. The practice also offered appointments with a nurse practitioner, practice nurses and a phlebotomist (person who takes blood samples).

The practice did not offer any extended hours appointments. The practice aimed to accommodate children of school age outside of school hours, and would see patients earlier or later by prior arrangement due to work commitments or medical conditions. One GP gave us an example of two patients who become anxious when around other patients, so they were seen before the main surgery started to reduce their anxiety.

The results from the national GP patient survey showed patients expressed lower than average satisfaction rates with their experiences of contacting, or making appointments at, the practice.

- 72% of patients were very satisfied or fairly satisfied with the practice's opening hours compared to the CCG and national averages of 76%.
- 60% of patients said they could get through easily to the practice by phone compared to the CCG and national averages of 73%.
- 63% of patients described their experience of making an appointment as good compared to the CCG and national averages of 73%.
- 67% of patients stated that the last time they wanted to see or speak with a GP or nurse they were able to get an appointment compared to the CCG average of 74% and national average of 76%.
- 46% of patients felt they didn't normally have to wait too long to be seen compared to the CCG average of 62% and national average of 58%.

However, patients told us on the day of the inspection they were able to get appointments, both routine and emergency, although they may have to wait to see a GP of their choice.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice offered telephone consultations with the duty GP at the end of morning surgery. Patients who needed to be seen the same day were booked into reserved appointments during the afternoon. The GPs routinely attended home visits when these requested during the

Are services responsive to people's needs?

(for example, to feedback?)

morning. Requests for home visits received during the afternoon were passed to the Acute Visiting Service (AVS). This service was provided by local GPs for patients in the local CCG area. AVS carried out home visits on behalf of practice after 2pm each weekday afternoon. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. Complaint leaflets were available at reception. All of the patients spoken with were aware of the complaints procedure, although none of these patients had made a complaint.

We looked at the summary of four complaints received since December 2015 and found they had been satisfactorily handled and demonstrated openness and transparency. Three of the complaints related to other organisations, and the practice had reported the information on Datix. Datix is an electronic system for reporting incidents and adverse events. The information was shared with the local Clinical Commissioning Group and the local NHS trust.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- Although the practice did not have a written mission statement, it was clear from discussion with staff that everyone was working towards the same aim of high quality healthcare.
- The GPs described their plans for the future and what options were available to them. However, there was no formal strategy in place or succession plan.

Governance arrangements

Governance within the practice was mixed, we saw examples of risks that had been well managed:

- Practice specific policies had been updated, implemented and were available to all staff.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

We did see some areas of governance that had not been well managed:

- There were inconsistencies in the level of detail recorded for significant events. Significant events were discussed at clinical meetings as they arose. Although significant events were discussed at meetings, the minutes did not contain the details of the discussion and lessons learnt, and did not support that learning had taken place and become embedded into practice.
- The practice did not have a formal process in place to act upon and follow up on alerts that may affect patient safety, or an accountable / lead clinician who ensured that alerts had been acted on appropriately.
- The practice did not have a system in place for checking the nurses' continued registration with the appropriate professional body.
- The practice did not have effective arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example: assessments into risks such as slips, trips and falls had not been completed, and the fire alarm system, emergency lighting and the stair lift had not been serviced.

Leadership and culture

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

At the time of the inspection, the practice did not have a clear leadership structure in place. The GPs did not have designated clinical or managerial roles. For example, responsibility for managing significant events, Medicines and Healthcare products Regulatory Agency (MHRA) alerts or Quality and Outcome (QoF) leads. Although the practice held regular clinical meetings, there was no set agenda and the minutes of meetings lacked detail and clarity.

However, staff told us there was an open and transparent culture within the practice and they had the opportunity to raise any issues and felt confident and supported in doing so. They told us they felt respected, valued and supported, particularly by the partners in the practice. Staff told us the GPs and practice manager were approachable and always took the time to listen to them.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through surveys, NHS Friends and Family Test and complaints received. The FFT is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. The practice had a patient participation group (PPG). Both the practice and the group members recognised that this group needed to develop further to become more proactive and work together to improve the service and to promote and improve the quality of the care. The group did not meet on a regular basis and the

Are services well-led?

Requires improvement 

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

majority of communication was by email. The PPG members discussed a number of ideas on how to promote the services of the practice, including the development of a newsletter.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice was working towards becoming a dementia friendly practice, and all staff were due to receive training to

become Dementia Friends. The nurse practitioner had been supported to undertake additional training to enable them to prescribe medicines within their area of competence. The practice was a Research Ready Accredited practice in association with Keele University and had been involved in a number of clinical trials.

The practice was part of a local initiative involving the four GP practices in Rugeley, known as Aspire Integrated Rugeley (AIR). The group was tasked with influencing and reshaping local health and care services by more integrated working and sharing of resources. For example, a shared duty surgery each day, inter-practice referrals for certain conditions, and liaison with local voluntary, social services and educational organisations.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are 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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>The provider did not have an effective process for assessing, monitoring and mitigating the risks to the health, safety and welfare of service users and others which arise from the carrying on of the regulated activity. This included:</p> <p>A formalised system to act upon medicines and equipment alerts issued by external agencies was not in place.</p> <p>A system to check the continued registration of the nurses with the appropriate professional body was not in place.</p> <p>Risk assessments into risks such as slips, trips and falls had not been carried out.</p> <p>All equipment, including the fire alarm, emergency lighting and stair lift had not been serviced in line with the manufacturer's instructions.</p> <p>Formal governance arrangements were not in place including systems for assessing and monitoring risks and the quality of the service provision.</p> <p>A clear leadership structure, including designated roles and responsibilities for staff was not in place.</p> <p>This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>