Dr Manickam Murugan

Quality Report

Hednesford Valley Health Centre
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Date of inspection visit: 11 Janaury 2018
Date of publication: 12/03/2018

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We previously carried out an announced comprehensive inspection at Dr Manickam Murugan on 16 May 2017. The overall rating for the practice was Inadequate and the practice was placed into special measures. This was because of the lack of clinical and management oversight within the practice which did not keep patients safe.

We undertook an announced focused inspection on 2 October 2017 to follow up on the warning notice. We found that the provider had developed a clinical supervision policy and a monitoring form, and the practice nurse was receiving regular supervision.

Both the full comprehensive report on the May 2017 inspection and the focused report on the October 2017 inspection can be found by selecting the 'all reports' link for Dr Manickam Murugan on our website at www.cqc.org.uk.

This inspection was an announced comprehensive inspection carried out on 11 January 2018 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous comprehensive inspection on 16 May 2017. This report covers our findings in relation to those requirements and also additional improvements made since our last inspection.

This practice is rated as requires improvement overall. (The practice was rated inadequate at our previous inspection on 16 May 2017)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Requires Improvement

Are services caring? – Requires Improvement

Are services responsive? – Requires Improvement

Are services well-led? – Requires Improvement

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Requires Improvement

People with long-term conditions – Requires Improvement

Families, children and young people – Requires Improvement

Working age people (including those retired and students – Requires Improvement

People whose circumstances may make them vulnerable – Requires Improvement

Summary of findings

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

Our key findings were as follows:

- We saw that the improvements seen during our previous inspection had been maintained.
- There had been an improvement in clinical leadership and capacity following the recent appointment of a salaried GP.
- The practice had some 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.
- There were areas where the practice did not have appropriate safety arrangements in place.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- The practice had a recruitment policy that set out the standards to be followed when recruiting clinical and non-clinical staff. However, there were exceptions, for example, a Disclosure and Barring Service check had not been obtained for one newly recruited member of staff.
- The practice did not have a structured system to keep clinicians up to date with current evidence-based practice or review the effectiveness and appropriateness of the care it provided.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients found the appointment system easy to use and reported that they were generally able to access care when they needed it. However, some patients made reference to the challenges getting through on the telephone to make an appointment, particularly in the morning.
- We found that the majority of the scores in the National GP Patient Survey published in July 2017 were lower than the scores in the July 2016 survey. The practice had since carried out its own patient satisfaction survey and developed an action plan to address identified issues.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

In addition the provider should:

- Ensure a review is undertaken to include a risk assessment of the availability of medicines to manage emergency situations.
- Review the storage arrangements and labelling of emergency medicines to ensure these can be easily identified in the case of an emergency.
- Review the process in place to ensure the identification of significant events through complaints received where appropriate.
- Review the reason for lower than average referral rates using the urgent two week wait referral pathway.
- Review the process in place to ensure all staff have read and signed minutes of meetings in line with practice policy.

I confirm that this practice has improved sufficiently to be rated Requires Improvement overall.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

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

Dr Manickam Murugan

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 second CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Manickam Murugan

Dr Manickam Murugan is registered with the Care Quality Commission (CQC) as an individual provider operating a GP practice in Hednesford, Cannock. The practice is part of the NHS Cannock Chase Clinical Commissioning Group. The practice holds a General Medical Services (GMS) contract with NHS England. A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract.

The practice operates from Hednesford Valley Health Centre, Station Road, Hednesford, Cannock, Staffordshire, WS12 4DH and provides regulated activities from this location only.

There are approximately 3,513 patients of various ages registered and cared for at the practice. The practice has a slightly higher than average population aged 0 to 4 years with six percent of patients falling in this category compared with CCG average of five percent. Nineteen per cent of the practice population is above 65 years which is higher than the CCG average of 16% and the national average of 17%. The percentage of patients with a long-standing health condition is 52% which is comparable to the local CCG average of 57% and national average of 54%. The practice provides GP services in an area considered as one of the less deprived within its locality. Deprivation covers a broad range of issues and refers to unmet needs caused by a lack of resources of all kinds, not just financial.

The staffing consists of:

- One full time male GP partner and one part time male salaried GP.
- A female part time practice nurse and a female part time phlebotomist.
- A practice manager, an assistant practice manager, reception staff and a secretary (locum).

The practice is open between 8am and 6.30pm Monday to Friday. Consultations with clinical staff are available from 9.30am until 12.30pm Monday to Friday, 4pm until 6pm on Mondays, Thursdays and Fridays, and 3.30pm until 6pm on Tuesdays. Extended hours consultations are available between 6.30pm and 7.30pm on Thursdays.

The practice does not routinely provide an out-of-hours service to their own patients but patients are directed to the out of hours service, via the NHS 111 service when the practice is closed.

The practice offers a range of services for example: management on long term conditions, child development checks and childhood immunisations, contraceptive and sexual health advice. Further details can be found by accessing the practice's website at www.drmmuruganssurgery.nhs.uk

Why we carried out this inspection

We undertook a comprehensive inspection of Dr Manickam Murugan on 16 May 2017 under Section 60 of the Health

Detailed findings

and Social Care Act 2008 as part of our regulatory functions. The practice was rated as inadequate and placed into special measures. The full comprehensive report following the inspection on May 2017 can be found by selecting the 'all reports' link for Dr Manickam Murugan on our website at www.cqc.org.uk.

We undertook an announced focused inspection on 2 October 2017 to follow up on the warning notice. We found that the provider had developed a clinical supervision policy and a monitoring form, and the practice nurse was receiving regular supervision.

We undertook a comprehensive follow up inspection of Dr Manickam Murugan on 11 January 2018. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care.

Requires improvement

Are services safe?

Our findings

At our comprehensive previous inspection on 16 May 2017, we rated the practice inadequate for providing safe services. This was because:

- The practice did not have systems in place to keep patients safe. There was no clinical oversight of the message / triage book and the provider could not demonstrate that staff working in advanced roles were taking appropriate action. Appropriate recruitment checks had not been undertaken prior to employment for newly appointed staff. Pathology results were not reviewed in a timely manner.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice did not keep patients safe. This included patient specific directions which allowed nurses to administer medicines in line with legislation, storage of vaccines, the lack of a risk assessment to explain the rationale for not stocking the suggested emergency medicines and records to demonstrate that the medicines used to treat symptoms of shock were checked and ready for use.

These arrangements had improved when we undertook a follow up comprehensive inspection on 11 January 2018, although further improvements were still required.

We rated the practice, and all of the population groups, requires improvement for providing safe services. This was because:

- The practice had not obtained all of the required staff checks when recruiting new staff.
- The practice had not assessed the impact of reduced reception staff hours on the service.
- Reception staff did not have access to 'red flag' alerts to assist them on how to respond to symptoms that might be reported by patients.
- It was not clear if there were any designated fire marshals within the practice and not all staff were up to date with their fire training.

Safety systems and processes

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

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training, although not all staff were up to date with training, for example fire safety and health and safety training, as deemed mandatory by the practice.
- The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance. The practice told us they were in the process of updating these policies to include modern slavery and female genital mutilation.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- We saw that improvements had been made to the recruitment procedures. We looked at the files for three newly recruited members of staff. The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The practice now asked employees for information regarding any physical or mental health conditions that they may have.
- However, we noted that a new DBS check for the salaried GP had not been obtained prior to employment. The practice had started this process but the DBS check had not been received at the time of our inspection. A DBS check from the previous employer was held on file. A documented risk assessment had not been completed in the interim to mitigate the potential risks of a clinician undertaking unsupervised consultations. The practice provided a copy of the new DBS certificate following the inspection.
- All staff received up-to-date safeguarding training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check. The chaperone policy had been updated to include details of where to stand during the examination.
- There was an effective system to manage infection prevention and control. The lead nurse had a clear

understanding of her roles and responsibilities. An external IPC audit had been carried out in November 2017 and demonstrated an improvement from the previous audit undertaken in August 2017. An action plan had been developed to address the issues identified.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- Since our previous comprehensive inspection there had been changes to the staff team. The advanced nurse practitioner, advanced clinical pharmacist, practice nurse and two reception staff had left their employment with the practice. The practice had recruited a part time practice nurse, part time receptionist and a salaried GP. Staff told us that a review of practice nurse hours had taken place and had increased for 20 to 25 hours, with the possibility of a further increase in the near future. The salaried GP worked five sessions a week, which resulted in an increase in the availability of GP appointments.
- Previously we identified that reception staffing levels were low, especially during the holiday period when staff covered for each other. Since our previous inspection the reception staff hours had reduced by a further 24 hours a week and we were told that another member of reception staff was leaving in the near future. The practice were not clear whether there were plans to recruit additional staff to cover this shortfall.Staff and patients told us they thought additional hours in reception would be beneficial.
- 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, for example, sepsis.
- However, receptionists did not have access to 'red flag' alerts to assist them on how to respond to symptoms that might be reported by patients.

Information to deliver safe care and treatment

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

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The 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 a system in place for sharing information with the out of hours service for patients nearing the end of their life or if they had a 'do not attempt cardiopulmonary resuscitation' (DNACPR) plan in place.
- The GPs held regular meetings with the community nursing teams and palliative care teams to discuss the care of patients were receiving end of life care.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice had made improvements since our last inspection and held the majority of the suggested emergency medicines. This list of emergency medicines had recently been updated to include a medicine to treat croup in children, however we observed the practice did not stock this medicine, A risk assessment had not been completed to explain the rationale for not stocking this medicine. We saw evidence to support that the emergency medicines, including those used to treat symptoms of shock were checked and ready for use. We observed some emergency medicines were not stored securely to minimise the risk of medicines falling if being transported. Some medicines required clearly labelling to ensure these could be easily identified.
- Improvement had been made to the storage of vaccines and we saw that the refrigerator temperatures were now checked and recorded twice a day. We saw that the Patient Group Directions (PGDs) which had been adopted by the practice to allow the nurse to administer medicines in line with legislation were all signed by the GP and the practice nurse.
- The practice now had access to their own defibrillator which was checked to ensure it was in good working order on a monthly basis.

Requires improvement

Are services safe?

- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance.
- The practice had introduced a system whereby all requests for antibiotic prescriptions were sent electronically to the GPs for authorisation if appropriate.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues and the practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The practice was located within a building owned and managed by NHS Property Services, who were responsible for maintaining the building. A representative was no longer available in the building although the records were kept on site. The practice manager told us that all the practices located in the building (including Dr Murugan's practice) were now responsible for maintaining certain aspects of the fire safety in the building. This included fire risk assessments, appointment of fire marshals and requirements to carry out regular fire drills.
- The practice was required to have fire marshals on site. However fire marshals were not currently in place.
- The practice was also responsible for providing staff with fire training. Not all staff were up to date with their fire training. This training was still outstanding from the previous inspection.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. We saw that the significant events recorded since the previous inspection were administrative. The GPs told us that no clinical significant events had occurred.
- 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.
- Staff shared an example of a recent significant event that had occurred and the subsequent learning that had been identified as a result of a complaint being received. We saw that this had been documented and discussed as a complaint rather than as a significant event and therefore had not followed the practice procedure for identification, recording and handling of significant events.
- There was a system for receiving and acting on external safety alerts. We saw that the improvements seen during the May 2017 inspection had been maintained. We looked at the action taken following three recent alerts. We found that the practice had taken appropriate action, for example carried out as a search of patients prescribed a particular medicine and recorded the action taken on the patient electronic record.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous comprehensive inspection on 16 May 2017, we rated the practice as requires improvement for providing effective services. This was because:

- The practice did not have a systematic approach for the receipt, sharing, monitoring and implementation of National Institute for Health and Care Excellence (NICE) best practice updates and guidelines.
- The provider could not provide any evidence to support they had assured themselves that the clinical staff, especially those working in advanced roles had the necessary skills and competency to carry out the role.
- The practice had no overarching approach to quality assurance and clinical audits demonstrated limited quality improvement.

These arrangements had improved when we undertook a follow up comprehensive inspection on 11 January 2018, although further improvements were still required.

We rated the practice, and all of the population groups, requires improvement providing effective services. This was because:

- The practice did not have a structured system to keep clinicians up to date with current evidence-based practice.
- The programme of quality improvement activity and reviews of the effectiveness and appropriateness of the care provided needed to be further developed.

Effective needs assessment, care and treatment

The practice did not have a structured system to keep clinicians up to date with current evidence-based practice. There was an intention to discuss guidelines as a regular agenda item at clinical meetings. However this had not been implemented at the time of our inspection.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice used electronic care plan templates to plan and monitor the care of patients
- The practice was following guidance and prescribing effectively in the following areas:
- The practice was comparable to other practices for hypnotic prescribing. The Clinical Commissioning Group (CCG) and England average daily quantity of hypnotic prescribing was broadly 1 (for that therapeutic group) whereas the practice average daily quantity was two for patients within that therapeutic group.
- The percentage of high risk antibiotics prescribed (Co-amoxiclav, Cephalosporins or Quinolones) was 4.3%, compared to the CCG average of 6.1% and the England average of 4.7%.
- The practice was comparable to the CCG and national averages for antibiotic prescribing. The number of items the practice prescribed was 1.2% compared with the CCG and national average of 1%.
- We saw no evidence of discrimination when making care and treatment decisions.
- 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. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services.
- 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.
- Patients were offered a range of immunisation programmes including influenza, pneumococcal and shingles vaccines.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- The practice also 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 for 2016/17 showed that 74% of patients with asthma had received an asthma review in the preceding 12 months that included

an assessment of asthma control. This was similar to the Clinical Commissioning Group (CCG) average of 79% and the national average of 76%. Their exception reporting rate of 2% was below the CCG and national average of 8%.

- 90% of patients with diabetes had a blood pressure reading (measured in the preceding 12 months) within recognised limits. This was higher than the CCG average of 81% and the national average of 78%. Their exception reporting rate of 3% was comparable to the CCG average and national averages of 9%.
- The percentage of patients on the diabetes register, in whom a specific blood test to get an overall picture of what a patients average blood sugar levels had been over a period of time was recorded as 82% compared with the CCG average of 81% and the national average of 79%. The practice exception reporting rate of 24% was higher than the CCG average of 15% and the national average of 12%.
- Exception reporting is the removal of patients from QOF calculations where, for example, patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice offered sexual health services, for example family planning, contraceptive services and sexual health.
- Expectant mothers were offered the whooping cough and influenza vaccines.

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

- The practice's uptake for cervical screening was 83%, which was in line with the 80% coverage target for the national screening programme. Their exception reporting rate of 4%, which was below the CCG average of 5% and the national average of 7%.
- 92% of patients aged 15 or over who were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months. This was comparable with the CCG average of 91% and the national average of 89%.
- 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.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including patients with a learning disability and children in need or with a child protection plan in place.

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

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the CCG and national averages of 84%.
- 100% of patients with a diagnosed mental health disorder had a comprehensive, agreed care plan documented in the previous 12 months. This was above the CCG average of 91% and the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 100% compared to the CCG average of 93% and the national average of 91%. The percentage of patients with a physical and/or mental health condition who had received discussion and advice about smoking cessation was 98% compared with the CCG average of 96% and the national average of 95%.

Monitoring care and treatment

The practice recognised that they needed to improve their programme of quality improvement activity and review the effectiveness and appropriateness of the care provided. The practice had participated in two audits recently undertaken by an external organisation. One of these was a completed audit which demonstrated improvements. The audit related to medicine prescribed for a specific condition osteoporosis. The first cycle identified 19 patients with the condition who were not on

Requires improvement

Are services effective?

(for example, treatment is effective)

recommended medicine. These patients were reviewed and offered the recommended medicine. The second cycle indicated that all patients with the condition were on the recommended medicine.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The most recent published results for 2016/17 showed the practice had achieved 100% of the total number of points available compared with the Clinical Commissioning Group (CCG) average of 98% and national average of 96%. Their overall clinical exception reporting rate was 9% which was comparable with the CCG rate of 11% and national rate of 10%.

The exception reporting rates for a small number of clinical and public health domains were higher than the CCG and national averages. These were discussed with the GPs, who reported there were plans to review the data and identify areas for improvement.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Staff were encouraged and given opportunities to develop.
- The newly appointed practice nurse was being supported to attend 'The Fundamentals of Practice Nursing' course at the local university.
- Staff had access to an on line training programme. We saw that not all staff were up to date with their required training, for example fire safety and health and safety training. The practice did not have a system in place to ensure staff remained up to date with training.
- Following our last inspection the practice had introduced a process for clinical supervision. We saw that the practice nurse had received supervision on a regular basis. The records demonstrated that the GP reviewed randomly selected consultations and discussed these with the practice nurse.

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, services and organisations, were involved in assessing, planning and delivering care and treatment.
- 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.
- The clinical staff at the practice met every month with the community nurses and palliative care team to discuss patients identified with palliative or end of life care needs.

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.
- The practice's referral rate for patients with possible cancer was lower than the CCG and national average. Data from 2015/16 published by Public Health England showed that 39% of new cancer cases (among patients registered at the practice) were referred using the urgent two week wait referral pathway. The CCG average was 45% and the national average of 50%.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data showed that the number of patients who engaged with national screening programmes was higher than the local and national averages.
- 68% of eligible females aged 50-70 had attended screening to detect breast cancer in the last 36 months. This was comparable to the CCG average of 68% and the national average of 70%.

Requires improvement

Are services effective?

(for example, treatment is effective)

- 53% of eligible patients aged 60-69 were screened for symptoms that could be suggestive of bowel cancer in the last 30 months. This was comparable to the CCG average of 56% and the national average of 54%.
- Staff encouraged and supported patients to be involved in monitoring and managing 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.

Consent to care and treatment

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

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Requires improvement

Are services caring?

Our findings

At our previous comprehensive inspection on 16 May 2017 we rated the practice as good for providing caring services. At this inspection we have rated the practice, and all of the population groups, as requires improvement providing caring services. This was because:

- The deterioration in the results of the National GP Survey published in July 2017.
- The lack of any clear action taken by the practice to address the worsening GP Survey results.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We received 69 patient Care Quality Commission comment cards. All except five of these were positive about the service experienced. The main issue raised was communication. This is in line with other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. A total of 296 surveys were sent out and 117 were returned. This represented about 3% of the practice population. The practice satisfaction scores on consultations with GPs were mixed and the scores in this survey in relation to listening and enough time during consultations were considerably lower than the scores obtained in the July 2016 survey. For example:

- 78% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 85% and the national average of 89%. This was a reduction of 12% compared to the previous survey results.
- 77% of patients who responded said the GP gave them enough time compared to the CCG average of 83% and the national average of 86%. This was a reduction of 13% compared to the previous survey results.
- 94% of patients who responded said they had confidence and trust in the last GP they saw, the same as the CCG average and similar to the national average of 95%. This was a reduction of 2% compared to the previous survey results.
- 82% of patients who responded said the last GP they spoke to was good at treating them with care and concern, compared to the CCG average of 81% and the national average of 86%. This was a reduction of 3% compared to the previous survey results.

However the practice was below the CCG and national averages for its satisfaction scores on consultations with nurses. These scores were lower than the scores obtained in the July 2016 survey. For example:

- 84% of patients who responded said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%. This was a reduction of 10% compared to the previous survey results.
- 80% of patients who responded said the nurse gave them enough time compared to the CCG average of 91% and the national average of 92%. This was a reduction of 16% compared to the previous survey results.
- 89% of patients who responded said they had confidence and trust in the last nurse they saw compared to the CCG and national averages of 97%. This was a reduction of 10% compared to the previous survey results.
- 79% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%. This was a reduction of 16% compared to the previous survey results.

The survey showed that 75% of patients said they found the receptionists at the practice helpful compared to the CCG average of 86% and the national average of 87%. This score was lower than the score of 87% obtained in the July 2016 survey.

The practice had carried out its own satisfaction survey during September and October 2017. Two hundred surveys

had been handed out and 125 were returned, although not all patients answered every question. The practice survey did not include questions to explore the reasons for the deterioration in above results.

Patients spoken with during the inspection told us they were satisfied with the care and treatment they received. They felt involved in decisions about their care and didn't feel rushed during their consultations.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language. Although we did not see notices in the reception areas informing patients this service was available, staff were fully aware of how to access interpretation services.
- Staff communicated with patients in a way that they could understand. One member of staff was able to share an example of how they supported a patient with hearing loss through written communication and lip reading.
- The practice had access to a loop system to assist patients with a hearing impairment although this had not yet been set up.
- We saw patients and their carers had access to information to community and advocacy services.

The practice proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 77 patients as carers (2% of the practice list).

- The practice had a policy in place to assist staff to identify carers. The practice registration form asked if the person was a carer or had a carer. Patients who identified themselves as carers were asked to provide additional information and indicate if they wished to have their details passed on to the carers association and be referred for a carer's assessment. Notices in the patient waiting room signposted patients and their carers to support services available to them.
- Carers were offered an annual health check and 'flu vaccine.
- One of the GPs told us if families had experienced bereavement they would contact them. Support was provided on one to one basis as required Leaflets were available for bereaved patients signposting them to local support services.

Results from the national GP patient survey showed how patients responded to questions about their involvement in planning and making decisions about their care and treatment. Results for GPs and nurses were lower than the local and national averages. These scores were lower than the scores obtained in the July 2016 survey. For example:

- 72% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 81% and the national average of 86%. This was a reduction of 9% compared to the previous survey results.
- 71% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and the national average of 82%. This was a reduction of 9% compared to the previous survey results.
- 78% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared to the CCG and the national average of 90%. This was a reduction of 20% compared to the previous survey results.
- 66% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and the national average of 85%. This was a reduction of 29% compared to the previous survey results.

Since our previous comprehensive inspection a new practice nurse had been employed. Patients had been asked about whether the nurse they saw was good at involving them in decisions about their care. The vast majority of patients indicated the nurse was good at involving them although eight of the 90 responses were either not good or neither.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.

Requires improvement

Are services caring?

- The practice complied with the Data Protection Act 1998.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous comprehensive inspection on 16 May 2017 we rated the practice as good for providing responsive services. Following this inspection we have rated the practice, and all the population groups, as requires improvement for providing responsive services. This was because:

- The deterioration in the results of the National GP Survey published in July 2017.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

- The practice understood the needs of its population and tailored services in response to those needs. For example, the practice provided extended opening hours with the practice nurse and the GP. Online services such as repeat prescription requests and booking appointments were also available.
- 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, home visits were provided for housebound patients and telephone consultations for patients unable to access the practice within normal opening times.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The provider was part of the Cannock Practice Network Surgery, based in the GP Suite at Cannock Hospital. Reception staff offered patients appointments at the Cannock Practice Network Surgery after 1.30pm when no appointments were available at the practice. Appointments were available between 3.30pm and 7.40pm. Pre-bookable appointments at the Cannock Practice Network Surgery were available on Saturdays and Sundays between 9am and 1pm.
- GPs were able to book appointments with the female GPs at the Network if requested by patients.
- Home visits were available with either the GPs or through the Acute Visiting Service (AVS) after 1.30pm. This service was provided by local GPs for patients in the local Clinical Commissioning Group (CCG) area.

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 in the process of identifying this group of patients and adding alerts to their notes stating they should be offered a same day appointment/advice if needed.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice was working towards offering patients over the aged of 75 years who visited the practice infrequently an annual health check.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Patients spoken with told us they were offered regular reviews.
- The practice communicated with the community 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.
- The practice co-hosted weekly antenatal clinics with the community midwives.
- The practice was in the process of identifying and adding alerts to the notes of patients under the age of five years stating they should be offered a same day appointment/advice if needed. All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The 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, extended hours appointments were available with the nurse on Tuesdays from 5.30pm to 6.30pm and on Thursdays from 6.30pm to 7.30pm, and with the GP on Thursdays from 6.30pm to 7.30pm.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice identified and maintained registers of patients living in vulnerable circumstances including those with a learning disability or physical disability, those living in care homes or alone, and carers. The practice was in the process of identifying and adding alerts to patient notes stating they should be offered a same day appointment/advice if needed.
- Longer appointments were available for patients with a learning disability.
- The practice worked with the palliative care team and community nursing teams to support patients near the end of their life and those who were frail and / or housebound.

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 register of patients living with dementia or with poor mental health.
- The practice was in the process of identifying and adding alerts to patient notes stating they should be offered a same day appointment/advice if needed.
- Patients identified with memory changes were referred to the memory care facilitator, who liaised with the memory clinic for further assessment of their needs.
- Patients with a mental health diagnosis were offered an annual review of their physical and mental health needs.
- The practice had a good working relationship with the community mental health team and were able to refer patients for support from this team.

Timely access to the service

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

- Patients had access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was lower than the local and national averages.
- 66% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 76%. This was a reduction of 20% compared to the previous survey results.
- 46% of patients who responded said they could get through easily to the practice by phone compared to the CCG average of 69% and the national average of 71%. This was a reduction of 20% compared to the previous survey results.
- 76% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared to the CCG and national averages of 84%. This was an improvement of 7% compared to the previous survey results.
- 73% of patients who responded said their last appointment was convenient compared with the CCG and national averages of 81%. This was a reduction of 25% compared to the previous survey results.
- 52% of patients who responded described their experience of making an appointment as good compared with the CCG average of 72% and the national average of 73%. This was a reduction of 27% compared to the previous survey results.
- 59% of patients who responded said they do not normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%. This was a reduction of 19% compared to the previous survey results.

Based on these results, the practice had carried out its own satisfaction survey during September and October 2017. Two hundred surveys had been handed out and 125 were returned, although not all patients answered every question. The practice had developed an action plan following the survey. The findings indicated that getting through to the practice by telephone was still an issue for patients. As a consequence at least two reception staff were now on duty from 8am, one to deal with face to face queries and one to answer the telephone. The practice had also discussed re-organising the reception area, so two staff members were available at the desk, or installing an electronic patient check in system. Thirty one patients (out

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

of 119) described their experience of making an appointment as fairly bad or bad. Staff were required to complete the on-line 'customer service' training module in an effort to improve the patient experience at reception.

The practice satisfaction survey asked patients about appointments and opening times at the surgery. Two patients had commented that they were not able to pre-book appointments. Patients were also asked how easy it was to book an appointment with the practice nurse. Seventy two patients had made appointments with the practice nurse and 52 patients commented that it was very or fairly easy. This was a slight improvement on the results obtained in the 2016 satisfaction survey.

Seventeen out of the 69 comments cards we received made reference to the challenges around making appointments and getting through to the practice on the telephone. Patients spoken with during the inspection commented that they were usually able to get an appointment when they needed one.

Staff told us that access to GP appointments had increased and improved following the recruitment of the salaried GP. The next available routine appointments were two working days after the inspection.

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 and included advice on the escalation process should they not be happy with the outcome.
- Not all patients spoken with were aware of how to make a complaint but told us they would raise any issues with reception staff. However, these patients had not had any cause to complain.
- The complaint policy and procedures were in line with recognised guidance. Five complaints were received during the previous 12 months. We reviewed all five complaints and found that they were satisfactorily handled in a timely way. However, we noted that the response letter sent to the complainant did not contain details of how to escalate their complaint if they were not happy with the response from the practice.
- 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, for example, improving communication through customer care training.

Are services well-led?

Requires improvement

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

Our findings

At our previous comprehensive inspection on 16 May 2017, we rated the practice inadequate for providing well led services. This was because:

- The practice had insufficient clinical leadership capacity and limited formal governance arrangements.
- Leaders did not have the necessary capacity and capability to lead effectively. The approach to service delivery and improvement was reactive and focused on short term issues.
- There was a lack of sustained improvement in the clinical leadership within the practice.
- There was a lack of clinical oversight to ensure staff working in advanced roles were taking appropriate action or recording information accurately in patient notes.
- Staff were unaware of the practice vision and a detailed plan to achieve the vision values was not in place, staff did not understand how their role contributed towards achieving the vision.

Although arrangements in leadership and governance arrangements had started to improve when we undertook a follow up comprehensive inspection on 11 January 2018, further improvements and embedding of the processes was still required.

We rated the practice, and all of the population groups, requires improvement providing well led services. This was because:

- Clinical leadership and capacity and governance arrangements needed to be further developed and embedded into practice.
- Effective processes to identify, understand, monitor and address current and future risks including risks to patient safety needed to be further developed and implemented.
- Arrangements were not in place to review and take effective action in response to the clinical performance of the practice.
- Limited arrangements were in place to explore and address the deterioration in the National GP Survey scores.

Leadership capacity and capability

We saw there had been an improvement in clinical leadership and capacity. There had been changes in the leadership team since our previous inspection. A salaried GP had joined the practice in November 2017, with the plan to become a partner in March/April 2018. The new GP had previous experience within a GP partnership and held the position of Clinical Director within a local Clinical Commissioning Group. They were also part of the Clinical Entrepreneur Fellowship with NHS England.

The leaders showed some knowledge about issues and priorities related to the quality and future of services. They were aware of challenges that affected the practice and changes that needed to be made.

Staff told us that the GPs were visible and approachable. Staff told us they felt able to raise any concerns or seek advice when required.

Vision and strategy

At the time of our previous comprehensive inspection the practice had developed a mission statement and vision to improve the health, wellbeing and lives of the patients under the care of the practice. However it had not been shared with staff. Staff told us during this inspection that the mission statement and vision had been shared and discussed with them and we saw it was on display around the practice.

The practice did not have a formalised business plan. The GPs recognised that they needed to develop a realistic strategy and supporting business plans to achieve their goals. They outlined provisional plans for the future development of the practice.

Culture

- Staff told us that they felt morale had improved since our previous inspection.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Patients were given an apology and told of action that had been taken following an incident or a complaint. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need, although systems were not in

Are services well-led?

Requires improvement

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

place to ensure staff remained up to date with their training. This included appraisal and career development conversations. All staff had attended an annual appraisal in the last year.
- The practice actively promoted equality and diversity. Staff had access to equality and diversity training.

Governance arrangements

The GPs recognised that framework for governance arrangements needed to be developed, implemented and embedded with the practice.

We saw that the improvements made to the administrative side of the practice had generally been maintained following our previous inspection. Staff attended regular staff meetings where they felt able to raise any concerns. Minutes of these meetings were available and staff were required to sign to say they had read them. However, we noted minutes were filled away before all staff had signed them.

Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.

Practice leaders had established proper policies, procedures and activities to ensure safety, although processes had not yet been developed to provide assurance that they were operating as intended.

Changes had been made to the way in which information received by the practice was shared amongst staff. Information received in paper form was scanned on the electronic system and shared through the workflow system, although one of the GPs preferred to review the paper copy rather than use the computer system. All messages were now sent via the task facility on the electronic system, removing the need for a hand written message book.

Managing risks, issues and performance

The practice had limited processes for managing risks, issues and performance, and there was a recognition that improvements needed to be made.

- The practice did not have 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. The performance of the practice nurse could be demonstrated through clinical supervision. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- We reviewed the records of the events that had occurred since our previous inspection. The records showed that significant events had been shared at practice meetings.
- There was limited evidence of clinical audit being used effectively to have a positive impact on quality of care and outcomes for patients. External audits had been completed and demonstrated a positive impact for patients. However the practice had not carried out any internal audits.
- The practice did not fully utilise all opportunities for learning and improving. For example, a more detailed review of deaths, or benchmarking information against other practices to identify areas for improvement.
- The practice had plans in place and had trained staff for major incidents, although not all staff were up to date with their training.

Appropriate and accurate information

The practice acted on some of the information available to them.

- The practice did not fully demonstrate that it acted on all information available to improve performance.
- Performance information was combined with the views of patients from national surveys and practice surveys to support improvements.
- The practice had not ensured it used clinical performance information to monitor and improve the delivery quality care. We found that the practice was not aware of areas of higher than average exception reporting within Quality Outcome Framework (QOF) clinical targets.
- Arrangements in place were 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 engaged with patients, the public, staff and external partners.

- 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.

Are services well-led?

Requires improvement

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

- There was a patient participation group. Meetings were held every three months. The results from the internal patient satisfaction survey and suggestions for improvements were discussed at the last meeting.
- We spoke with a member of the patient participation group. They told us the practice was open and honest with them, valued their views and listened and acted upon their suggestions. For example the changes to the appointment system and the increase in nurse appointments.
- The practice had been working closely with external stakeholders following our previous inspection to make improvements.
- Clinical and practice meetings took place on a regular basis.

Continuous improvement and innovation

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

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

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 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 Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **There were limited systems or processes that enabled the registered person to evaluate and improve their practice in respect of the processing of information obtained throughout the governance process. In particular** • The programme of quality improvement activity and review of effectiveness and appropriateness of care provided needed to be further developed. • Clinical leadership and capacity and governance arrangements needed to be further developed and embedded into practice. • Effective processes to identify, understand, monitor and address current and future risks including risks to patient safety needed to be further developed and implemented. • Arrangements were not in place to review and taken action in response to the clinical performance of the practice. • Limited arrangements were in place to explore and address the deterioration in the National GP Survey scores. **The registered person had systems or processes that operated ineffectively in that they failed to enable the registered person to assess, monitor and mitigate the risks relating to health, safety and welfare of service users and others who may be at risk. In particular:** • The practice had not assessed the impact of the reduced reception staff hours on the service. • Reception staff did not have access to 'red flag' alerts to assist them on how to respond to symptoms that might be reported by patients. • The practice did not have designated fire marshals and not all staff were up to date with their fire training.

This section is primarily information for the provider

Requirement notices

- The practice did not have a systematic approach to the receipt, sharing, monitoring and implementation of National Institute of Health and Social Care Excellence (NICE) best practice updates and guidance.
- Not all staff were up to date with their required training.

This is a breach of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • A Disclosure and Barring Service check had not been obtained for one clinician prior to their employment. This was a breach of Regulation 19 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014.