Dr Abid Hussain

Quality Report

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Date of inspection visit: 27 May 2015
Date of publication: 15/10/2015

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

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 Pearl Medical Centre on 28 May 2015. Overall the practice is rated as inadequate.

Specifically, we found the practice inadequate for providing safe, effective and well led services. The practice requires improvement for providing a caring and responsive service.

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

- Patients were at risk of harm because systems and processes were not in place to keep them safe. Recruitment checks were not robust. Risks such as fire and health and safety had not been assessed and managed.
- The arrangements in place to identify, review and monitor patients with some long term conditions and at risk groups were not effective. The most recent national data for the year 2013-2014 showed that the practice was below the national average for diabetes.
- The practice did not have a robust and formal process in place to manage staff performance or their training needs
- The practice had limited formal governance arrangements that enabled the monitoring of performance, quality and risks.

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

- Establish effective systems to assess, monitor and mitigate risks relating to the health, safety and welfare of patients, staff and visitors to the practice.
- Develop systems to seek feedback from staff and patients at the practice and ensure this feedback is recorded and acted upon.
- Implement a robust complaints policy and procedure that is accessible and understood by all patients and demonstrates a commitment to responding to and resolving all complaints where possible. Where any trends are identified, actions are taken to improve the quality of care for patients.

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- Ensure that all staff receive appropriate training, professional development and supervision appropriate to their role.
- Ensure that all non clinical staff who administers vaccines uses Patient Specific Directions that have been produced by the prescriber.
- Ensure that non-clinical staff receive appropriate training, professional development and supervision in the administration of vaccines.
- Review the availability of emergency medicines so that emergencies are managed effectively.
- Ensure that all relevant staff including those who carry out chaperone duties has either undergone a Disclosure and Barring Service check or have a risk assessment in place.
- Operate effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying out a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed and is physically and mentally fit for that work.

In addition the provider **should**:

- Ensure that lessons learned from all significant events, incidents and complaints are shared and recorded.
- Develop robust training needs and analysis systems to ensure that all staff are up-to-date with training such as chaperone, fire safety awareness and infection control.
- Ensure that all policies and procedures/protocols are up to date and are understood and implemented by staff.
- Conduct an analysis of required staffing levels to ensure that enough staff, particularly clinical staff are employed to safeguard the health, safety and welfare of patients.
- Ensure that systems to undertake regular checks on emergency equipment are in place.
- Research best practice guidance to determine those medicines most appropriate to include in emergency medicine kits.
- Put plans in place to demonstrate and monitor action in relation to improving outcomes for patients with long term conditions such as diabetes.
- Ensure that the practice leaflet for patients is updated to include current details about the surgery opening times.
- Ensure that all staff receive regular supervision and annual appraisals which identify learning needs from which action plans are documented when required
- Develop an up-to-date leadership structure which clearly identifies lead roles and responsibilities for each staff member.
- Develop ways to improve patient satisfaction and develop an action plan in response to information from the national patient survey information.
- Update the business continuity plan.
- Develop robust health and safety systems and complete risk assessments.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

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?

Inadequate

The practice is rated as inadequate for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. Risks to patients who used services were considered, however the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe, for example recruitment, staff training and infection control. The practice demonstrated actions they had recently taken to address some of these risks, for example in relation to recruitment.

Are services effective?

Inadequate

The practice is rated as inadequate for effective services as there are areas where improvements should be made. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. There was no evidence that all clinical staff had received training appropriate to their roles or that any further training needs had been identified or planned to meet these needs. There was no evidence of recent appraisals for most staff. The practice had taken steps to address this and had plans for all staff appraisals to be completed within six months. Staff worked with multidisciplinary teams.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services. Data showed that patients had mixed views about the practice, however patients we spoke with and most feedback from the comment cards said that they were treated with compassion, dignity and respect. They confirmed that they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

We saw that staff tried to ensure patient confidentiality when discussing patients' treatments at the reception desk. However, we saw that this was difficult due to the layout of the two reception desks. We also saw that the receptionists also answered telephone calls from patients and we were able to overhear these in the waiting area. We saw that the practice provided a room next to

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reception if patients wished to discuss any private issue. In the GP national patient survey January 2015 we found that 77% of those patients who responded said that they found the receptionists at the practice helpful which was below the local CCG average of 83%.

The national patient survey information we reviewed showed that 57% of patients who responded said that the last GP they spoke to was good at treating them with care and concern. Survey information also showed that 69% of respondents said the last nurse they spoke to was good at treating them with care and concern. These results were below the local CCG averages of 84% and 89% respectively.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services. Although the practice had reviewed the needs of its local population, it had not put in place a plan to secure improvements for all of the areas identified. Feedback from patients reported that access to a named GP was variable, although urgent appointments were usually available the same day.

The practice was not well equipped to treat patients and the premises needed upgrading. Information about how to complain was not available for patients. There was a designated person responsible for handling complaints however we found that complaints had not been managed or progressed in a way to provide a timely and adequate response to patients' concerns and complaints. There was no evidence that learning from complaints had been shared with staff.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led. There was no clear leadership structure and some staff did not feel supported by management. The practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. The practice had not proactively sought feedback from staff or patients and did not have a patient participation group (PPG) although they had made contact and received facilitators training with the lead for engagement at the CCG to improve this situation. Staff told us they had not received regular performance reviews and did not have clear objectives. Not all staff training was up-to-date and a number of staff did not have a Disclosure and Barring Service (DBS) clearance in place. (DBS checks to 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 was taking steps to address this.

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

Inadequate

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in admissions avoidance and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Longer appointments and home visits were available for older people when needed, and this was acknowledged positively in feedback from patients.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Nursing staff had lead roles in chronic disease management. The practice had lower than the national average rate for outcomes in relation to patients with diabetes. We found that the practice was taking action to address this although we were not able to evidence the impact of this action at inspection. Longer appointments and home visits were available when needed. Most of these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Inadequate

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm. Immunisation rates for the standard childhood immunisations were mostly below the local Clinical Commissioning Group (CCG) averages. For example, data for childhood immunisation rates for

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the vaccinations given to under twos ranged from 87.6% to 97.2% (four out of eight areas were higher than the CCG average, four were below the CCG average) and for five year olds from 69.4% to 95.9% (seven out of eight records were below the CCG average).

There was evidence of joint working with midwives and health visitors. Appointments were available outside of school hours. There was no baby changing facility and the corridors on the first floor were narrow making it difficult to manoeuvre pushchairs. There was only one toilet facility for patients to access at the practice.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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 did not offer online services for patients however the practice was open on a Saturday morning each week and provided a full range of health services to reflect the needs of this age group

People whose circumstances may make them vulnerable

Inadequate

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and we found that most of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were supported to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding raising safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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People experiencing poor mental health (including people with dementia)

Inadequate 

The provider was rated as inadequate for safety, effective and for well-led and requires improvement for responsive and caring. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health. For example, we saw evidence of multidisciplinary team (MDT) working and case management of patients with mental health problems. The practice referred to a community led counselling service for Muslims and people related to the Muslim community in Birmingham.

The practice also worked closely with the Improving Access to Psychological Therapies (IAPT), a national NHS programme which offers treatments for patients with depression and anxiety disorders. We found that the practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

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What people who use the service say

We reviewed 36 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that the majority of comments recorded were positive. Patients commented that they were treated with dignity and respect and staff were perceived to be polite, informative and approachable. The majority of patients were satisfied with the appointments system. With a few exceptions, most patients commented that they were content to see any GP although some female patients requested and received a female GP when required.

We reviewed the most recent data available for the practice on patient satisfaction from the national GP Patient Survey dated January 2015. The survey highlighted that the practice was below the national average in relation to access to appointments and generally rated the practice below the local and national average in these areas. The survey showed that 57% of patients who responded said that the last GP they spoke to was good at treating them with care and concern. Survey information also showed that 69% of respondents said the last nurse they spoke to was good at treating them with care and concern. These results were below the local CCG averages which were 84% and 89% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

On the day of the inspection we spoke with 13 patients and had the support of an interpreter for those patients who did not have English as their first language. Most patients we spoke with told us they were satisfied with the care provided by the GPs and nurse. Three patients made negative comments, for example two patients said that it was difficult to make an appointment and one said that they had to wait months to see a nurse.

The practice did not have a patient participation group (PPG). PPGs are a way in which patients and GP surgeries can work together to improve the quality of the service. The practice told us that they were working with the lead for engagement at the Clinical Commissioning Group (CCG) to address this.

Areas for improvement

Action the service MUST take to improve

- Establish effective systems to assess, monitor and mitigate risks relating to the health, safety and welfare of patients, staff and visitors to the practice.
- Develop systems to seek feedback from staff and patients at the practice and ensure this feedback is recorded and acted upon.
- Implement a robust complaints policy and procedure that is accessible and understood by all patients and demonstrates a commitment to responding to and resolving all complaints where possible. Where any trends are identified, actions are taken to improve the quality of care for patients.
- Ensure that all staff receive appropriate training, professional development and supervision appropriate to their role.
- Ensure that all non clinical staff who administers vaccines uses Patient Specific Directions that have been produced by the prescriber.
- Ensure that non-clinical staff receive appropriate training, professional development and supervision in the administration of vaccines.
- Review the availability of emergency medicines so that emergencies are managed effectively.

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- Ensure that all relevant staff including those who carry out chaperone duties has either undergone a Disclosure and Barring Service check or have a risk assessment in place.
- Operate effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying out a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed and is physically and mentally fit for that work.

Action the service SHOULD take to improve

- Ensure that lessons learned from all significant events, incidents and complaints are shared and recorded.
- Develop robust training needs and analysis systems to ensure that all staff are up-to-date with training such as chaperone, fire safety awareness and infection control.
- Ensure that all policies and procedures/protocols are up to date and are understood and implemented by staff.
- Conduct an analysis of required staffing levels to ensure that enough staff, particularly clinical staff are employed to safeguard the health, safety and welfare of patients.
- Ensure that systems to undertake regular checks on emergency equipment are in place.
- Research best practice guidance to determine those medicines most appropriate to include in emergency medicine kits.
- Put plans in place to demonstrate and monitor action in relation to improving outcomes for patients with long term conditions such as diabetes.
- Ensure that the practice leaflet for patients is updated to include current details about the surgery opening times.
- Ensure that all staff receive regular supervision and annual appraisals which identify learning needs from which action plans are documented when required
- Develop an up-to-date leadership structure which clearly identifies lead roles and responsibilities for each staff member.
- Develop ways to improve patient satisfaction and develop an action plan in response to information from the national patient survey information.
- Update the business continuity plan.
- Develop robust health and safety systems and complete risk assessments.

Dr Abid Hussain

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice nurse specialist advisor, a second inspector and an Expert by Experience who had personal experience of using primary medical services. An interpreter also spoke with patients who did not have English as their first language to ensure as many patients' views could be taken into account as possible.

Background to Dr Abid Hussain

Dr Abid Hussain's practice is known locally as Pearl Medical Centre. It is located in Ward End, Birmingham which is an area of high deprivation and associated health needs. The practice is based across two adapted shops and one residential property that have been extended to provide primary care services. The registered patient size is 9790 patients. Pearl Medical Centre has an inherently younger population with twice the national average of 5 to 14 year olds (22.3% compared to 11.2%) and very low numbers of older patients. For example, the practice has 1.7% of patients aged 75 years or over registered with the practice compared to a national average of 7.8%. The practice also has a high ethnic population, mainly from the Pakistani community and low levels of economic activity.

The practice has a Primary Medical Services Growth contract with NHS England. This contract enables the practice to respond to the needs of the community by allowing more flexibility in the approach to disease management by utilising a wide variety of health care professionals. The practice also provides some enhanced services. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract.

The practice is open from Monday to Friday each week from 8.30am to 6.30pm and is closed at lunchtime from 1pm to 2pm. The telephones remain manned should any patient call during this lunchtime period. Extended hours appointments are available on Monday evenings from 6.30pm to 8pm and on Saturday mornings from 8.30am to 1pm**.** The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed.

There is a principal GP, three salaried GPs, one trainee GP, one regular locum, a practice nurse, a locum nurse, a strategic development manager, a practice pharmacist, a prescribing pharmacist, a senior receptionist and a number of healthcare assistants and receptionists employed by the practice. There is however, no practice manager in post.

The practice is a GP training practice for trainee GPs (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students. The principal GP is responsible for the induction and overseeing of the training for the trainee GPs at Pearl Medical Centre.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal

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requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had been inspected on 25 July 2013 and 24 February 2014. We found that there had previously been an area of non-compliance in relation to recruitment of staff which had subsequently been addressed.

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.

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 carrying out our inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 27 May 2015. During our inspection we spoke with a range of staff, including the principal GP, three salaried GPs, one trainee GP, one regular locum, a practice nurse, a locum nurse, the strategic manager, the practice pharmacist, a prescribing pharmacist, the senior receptionist, two healthcare assistants and a receptionist. We reviewed 36 comment cards where patients and members of the public shared their views and experiences of the service.

Inadequate

Are services safe?

Our findings

Safe track record

The practice had a system in place for reporting significant events and that significant events were included as a standing item on the clinical meeting agenda. We saw evidence that the practice held monthly meetings with staff and at some of these meetings significant events were discussed. However, there was no evidence that safeguarding or complaints were discussed at these meetings or shared with staff. There was no evidence available to show that significant events were analysed over time or that the effectiveness of learning actions had been reviewed.

The practice did not have effective arrangements in place to ensure the delivery of safe patient care or systems to protect the health and safety of patients, staff and visitors to the practice. Report forms were available to staff on the practice computer which we saw staff had completed for incidents, near misses and complaints about the practice. We saw that there was no system for recording events according to type such as accidents, near misses or significant events to allow a clear analysis. Records we looked at for example showed incidents that included staff sickness, issues with prescribing, complaints received from patients, delayed referrals, unprocessed letters and breaches in confidentiality. For each incident very brief details had been recorded with no information about any action or response taken. There was insufficient information or documented evidence made available to show how the practice had managed risks to patients and to demonstrate a safe track record over time.

Learning and improvement from safety incidents

We reviewed records of 38 significant events that had occurred during 6 January 2014 and 30 April 2015. However, we found that the system did not demonstrate learning or improvement from the significant events. For example, we saw evidence where a receptionist had identified an issue in relation to a patient where details of their location could have been compromised. We looked to identify how this incident had been managed and shared with staff. We did not see any evidence of learning to ensure that this type of incident did not happen again.

Another example was where the practice had correctly identified an issue in relation to a staff member removing prescriptions from the practice. However, the practice was unable to provide any evidence of how this had been discussed at practice meetings or shared with staff. No actions were seen to have been recorded to ensure that this would not happen again in the future or that procedures had been changed as a result of learning from this.

National patient safety alerts were disseminated by the practice pharmacist to relevant practice staff. The practice pharmacist and other staff we spoke with were able to give examples of recent alerts that were relevant to their areas of responsibility and the action they had taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding. For example, records showed that the principal and salaried GPs had completed the higher level training each year although locum GP records showed no evidence they had completed safeguarding training. The records showed mixed results for nursing staff and HCAs. It was not clear that reception staff had completed any safeguarding training specific to their role.

We asked members of medical, nursing and administrative staff about their most recent training and we found that they were able to demonstrate how to recognise signs of abuse in older people, vulnerable adults and children. Staff told us that if they had any safeguarding concerns about a patient, they would contact a GP or the senior healthcare assistant.

We saw that the practice had a safeguarding policy which was updated on 13 March 2015 with information and guidance for staff to follow if they had any concerns.

The principal GP was the dedicated lead for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. Two staff we spoke with were not aware who the lead was but they were clear that they would speak to the senior healthcare assistant if they had a safeguarding concern.

The lead GP for safeguarding told us that once per week they met with the health visitors to discuss any potential

child safeguarding issues. They also worked closely with the staff from the local Children's Centre to support ways for mothers to interact with the service. The practice was unable to provide any records of these meetings.

We saw that the practice had a chaperone policy which was due for review on 12 April 2015. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The practice was unable to provide evidence to demonstrate that any staff had been trained to act as a chaperone. We found that not all staff who may undertake chaperone duties had received Disclosure and Barring Service (DBS) clearance. (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). Risk assessments had not been completed to determine the suitability of non-clinical staff to carry out chaperone duties where a DBS had not been obtained.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found that they were stored securely and only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. However this was dated May 2012 and was not complete. It did not show details about how the stock should be managed or how often the stock checks should take place. Records showed that fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

There were arrangements in place for repeat prescribing so that patients were reviewed appropriately to ensure their medicines remained relevant to their health needs. There was a system in place for the management of high risk medicines which included regular monitoring in accordance with national guidance. For example, we saw that patients on these medicines were called to attend for regular blood tests.

The nurse administered vaccines and medicines according to Patient Group Directions (PGDs) that had been produced in line with legal requirements and national guidance. We found that these PGDs were up-to-date.

We found that health care assistants at the practice administered vaccines and other medicines. We were told that they had training in relation to this. However, we did not see any evidence that they followed Patient Specific Directions (PSDs) that had been produced by the prescriber. The strategic development manager told us that they would address this immediately. The practice was unable to show us evidence that all nurses and health care assistants had received appropriate training and had been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us that painting had been carried out and new carpets had been laid recently which had improved the practice significantly. They told us that the patient toilet was not always clean. On the day of the inspection we checked the patient toilet and found it to be clean and tidy.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. We saw that there was a protocol for providing guidance for the urgent treatment and attention to injuries by sharps (such as needles). This was dated 2 May 2013 and had not been reviewed since this date.

We were told that the strategic manager was the lead for infection control at the practice. We saw evidence of two infection control audits carried out by the practice on 2 March 2015 and 21 May 2015 which identified areas for improvements such as replacement carpets and repainting of the waiting areas of the practice. We saw that action had been taken to replace carpets and repaint the waiting rooms the week before we inspected the practice on 27 May 2015. We did not see any evidence that staff received training about infection control specific to their roles, or

that they received annual updates. For example, the training record indicated that eight staff had completed infection control training in 2012 but the was no record to show staff had completed update training since then.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available and notices about hand hygiene techniques were displayed in the treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We checked to see if equipment was tested and maintained regularly. We found examples of portable electrical equipment which had been routinely tested and were up-to-date, for example a blood pressure monitoring machine. We saw evidence of calibration of relevant equipment; for example a pulse oximeter and blood pressure measuring devices.

Staffing and recruitment

The registered patient list size for Pearl Medical Centre was 9,790 patients. We were told that there were between 836 - 936 appointments available for patients each week. The staffing levels at Pearl Medical Centre consisted of one principal GP, three salaried GPs, a GP locum, a practice nurse and a locum nurse. There was also a practice pharmacist, a prescribing pharmacist and reception and administrative staff. We were told that 14 receptionists had been trained to become healthcare assistants and in particular had received training in venepuncture and could offer blood testing for patients who were unhappy to make arrangements at the local hospital and experience long wait times. These staff offered appointments morning and afternoon.

We identified a lack of stability in the clinical staff team to ensure patients received continuity of care. We were told that a number of staff had left and others were leaving. For example, one of the salaried GPs and the practice nurse were leaving at the end of the week. Another salaried GP told us they were resigning and leaving at the end of July 2015. We were informed that the practice manager who was currently on sick leave had also resigned. Staff who were leaving the practice told us that they had raised issues about the extensive workload that they had to deal with, however they felt that no action had been taken to improve this.

We saw that the practice had contacted the Clinical Commissioning Group (CCG) and NHS jobs to advertise vacancies during March and April 2015. We saw that the practice had advertised for a practice nurse and a health care assistant on 8 May 2015 and had been trying to recruit a GP and a practice nurse since March 2015. We saw that the one of the locum nurses used by the practice had been appointed to a permanent position and was due to start their contract at the end of June 2015.

Following the inspection, the principal GP confirmed to us that two of the staff that were leaving were on a specific programme to gain experience at a primary care practice and were always due to complete their 'placements' in May 2015. They also informed us that the salaried GPs who were leaving were part time and both positions had been advertised. They confirmed that the positions would be covered by a full time GP from September 2015 who would provide continuity within the practice as they were an experienced GP trainer.

The principal GP also told us that the current trainee GP had indicated that they intended to apply to work for six sessions at the practice once they had received their final registration in September 2015. In addition to this, a part time GP who worked at the practice had agreed to become full time. The principal GP told us that the strategic development manager was managing the duties of the practice manager until a suitable replacement was found. They confirmed that they felt assured that all of these changes would provide continuity of care for the patients. They also confirmed that they had contacted the Commissioning Support Unit to help them to undertake searches on the clinical system to evidence that there had been no statistical change in the number of appointments offered compared to a similar time period with last year; the number of hospital attendances over a similar time period to last year; and the number of attendances in out of hours clinics or walk-in clinics. A meeting had been arranged for 17 June 2015 to do this.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there were some systems in place to monitor and review staffing levels to manage and address any shortages in order that there was no impact on the delivery of the service. We saw that there was a rota system in place and administrative staff were able to cover each other's annual leave.

Inadequate

Are services safe?

The practice had a recruitment policy dated May 2015 which set out the standards it followed when recruiting clinical and non-clinical staff. This policy did not specify the required employment checks such as proof of identification, qualifications and registration with the appropriate professional body. The policy included a requirement to ensure appropriate checks were made through the Disclosure and Barring Service. (These 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).

We saw that a number of staff did not have a DBS clearance in place, one of which was the practice nurse. On the day of the inspection we saw that the practice had recently identified this problem and was in the process of requesting DBS checks for all staff. We raised our concerns with the practice about the possible implications of employing clinical staff without a DBS check. The practice took immediate steps to reduce any possible risks and cancelled the nurse's clinics for the day. The day following the inspection they confirmed that the practice nurse would be supervised to carry out the clinics allocated for that day. The practice informed us that they had completed a more considered risk assessment in relation to this and confirmed that the nurse had worked for them for nine months. They told us the nurse did have a DBS clearance in place albeit this was from an agency for which the nurse had worked previously.

Monitoring safety and responding to risk

The practice did not have systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was no evidence to show that any health and safety checks of the building had been undertaken. We were told that the strategic development manager was the identified health and safety representative. We spoke with the strategic development manager who confirmed that this was a recent addition to their responsibilities and they were not aware of any health and safety checks of the building being completed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support however update training was seen to be variable. Some staff had received basic life support training in 2012 or 2013 and there was no policy of how often this would be updated. Emergency equipment was available including access to oxygen and a defibrillator (used to restart a person's heart in an emergency). We saw that the emergency oxygen cylinder was empty during the inspection. The practice had not been aware of this and immediately took steps and changed it for a full oxygen cylinder. There was no evidence to demonstrate that regular checks were in place to ensure that this situation would not occur again in the future.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. We saw that these only included medicines for the treatment of anaphylaxis (a severe allergic reaction) and adrenaline (used in the event of heart failure). Processes were in place to check whether these emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of an electrician to contact if any electrical system failed. However, the plan was last reviewed in 2012 and did not identify any risk in relation to the loss of key staff which was seen to be a significant risk during the inspection.

We did not see any evidence that the practice had carried out a risk assessment or actions required to maintain fire safety. For example, the practice training summary showed that staff were not up to date with fire awareness training or that they practised regular fire drills. Some staff had not received fire awareness training since 2012 and for other staff there was no record of any fire awareness training.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were able to demonstrate how they accessed and implemented guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

NICE provides national guidance and advice to improve health and social care.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with a learning disability had regular health checks and were referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

We found that the principal GP led on safeguarding and another GP led on rheumatoid arthritis. The practice had nurse led clinics to review long term conditions such as asthma, diabetes and heart disease. Administrative staff were involved in calling and recalling patients for their reviews.

We saw that the practice had achieved 88.8% for the Quality and Outcomes Framework (QOF) for the last financial year 2013 to 2014. This was lower than 94%for the national average. The QOF is the annual reward and incentive programme which awards practices achievement points for managing some of the most common chronic diseases, for example asthma and diabetes. The practice also had a higher than the national average rate of clinical exception reporting at 10.6% compared to the national average of 7.9%. The QOF includes the concept of 'exception reporting' to ensure that practices are not penalised where, for example, patients do not attend for review or where a medicine cannot be prescribed due to a contraindication or side effect. The practice told us that this was partly as a result of their lower than average proportion of older people in their patient population and diseases such as dementia and diabetes were less likely or prevalent among younger patients. Data taken from Public Health England showed that 27% of their population was under the age of 18 which was higher than the national average of 14.8%; 3.7% of patients aged 65 and over which was lower than the national average of 16.7%; and patients over the age of 75 years at 1.7% which was lower than the national average of 7.6%.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. We found that the practice had identified a low percentage of patients who were at high risk of admission to hospital. The practice had a named GP for older people and in addition, the senior healthcare assistant was the practice lead for older people. They told us that they provided continuity of care by always accompanying clinicians when older people were visited outside the practice. The senior healthcare assistant also confirmed that they provided telephone support for patients over the age of 75 years which helped them to feel supported. We were told that there was a separate telephone number for those patients to access the practice and its staff more easily. However, we were told that this mobile number was not being used currently and the landline number was not yet connected. This was in progress at the time of the inspection.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits that had been undertaken in the last 12 months. We saw that one of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. This was in relation to a medicine prescribed for heart rhythm disorders. We found that the practice had identified actions to take in response to the audit to improve outcomes for patients. This included checking and amending the appropriate coding on records for these patients.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a national performance monitoring tool). For example, we saw examples of medicine audits that had been undertaken by the practice pharmacist which included an audit of a particular

medicine used by patients who were pregnant. Following the audit, we saw evidence the prescribing practice of the clinicians was altered to ensure it aligned with national guidelines.

The practice also used information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, we saw that the percentage of patients identified at risk, aged over six months and under 65 years that received the seasonal influenza vaccination was in line with national average rates.

The practice had a system in place for identifying and reviewing patients and we saw that some patients, such as those with a learning disability had received an annual review. However the most recent national data seen for the year 2013 to 2014 showed that the practice rate for identifying patients with chronic obstructive pulmonary disease (COPD) (lung disease) was slightly lower than the national average. The practice rate was 49% compared to the CCG average of 50.14% and the national average figure of 50.29%. The practice told us that this was partly as a result of their lower than average proportion of older people in their patient population and diseases such as dementia and diabetes were less likely or prevalent among younger patients.

The practice also had a lower than national average rate for outcomes in relation to patients with diabetes. For example, the percentage of patients with diabetes on the register with a record of a foot examination within the preceding 12 months was 61.22% compared to the national average of 77.75%. Staff told us that they recognised that this was an area that required improvement. We were told that the practice was taking steps to address this position, for example by including foot checks as part of an individual patient's diabetic review. The principal GP also told us that the practice was in the process of training staff in the 'alphabet strategy'. This was a mnemonic-based approach to diabetes management to ensure a robust review for all patients with diabetes was completed. The principal GP told us that they had received this training from a diabetes specialist and had already held a clinic this year at a weekend for patients with diabetes. There was no evidence at the time of the inspection to show any impact for patients as a result of this initiative.

The practice had a palliative care register and held quarterly multidisciplinary (MDT) meetings to discuss the care and support needs of patients and their families. The principal GP at the practice provided their personal mobile number to families of patients who were at the end of their lives to enable easy access for them to their GP.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending courses such as annual basic life support. There was evidence that the GPs had completed training in areas such as safeguarding vulnerable adults and children and basic life support.

However the practice training matrix showed that staff were not up-to-date with training such as fire safety and infection control. We did not see any evidence that staff had received recent appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that annual appraisals had not taken place for about two years. We were told that the senior healthcare assistant had never received a formal appraisal. We were told that self-appraisal forms had been issued to staff and the practice had plans for all staff appraisals to be completed within six months.

We found that healthcare assistants at the practice had been trained in venepuncture and to administer vaccines and other medicines. We were told that they had in-house training in relation to this. However, we did not see any evidence that they used Patient Specific Directions (PSDs) that had been produced by the prescriber. We did not see evidence that all nurses and healthcare assistants had received appropriate training and been assessed as competent to administer the medicines referred to either under a Patient Group Directions (PGD) or in accordance with a PSD from the prescriber. Following the inspection, the principal GP told us that a new nurse prescriber who was due to start in June would be responsible for managing the competency requirements of the practice, particularly in respect to clinical matters.

The principal lead GP also told us that staff had been trained in 'Five Ways to Mental Health', however we did not see any record of this. However, following the inspection the practice sent us copies of certificates for the staff that had completed this training in 2013.

Inadequate

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

There was evidence that the practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All staff we spoke with understood their roles and felt the system in place worked well. Staff told us that there had been instances where results or discharge summaries had not been followed up for some time. On the day of the inspection we found that all of the results and discharge summaries had been actioned.

We saw that there was multidisciplinary working in place and meetings were held with health care professionals such as district nurses and Macmillan nurses for end of life care.

We also saw evidence of multidisciplinary team (MDT) working and case management of patients with mental health problems. The practice referred some patients to a community led counselling service for Muslims and people related to the Muslim community in Birmingham.

The practice also worked closely with the Improving Access to Psychological Therapies (IAPT), a national NHS programme which offers treatments for patients with depression and anxiety disorders.

We saw that there were seven children on the register who were considered to be at risk of harm. A MDT meeting had taken place the week prior to the inspection which included the attendance of the health visitor to discuss the needs of these children.

Information sharing

The practice used electronic systems to communicate with other providers. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that the practice supported midwives employed by the local hospital to hold clinics three days per week at the practice. We were told that the midwives were asked to sign confidentiality agreements to enable them to have shared access to patients' records.

Consent to care and treatment

We found that the principal GP was aware of the Mental Capacity Act 2005 (MCA), the Children Acts 1989 and 2004 and their duties in fulfilling it. They told us that they had completed training in MCA and would discuss the MCA with staff during the weekly staff meeting at the practice. We did not see any evidence of any MCA training for other staff.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. We saw that this included the steps to take to obtain consent from patients. The policy did not include specific reference to those patients who did not have capacity to make decisions or the Mental Capacity Act 2005. We found that the practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check by a healthcare assistant to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the clinicians to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years. We saw that the practice offered smoking cessation advice to smokers. The principal GP told us that the practice was one of the higher achievers for Birmingham smoking cessation this year. QOF data showed that the practice had achieved 94.2% which was slightly higher than the CCG average of 93.8% and the national average of 93%. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We saw that since April 2014 458 patients had been invited for a health check out of 757 of those eligible and 429 patients had completed their health check.

The practice's performance for the cervical screening programme was 88.11%, which was above the national

Inadequate

Are services effective?

(for example, treatment is effective)

average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice nurse had responsibility for following up patients who did not attend.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Last year's performance was below average for the childhood immunisation rates for five year olds and in the expected range for flu vaccinations where comparative data was available. For example:

- Childhood immunisation rates for the vaccinations given to under twos ranged from 87.6% to 97.2% (four out of eight areas were higher than the CCG average, four were below the CCG average) and for five year olds from 69.4% to 95.9% (seven out of eight records were below the CCG average). The CCG averages ranged from 86.2% to 96.3%.
- The percentage of patients aged 65 and older who had received a seasonal flu vaccination was 68.1% which was similar to expected in the CCG.

The practice did not have a website to provide information and links to patient information on various health conditions such as diabetes, as well as advice on self-care for treating minor illnesses. The strategic development manager told us that they were currently exploring this facility to provide a community resource for patients and the wider community.

Requires improvement

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were available in consulting and treatment rooms so that patients' privacy and dignity could be maintained during examinations, investigations and treatments. We saw that consultation and treatment room doors were closed during consultations.

Data from the national patient survey January 2015 showed that 76% of the practice respondents felt that the GPs were good at listening to them and 77% for the nurses, compared to weighted Clinical Commissioning Group (CCG) averages of 88% and 90% respectively. There were 58% of practice respondents who stated the GP gave them enough time. This was also below the weighted CCG average of 86% for consultations with clinicians.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards and the majority were positive about the service experienced. Patients said they felt that staff were helpful and caring and treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with 13 patients on the day of our inspection with the support of an interpreter for those patients who did not have English as their first language. Most patients we spoke with told us they were satisfied with the care provided by the GPs and nurse. Three patients had negative comments. For example, two patients said that it was difficult to make an appointment and one said that they had to wait months to see a nurse.

We saw that staff tried to ensure patient confidentiality when discussing patients' treatments at the reception desk. However, we saw that this was difficult due to the layout of the two reception desks. We also saw that the receptionists also answered telephone calls from patients and we were able to overhear these in the waiting area. We saw that the practice provided a room next to reception if patients wished to discuss any private issue. In the GP national patient survey January 2015 we found that 77% of those patients who responded said that they found the receptionists at the practice helpful which was below the local CCG average of 83%.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed that 65% of patients who responded said the last GP they saw was good at explaining tests and treatments and 51% said the last GP they saw was good at involving them in decisions about their care. Both of these results were below the local CCG averages of 85% and 80% respectively.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. Staff and patients told us that twice weekly clinics were held specifically for patients who were Romanian and support from an interpreter was provided by the practice. We also found that a number of practice staff could speak other languages to support patients.

Patient/carer support to cope emotionally with care and treatment

The national patient survey information we reviewed showed that 57% of patients who responded said that the last GP they spoke to was good at treating them with care and concern. Survey information also showed that 69% of respondents said the last nurse they spoke to was good at treating them with care and concern. These results were below the local CCG averages of 84% and 89% respectively.

The patients we spoke with on the day of our inspection and the comment cards we received were positive about the emotional support provided by the staff at the practice. For example, one patient stated that they wished to credit the staff and GPs at the practice for the way they supported an elderly, housebound relative at the end of their life and the family as a whole. Another patient was provided with a taxi paid for by the principal GP to get an urgent visit to a local hospital. Other patients commented that staff responded compassionately when they needed help and provided support when required.

Requires improvement

Are services caring?

We saw that the practice enabled the Citizen's Advice Bureau service to provide two sessions per week for patients at the practice and also helped patients who had alcohol and drug related problems by referring them to other relevant services for support.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We were told that the practice also had to take an opportunistic approach to meet some patients' needs. The practice was located in an area with high levels of deprivation and was culturally diverse.

We saw that the last annual survey carried out by the practice was in 2013. We discussed this with the strategic development manager and the senior healthcare assistant who recognised that this was an issue. They confirmed that they would take action to ensure that the annual satisfaction survey for patients would be carried out.

The principal GP told us that they were currently working with the lead for engagement at the CCG to develop facilitation work with specific community groups to access patient views. We saw evidence that this communication had commenced. We also saw that some staff had attended a facilitator training session with the lead for engagement in March 2015.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients, such as those with a learning disability. The practice supported a range of ethnic groups and we saw that translation services were available if they were needed. Staff members spoke a range of different languages to support patients. For example, we were told that one receptionist could speak Romanian.

Although the practice building was old it was accessible to patients with mobility difficulties. Clinicians supported patients who used a wheelchair in a ground level consulting room. Other consulting rooms were available on the first floor and a lift was available for those who needed it. We saw that the corridors upstairs were very narrow. There was only one toilet in the practice for patients and no baby changing facilities. Staff told us that this was difficult for the number of patients who accessed the practice.

However plans were in place to move to a new building in the future with better facilities. The practice had applied to the Primary Care Infrastructure Fund and had secured support in principle to move the project forward.

Staff told us that any homeless patients were able to see a clinician if they came to the practice asking to be seen and they would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female GP as they preferred.

Access to the service

We were told that the practice was open to book appointments from 8.30am to 6.30pm and was closed at lunchtime from 1pm to 2pm. The telephones remained manned should any patient call during this lunchtime period. Extended hours appointments were available on Monday evenings from 6.30pm to 8pm and on Saturday mornings from 8.30am to 1pm**.** The practice leaflet for patients included details about the surgery opening times but these were seen to be different times from those staff had described. We were told that the practice leaflet needed to be updated. We saw that there were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Staff told us that patients calling the practice would be diverted to the out of hours service. We found that information about how to access the out of hours service was available in the practice leaflet.

Longer appointments were available for older patients and patients with learning disabilities and those with long-term conditions if required. Staff told us that children were given an appointment within three hours of the request.

The national GP patient survey information (January 2015) we reviewed showed that 94% of patients who responded felt that the last appointment they got was convenient, compared to a CCG average of 90% and a national average of 92%. However we saw that patients responded negatively to most questions about access to appointments and generally rated the practice below the local and national averages in this area. For example:

- 69% were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 75%.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

- 57% described their experience of making an appointment as good compared to the CCG average of 67% and national average of 73%.
- 54% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 62% and national average of 65%.
- 54% said they could get through easily to the surgery by phone compared to the CCG average of 62% and national average of 73%.

We saw that the practice had taken steps to improve this situation. A team of staff had been set up to manage the appointments system. At the time of the inspection, the practice was not able to demonstrate how effective this initiative had been or how it had improved outcomes for patients. Patients we spoke with on the day of the inspection had variable views about the appointments system and said it was either hard to get an appointment or reasonably easy to use. The senior healthcare assistant told us that they would carry out an audit of the appointments system to identify any further areas for improvement that may be needed.

Listening and learning from concerns and complaints

The practice was unable to show that they had a complaints policy or procedures in place for handling complaints and concerns, however there was a designated responsible person who handled all complaints in the practice. Following the resignation of the practice manager, we found that the senior healthcare assistant had taken responsibility for the complaints received by the practice.

Staff told us that if a patient wished to make a complaint they would try to resolve the issue straightaway. Patients were invited to discuss their complaint privately in a side room if they wished to. Staff confirmed that if the complaint could not be resolved, they would escalate to the senior healthcare assistant or give the patient a complaint form.

We did not see any information in the waiting area to help patients understand the complaints system. None of the patients we spoke with were aware of any complaints procedure at the practice and had never had to make a complaint.

We looked at four complaints received in the last four months and found that patients had been informed that their complaints would be investigated and a response provided once the investigation was concluded. There was no evidence available to show that this had happened.

The practice had sent us a summary of complaints received for the previous 12 months prior to the inspection. However, when we looked at the complaints log we found that not all complaints received had been included in this summary. The summary therefore had not accurately reflected the complaints received for the 12 months period. We found that the practice did not review complaints annually to detect themes or trends and there was no evidence seen that lessons learned from individual complaints had been acted on or improvements made to the quality of care as a result.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

The principal GP told us of their plans to move the practice to a new site across the road to a property that they had purchased in 2009. They told us that they were working with the local Clinical Commissioning Group (CCG) and hoped to realise this vision in the near future.

We saw that the practice had a vision to deliver the highest standards of care to every patient and to ensure that the patient was the priority for the service at all times.

We spoke with 12 members of staff and they all knew about the plans to move to a new site. They told us that they felt the move to the new site would be much better for patients. We found that most staff had a generic role and a wide range of responsibilities.

We found that there were a number of meetings which took place, including managers' meetings, clinical meetings and practice meetings. Some of these took place monthly; others such as the clinical meetings had not taken place since February 2015 due to staffing issues. Minutes seen showed that a number of key areas were discussed at these meetings however, we found there were no actions or timescales for completion recorded.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. Staff told us and we saw that these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and saw that most of the policies and procedures had been reviewed annually and were up to date. However, when we looked at these policies and procedures we found the practice did not have a system in place to assure them that these policies and procedures were being followed and implemented. For example, the practice had failed to identify that required training had not been completed in areas such as chaperoning and fire safety training. The practice was also not following its own health and safety and recruitment policies.

The practice did not have robust arrangements in place to identify, record and manage risks, issues or to implement mitigating actions. It had carried out a number of clinical audits which it used to monitor quality and systems to identify where action should be taken. However, it did not use evidence from other sources including incidents and complaints to identify areas where improvements could be made. Additionally, there was no up-to-date process in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. We saw that the practice had developed a risk log but we found no evidence of completed risk assessments where risks had been identified or any action plans produced to reduce the possibility of any future recurrence.

Leadership, openness and transparency

The principal GP was seen to be visible in the practice. We saw from minutes that practice meetings were held every month to enable staff to be kept up to date with current issues and changes. Staff we spoke with gave us mixed views about whether they felt they could approach the management in the practice. Two staff told us that they always felt supported and the principal GP and other salaried GPs were accessible and approachable. Three other staff told us that there was a culture where they were not able to raise any concerns or issues and if they did, their views were not listened to. Another staff member told us that it used to be a good team and they felt that this had been 'lost' but that they felt it was coming back. Two members of staff told us that there were a number of family members within the practice which made it more difficult to raise issues.

We saw a copy of a leadership structure with named members of staff in lead roles which we were told was out of date. The structure included a nurse manager who was responsible for practice nurses, podiatrists and healthcare assistants. On the day of the inspection there was no nurse manager in post. We spoke with 12 members of staff and they were all clear about their own roles and responsibilities.

Seeking and acting on feedback from patients, public and staff

The practice was unable to provide any evidence that they had actively sought the views of patients over the last year. The practice did not have a patient participation group (PPG) with which to discuss local needs and service improvements. A PPG is a way in which the practice and patients can work together to help improve the quality of the service. In the absence of a PPG the practice did not have any other forums in which the patient voice could be regularly heard. The principal GP told us that they had had a PPG previously however due to the diversity and

Are services well-led?

Inadequate

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

expectations of the patient population and community, it had not been sustainable. They also confirmed that there were a higher number of younger patients in the practice's population and they wished to include them. The practice told us that they were working with the engagement lead from the CCG to address this and we saw evidence that this communication had commenced. We also saw that some staff had attended a facilitator training session with the engagement lead in March 2015.

The strategic development manager showed us the analysis of the last patient survey which was carried out by the practice in November 2013. We saw that the results of this survey showed that patients at that time were generally satisfied with the service provided by the practice. Areas of dissatisfaction identified by patients included the environment of the practice, (lack of chairs and baby changing facilities for example) and more female doctors were needed. During the inspection patients told us that there had been improvements to the environment at the practice during the last few weeks. They told us that new chairs and carpets had been put in place which they felt had made a big difference to their visit. We did not see any evidence that the practice had reviewed its results from the national GP survey to see if there were any areas that needed addressing.

Management lead through learning and improvement

We identified a lack of stability in the clinical staff team to ensure patients received continuity of care. We were told that a number of staff had left and others were leaving. For example, one of the salaried GPs and the practice nurse were leaving at the end of the week. Another salaried GP told us they were resigning and leaving at the end of July 2015. We were informed that the practice manager who was currently on sick leave had also resigned. Staff who were leaving told us that they had raised issues about the extensive workload that they had to deal with, however they felt that no action had been taken to improve this.

We saw that the practice had contacted the Clinical Commissioning Group (CCG) and NHS jobs to advertise vacancies during March and April 2015. We saw that the practice had advertised for a practice nurse and a health care assistant on 8 May 2015 and had been trying to recruit a GP and a practice nurse since March 2015. We saw that the one of the locum nurses used by the practice had been appointed to a permanent position and was due to start their contract at the end of June 2015.

The practice was a GP training practice for trainee GPs (qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine) and medical students. The principal GP was responsible for the induction and overseeing of the training for the trainee GPs at Pearl Medical Centre.

The principal GP told us that they were proactive in supporting staff to develop their careers and gave examples of healthcare assistants who had previously worked at the practice and had gone on to complete degree courses in nursing, midwifery and pharmacy. One staff member we spoke with said that the practice was very supportive and training needs were always supported. Two other staff members told us that they had asked for additional training and initially this had been agreed but then cancelled. We were told that this was due to the difficulties of recruiting staff and having enough staff to cover training days for other staff members.

We were told that the practice had begun to introduce group supervision sessions for staff. We saw evidence of feedback from staff following the first session in April 2015. We were also told that there were three daily discussions between senior GPs and senior administrative staff in relation to progressing letters and test results from hospital. The practice did not have any records to evidence these meetings however the principal GP informed us that this would be addressed with immediate effect.

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 Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected service users and others who may be at risk from inappropriate or unsafe care and treatment, by means of an effective operation of systems designed to - Regularly assess and monitor the quality of services provided in carrying on the regulated activity, and Identify, assess and manage risks relating to the health, welfare and safety of service users and others. **The registered person had also failed to-** Have regard to policies and procedures that set out the processes to be followed where complaints and comments were received by patients. **And where necessary, make changes to the treatment or care provided to reflect information relating to-** The analysis of complaints to identify themes or trends and views expressed, with actions taken to improve the quality of care. **Regularly seek the views of patients, persons acting on their behalf and persons who are employed for the purposes of regulated activity.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 HSCA (RA) Regulations 2014 Staffing** We found that the registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity received such appropriate support, training, professional development, supervision and appraisal as

Requirement notices

is necessary to enable them to carry out the duties they are employed to perform. This included ensuring that non-clinical staff received appropriate training, professional development and supervision in the administration of vaccines.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed** We found that the registered person had not operated effective recruitment procedures in order to ensure that no person was employed for the purposes of carrying out a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed and is physically and mentally fit for that work. To ensure that information specified in Schedule 3 was available in respect of a person employed for the purposes of carrying on a regulated activity.