# Dr N Raichura & Dr J Mehta

## Quality Report

The Medical Centre
18 Drayton Road
Hodnet
Market Drayton
Shropshire
TF9 3NF
Tel: 01630 685230
Website: www.hodnetmedicalcentre.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

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## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Dr N Raichura and Dr J Mehta on 29 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be requiring improvement for safe services and good for providing effective, caring, responsive and well-led services. It was also good for providing services for 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 and people experiencing poor mental health (including those with dementia).

Our key findings were as follows:

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us that the continuity of GPs was a good feature of the practice, although some told us that waiting times at urgent appointments could be long.
- The security of medicines and recording of risk in the dispensary was not robust.

We saw an area of outstanding practice:

- The practice had a higher than average population of both patients who were older and lived in nursing homes. The number of patients at the practice who lived in a nursing home was six times the national average. The practice was responsive to the needs of patients in this group by a regular GP visiting each home at least twice a week. They worked in partnership with the clinical commissioning group (CCG) pharmacist and care home staff to ensure that

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patients' needs were met. For example, on admission to a nursing home a patient's full medical history, blood screening and medicines review was undertaken by the GP in a half hour visit and ongoing treatment plan decided. The practice received no extra finance for this care provision and saw it as part of the service that had work effectively for a number of years.

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

Importantly, the provider must:

- Improve the storage of medicines within the practice.
- Ensure that risks associated with dispensing medicines are robustly recorded and mitigated.

In addition the provider should:

- Act on outstanding actions from the most recent infection prevention control audit and introduce a regular practice initiated cycle of infection prevention control audits.
- Consider documenting discussions from Multi-Disciplinary Team (MDT) meetings to ensure actions are recorded and followed.
- Ensure practice recruitment guidance includes all members of staff including those classed as locums.

Improve security for the issue and tracking of blank prescription forms to reflect nationally accepted guidelines as detailed in NHS Protect.

**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?**

**Requires improvement**

The practice is rated as requires improvement for safe. We saw that the storage of medicines and the recording of risk within the practice dispensary were not robust. The practice had recognised and taken action in some areas of risk within the dispensary, although further improvements were needed. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services. Data showed that patients rated the practice in line with others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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

**Good**

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on the same day. The practice had good facilities and was well equipped to treat patients and meet their

# Summary of findings

needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders

**Are services well-led?**

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify most risks. The practice proactively sought feedback from staff and patients. The practice had an active patient participation group (PPG). Staff had received inductions, regular performance reviews and attended staff meetings and events

# 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**

Outstanding ☆

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

The number of patients registered at the practice and who lived in a nursing home was six times the national average. Many of these patients were older, although some patients also had conditions that would place them within the other population groups we look at. We saw that the practice had a long track record of providing a responsive service to ensure that the care needs of patients who were older were met. A GP told us that on first coming to live at a nursing home, the patient would be visited within days by a regular GP and a full holistic health assessment would be carried out including blood tests. All patients in the nursing home were part of the avoiding unplanned admissions enhanced service and had comprehensive care plans in place that were regularly reassessed. We spoke with a registered manager from one of the nursing home and a pharmacist from the clinical commissioning group (CCG) who told us that the practice worked with them to improve patient care and experience. A regular GP visited each nursing home at least twice a week and more often if required. The nursing home registered manager told us that the practice responded quickly to any requests for advice or visits and that all medicines were dispensed within 24 hours or sooner if required. The practice received no extra remuneration for providing this level of service and did so as they believed it provided good and caring clinical care.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. All staff took a lead role in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had a strong performance in providing care and treatment to this group of patients. For example, 100% of eligible patients with chronic pulmonary obstructive disease (COPD) had received a seasonal influenza vaccine.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. Patients told us that children and young people were

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treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. Immunisation rates were in line or higher than the local average for all standard childhood immunisations. For example, 100% of children aged one had received the pneumococcal vaccine (PCV) to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis. This was higher than the CCG average of 97.1%.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how 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 information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out-of-hours.

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

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Eighty per cent of patients on the practice register dementia had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people who experienced poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary

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organisations and had employed an in house counsellor to provide support to patients. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

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## What people who use the service say

We spoke with 13 patients during our inspection. The majority were highly positive about practice staff and described them as approachable, caring and compassionate. The patients told us staff were good at listening, explaining medicines and tests and they all felt very much involved in their care. The patients gave us positive examples of the care and support provided at the practice.

We collected nine comment cards from a Care Quality Commission (CQC) comments box left in the practice waiting room for two weeks before our visit. Seven cards contained comments that expressed care was excellent or very good. Four patients said that waiting times at the morning clinic could be lengthy.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey published in January 2015. The survey was undertaken in January to March 2014 and July to September 2014 and was based on 250 surveys being sent to patients at the practice, of which 122 were returned. The results from this survey were broadly in line with local and national averages.

We spoke with the registered manager of a local nursing home where a number of registered patients lived, many of which were older. The manager told us that the practice was very responsive to the needs of patients and visited the home at least twice a week to review patients' care needs. They also told us that they could contact the practice at any time and would get a prompt response to enquiries or if urgent care needs were identified.

We also spoke with a senior pharmacist within the clinical commissioning group (CCG). They told us that a regular pharmacist worked in partnership with the practice to robustly review the medicines taken by patients to ensure they were the most suitable treatment.

## Areas for improvement

**Action the service MUST take to improve**

- Improve the storage of medicines within the practice.
- Ensure that risks associated with dispensing medicines are robustly recorded and mitigated.

**Action the service SHOULD take to improve**

- Act on outstanding actions from the most recent infection prevention control audit and introduce a regular practice initiated cycle of infection prevention control audits.
- Consider documenting discussions from Multi-Disciplinary Team (MDT) meetings to ensure actions are recorded and followed.
- Ensure practice recruitment guidance includes all members of staff including those classed as locums.
- Improve security for the issue and tracking of blank prescription forms to reflect nationally accepted guidelines as detailed in NHS Protect.

## Outstanding practice

The practice had a higher than average population of both patients who were older and lived in nursing homes. The number of patients at the practice who lived in a nursing home was six times the national average. The practice was responsive to the needs of patients in this group by a regular GP visiting each home at least twice a week. They worked in partnership with the clinical commissioning group (CCG) pharmacist and care home staff to ensure that patients' needs were met. For example, on admission to nursing home a patients' full medical history, blood screening and medicines review was undertaken by the GP in a half hour visit and ongoing treatment plan decided. The practice received no extra finance for this care provision and saw it as part of the service that had work effectively for a number of year

# Dr N Raichura & Dr J Mehta

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

a Care Quality Commission (CQC) lead inspector. The team also included two CQC Pharmacist Inspectors, a GP specialist advisor advisor and an expert by experience. An expert by experience is a person who has personal experiences of using or caring for someone who uses this type of service.

## Background to Dr N Raichura & Dr J Mehta

Dr N Raichura and Dr J Mehta are a GP partnership based in the village of Hodnet, Shropshire. The practice has strong and historic links within the locality. The roots of the practice can be traced back to the year 1850. The GP partnership is one of longstanding; one partner has been at the practice for 28 years and the other 18 years. The practice is authorised to dispense medicines to registered patients who chose to receive medicines in this way.

The practice currently has 3,646 patients registered and has a higher than national average population in all age groups above 45 years. The practice holds a contract with NHS England to provide Personal Medical Services to their registered patients.

Demographically the practice has a high proportion of registered patients who live in nursing care homes. This equates to over 150 patients in total and when compared with statistics from Public Health England the practice has three times the local, and six times the national, rate of patients who live in a nursing home. It would be expected that patients who require nursing care would increase the demand on a practice due to their increased care needs.

Two male GPs work as GP partners with a further part time male GP providing additional cover. Two female practice nurses undertake a range of nursing duties including the provision of minor illness triage, long-term condition review and cervical cytology. The administrative team of five are led by a practice manager. The practice dispensary has a manager and three trained dispensers.

The practice is open from 8:30am to 1pm and 2pm to 6pm on Monday, Tuesday, Thursday and Friday and 8:30am to 12:30pm on a Thursday. During 1-2pm on weekdays the practice reception is closed, urgent requests are still accepted by telephone and responded to as necessary. Out-of-hours and marginal cover is provided by Shropshire Doctors Cooperative Ltd (Shropdoc). Marginal cover relates to times when the practice is closed and is not in the out-of-hours period of 6:30pm until 8am on weekdays and all other times at weekends and bank holidays.

The practice also has a branch surgery in the village of Ellerdine. The branch surgery has not operated for a number of years, due to renovations of the premises. It is expected that the branch surgery will reopen in the Summer of 2015. We did not inspect the branch location as part of our inspection.

## Why we carried out this inspection

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 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.

# Detailed findings

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations including NHS England and NHS Shropshire Clinical Commissioning Group (CCG) to share what they knew. We carried out an announced visit on 29 June 2015.

During our visit we spoke with a range of staff including three GPs, a practice manager, two practice nurses, two members of administration staff, the dispensary manager and a dispensing assistant We also spoke with 13 patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We received nine Care Quality Commission (CQC) comment cards where patients and members of the public shared their views and experiences of the service.

After our visit we spoke with the registered manager of a local nursing home and a senior pharmacist from the CCG. We did this to understand how the care provided at the practice met the needs of patients.

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)

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. A GP told us the practice team had discussed significant events at practice meetings for a number of years.

Staff told us that any significant incidents that involved the dispensary would be reported directly to the practice manager, however it was not clear what determined a dispensary significant incident. Staff gave us examples of action taken in relation to incidents that occurred in the dispensary, for example an incorrect medicine being selected for dispensing. Staff were able to explain the action they had taken, whilst this may have been appropriate it was not recorded.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these.

Significant events within the practice were raised by completion of a standard form available on computer which was completed and submitted to the practice manager. The practice had recorded four significant events in the last year. We tracked all four incidents and saw that investigation, discussion and action had taken place in a comprehensive and timely manner in all of them. We saw the recording and discussion of significant events within the practice had led to changes to improve safety. For example, following a medicine prescribing error, the root cause of the incident was established as an omission during the conversion of hand written patient records to computerised records. Procedures were put in place to minimise the risk of the incident occurring again. This included staff cross checking computerised and hand written notes and notices were placed in the practice waiting areas to request patients confirm their details with the reception staff to ensure they were correct and up to date.

Although dispensary staff were open and willing to discuss incidents such as dispensing errors there were no procedures available for staff to follow in the event of an error or a near miss. There were no records of dispensing errors kept. It was therefore not possible to determine how patterns of incidents could be identified or how lessons were learnt in order to protect patients from harm.

We were told that action would be taken for any medicine recalls. There were no standard procedures available which documented what action should be taken. There were no records available which documented that checks had been made on medicine recalls.

Significant events, complaints, incidents and any other concerns were discussed at monthly practice and clinical meetings. National patient safety alerts were shared by the GP who received them. Staff we spoke with were able to give examples of recent alerts. They also confirmed alerts were discussed within the practice to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to children, young people and vulnerable adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding to an appropriate level. For example, the GPs had received training to level three and practice nurses to level two as suggested in guidance by the Royal College of Paediatrics and Child Health on safeguarding children and young people (March 2014).

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. We saw that contact details for local safeguarding teams were easily accessible.

As a smaller practice there was no individual lead for safeguarding, however all clinical staff were aware of their

individual and collective responsibility to raise concerns. A practice nurse we spoke with told us about a situation when concerns about the safety of a child had been appropriately raised and actioned.

The practice met with a number of partner health professionals at monthly multi-disciplinary team (MDT) meetings to discuss patients with complex health needs. This included the local health visitor and both palliative care, and community nurses. Information was shared and actions were tasked to individual members. We saw that although attendance at the meetings and the patients discussed was recorded the details of discussion and any actions arising were not recorded in the form of minutes. A GP we spoke with told us that each member of the team took ownership of the actions allocated to them.

The practice had a policy on providing chaperones and displayed the availability of chaperones on the waiting room noticeboard and in consulting rooms. (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). Both practice nurses had been trained to act as a chaperone as part of their professional training and knew their responsibilities when performing the task.

All of the clinical and nursing staff at the practice had received appropriate checks with the Disclosure and Barring Service (DBS). 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.

### Medicines management

The practice was a dispensing practice and was authorised to dispense prescribed medicines to patients who choose to receive medicines in this way. We saw the way in which risks were recorded, the number of staff available to dispense medicines and the way in which medicines were stored may lead to increased risk of incidents or harm.

We checked medicines stored within the dispensary, treatment rooms and staff area and found that they were not stored securely. For example, both refrigerators used to store vaccines were lockable however they were unlocked and the keys had been left in The practice had a process in place for checking that medicines stored were in date, however we saw examples that the checks were not robust. For example, the medicines in a GPs bag were checked and recorded on a six monthly basis. The records that detailed the checks did not state what medicines should be in the bag or their expiry dates.

The practice nurses administered vaccines using patient group directions (PGDs) that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of these directions and found that they had not all been signed. Our finding was shared with staff who immediately reviewed the PGDs and ensured that they were signed in line with legal requirements and legal guidance. We saw evidence that the nurses had received appropriate training to administer vaccines.

The practice held stocks of controlled drugs. These are medicines that require extra checks and special storage arrangements because of their potential for misuse. We noted there were standard procedures available which set out how they were managed. We noted that these procedures did not state that two people should be involved in controlled drug record keeping or what checks were needed. The procedures were not dated. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted with the keys held securely when the dispensary was open. The total quantities of controlled drugs were documented in a Controlled Drugs Register (CDR). We noted that only one person's signature was recorded for all entries in the CDR. We were told that the dispensary staff also undertook regular audits of controlled drugs which was seen as good practice. However the record of these extra audits did not document what had been checked and was signed by one person. Although arrangements were in place for the destruction of controlled drugs the records only had one signature. Due to the lack of double checks in place there was an increased risk of an incident involving a controlled drug.

All prescriptions were reviewed and signed by a GP before they were given to the patient. We reviewed the storage of blank prescription pads and found that they were not stored in line with national guidance. The NHS Business Authority guidance "NHS Protect" provides guidance to staff members in all roles and healthcare settings who handle or issue prescriptions. The practice was not following this guidance. The practice did not keep records to track the issue of prescription pads within the practice. The records we reviewed did not accurately and clearly show the number of blank prescription pads in stock. We

also saw that there were no records of the person issuing or receiving prescription pads. The practice did not have a system in place to monitor that amount of prescriptions pads that were ordered and that the number received was consistent with the amount of prescriptions that had been used. If blank prescription pads are not handled appropriately, this could lead to misuse and could cause harm by individuals obtaining medicines that they are not entitled to receive.

### Cleanliness and infection control

We observed the premises to be visibly clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control and prevention nurse from the local Clinical Commissioning Group (CCG) had undertaken an infection control audit in 2013. The audit highlighted a number of areas that required action including changing floor surfaces and waste disposal arrangements. The CCG performed a follow up audit in August 2014 and found that the majority of issues had been addressed, although some remaining items required action. We checked the remaining issues that had been recorded as still needing action and saw that they had not all been addressed. For example, screw top taps had been replaced with elbow operated taps in some clinical and treatment rooms but not others. The practice manager told us the work was still in progress and should be completed in the next few months.

Cleaning took place on a daily basis; however this was not recorded for each area as had been recommended in the infection control audit undertaken in 2013. The practice had started to record cleaning of one area; the patient toilet. The practice manager told us and showed us evidence to show that they were in the final stages of completing written schedules for each room.

The practice had a written policy on good infection control practise. .We saw examples of when the practice infection control policy had not been followed. For example, the policy reflected national guidance on the disposal of sharp instruments such as needles and blades. We saw that the sharp disposal bins in use did not reflect the guidance in the policy and national guidance for the segregation of clinical waste.

All staff had received recent appropriate training relevant to their role. Where appropriate staff involved in procedures that may increase their risk of exposure to blood borne viruses, vaccination to help minimise the risk of contracting an illness had been provided and this was recorded.

The practice had hand gel dispensers and hand decontamination notices at regular points throughout the premises. All treatment rooms had hand washing sinks with soap dispensers, paper towels and hand gel dispensers available.

The practice had completed a risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

### Equipment

Staff we spoke with told us they had suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the date of the last test. We saw that equipment used in the assessment of a patient's condition had been checked and calibrated where necessary to ensure it gave accurate readings. For example, a set of weighing scales.

### Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to a staff member commencing employment in all but one case. For example, proof of identification, references, qualifications, professional registrations with the appropriate body and criminal records checks through the Disclosure and Barring Service (DBS) where required. We saw that a locum part-time member of clinical staff employed at the practice had not had thorough checks performed as other staff had. The practice manager told us that they did not realise that this should have been performed for a locum due to the basis of their employed status. NHS Employers produced guidance on the appointment and employment of NHS locum doctors in August 2013. The guidance and legislation places the ultimate responsibility on the

employer to ensure that a locum GP is suitable for the role. Following our discussion the practice manager immediately commenced arranging suitable employment screening for the locum member of staff to the same standard as other practice staff.

The practice manager told us about the number, and skill mix, of staff required to meet patients' needs. This was based on knowledge on busy periods during the practice day. Most staff were trained to operate within the areas of the practice, with the exception of the dispensary. A GP told us that a number of actions had been implemented to address recent staff changes within the dispensary. This included recruitment of a new member of staff due to commence employment two working days after the inspection and advertisement for another member of dispensary staff. They also told us that some dispensing for patients in the local nursing homes was taking place in protected time at weekends when the practice was closed to avoid interruptions and distractions.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. However, some told us it could sometimes be difficult to complete actions not seen to be direct patient care such as updating records and following up on audits as the practice could be very busy at times.

### Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice.

Risks from equipment, suitability of staff, buildings and environmental factors had been mitigated by commissioning outside agencies to deal with issues that may impact on safety. For example, all fire equipment, servicing, testing and fire drills were managed by a company with a background in that area. The practice had recently commissioned a health and safety company to perform a risk assessment on the practice. The risk assessment highlighted areas that required action. This included restricting access to the dispensary and trip hazards had been identified.

The staff we spoke with were able to describe the actions they would take if they were faced with an emergency situation, for example a patient whose health deteriorated suddenly. Practice staff gave us examples of situations they had appropriately dealt with.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support.

Emergency equipment was available at a secure central point. Equipment included a nebuliser (a device to help to deliver medicine into the lungs to assist someone with difficulty in breathing), a pulse oximeter (to measure the level of oxygen in a patient's bloodstream) and an automated external defibrillator (which provides an electric shock to stabilise a life threatening heart rhythm).

Emergency medicines were available in a lockable carry box within a secure central area of the practice. A range of medicines were available to deal with medical emergencies. Examples were medicines for anaphylaxis (allergic reaction), convulsions (when a patient suffers a seizure/fit) and hypoglycaemia (a very low blood sugar level).

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 practice manager told us that the document had recently been introduced and all staff had played a part in compiling it.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. A GP told us that information was shared informally within peer discussions within the small staff group.

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.

The practice delivered care to a high number of older patients who lived in nursing care homes. Data from both the practice and Public Health England from 2010/11 showed that the number of patients registered at the practice who lived in a nursing home was over three times the clinical commissioning group (CCG) average and six times the national average. This equated to 3.1% of the total practice population compared with a 1% CCG average and 0.5% national average. A GP told us in the three nursing homes within the practice area there were at least 150 registered patients. The practice had implemented enhanced services to meet the needs of patients in this group many of whom had complex care needs and took numerous medicines. We saw examples of effective partnership working between the practice and CCG pharmacist. Systematic medicines reviews were held for each patient in the care homes. We saw that medicine reviews looked specifically at the reasons for patients taking medicines and were a way of ensuring that patients took medicines that were clinically relevant and that alternatives that may be better were explored.

The practice had identified 2% of patients at highest risk to unplanned admission to hospital. The practice manager told us that although they identified the patients, they had not implemented all of the individual care plans as required. The practice compiled an action plan and hoped to improve performance in this area in 2015/16.

Emergency admissions to hospital were in line with the local average for patients aged up to 65 years. Patient over the age of 65 had higher rates of admission to hospital average which could be explained by the much higher practice population of patients who lived in nursing homes than the local and national average. Data from the CCG from 2014/15 showed that emergency admissions to hospital in patients aged 65 and over was 63% higher than the local average. This was a strong performance considering that the practice had three times the CCG average number of patients who lived in nursing homes. A GP told us that many of the patients had complex care needs and required a higher level of GP support when compared with average patient need.

Patients who were at risk of, or displayed signs of, developing dementia were assessed by GPs who used nationally recognised methods of cognition testing. Cognition relates to attention, memory, judgment and reasoning. Cognitive impairment can be a sign of dementia; patients with impaired cognition were referred to a special hospital clinic for diagnosis. The practice had identified 1.1% of their registered patients with dementia. This figure was higher than the CCG average of 0.8% and national average of 0.6%.

Patients recorded on the practice register for experiencing poor mental health were supported with individual comprehensive care plans. We saw that all of the patients in this group had been reviewed within the previous 12 months.

We looked at the latest available data from NHS Business Authority (NHSBA) published in December 2014 on the practice levels for prescribing antibiotic and hypnotic medicines. We saw that the practice levels of prescribing antibiotics were in the similar to expected range when compared to the national average

### Management, monitoring and improving outcomes for people

Information about patients' care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

Good

# Are services effective?

## (for example, treatment is effective)

The practice showed us four clinical audits that had been undertaken in the last two years. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The completed audit looked at the monitoring of patients who were actively receiving treatment for Glaucoma. Glaucoma is the name given to a group of eye conditions which cause optic nerve damage and can affect vision. The first cycle of the audit undertaken in 2013 established that out of 55 patients, 10 patients were not receiving hospital follow up and monitoring as they should be. Changes were made to ensure that patients received hospital follow up. The process was repeated as a second cycle audit in 2014, the results were positive. Out of 61 patients, two were not receiving the hospital follow up and monitoring as they should be. We saw other audits involving medicines and patient opinion on the effectiveness of joint injections.

We saw that staff discussed the practice performance in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures.

The practice had achieved 83.8% of the total QOF points available to them in 2013/14; this was lower than the national average of 94.2%. The practice manager told us that they expected the 2014/15 results to be higher than the previous year's performance. We saw examples of practice performance that was in-line or higher than the national average. For example, in the published 2013/14 QOF data :

- 81% of patients were recorded as having hypertension (high blood pressure) and had a recent blood pressure reading that was lower than the accepted higher level. This performance was higher than the national average of 79%. Practice records for 2014/15 showed that the performance had increased to 87%.
- 82% of patients who were recorded as having rheumatoid arthritis had received an annual health check. This performance was the same as the CCG of 82% and in line with the national average of 83%. Practice records for 2014/15 showed that this performance had improved to 100%.
- 89% of patients with chronic obstructive pulmonary disease (COPD) had been reviewed in the last year. This performance was higher than the CCG average of 81% and national average of 80%. Practice records for 2014/15 showed that the performance had further improved to 93%.
- 70% of patients with dementia had received a face to face care review in the last 12 months. This performance was lower than the CCG average of 77% and national average of 78%. Practice records for 2014/15 showed that the performance had increased to 80%.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

GPs told us they used nationally recognised methods for the fast track referral to hospital specialists for patients who had symptoms that could be suggestive of cancer. We reviewed data from Public Health England from 2014 which showed the rates for using nationally accepted standards for patients with symptoms that could be suggestive of cancer were in line with both the local and national average.

### Effective staffing

Practice staffing included medical, nursing, managerial, dispensary and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. We noted a wide range of experience and good skill mix amongst the GPs, with one providing in house joint injections. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

At the time of our inspection the dispensary was very busy. We observed that one member of the dispensary team was

Good

# Are services effective?

## (for example, treatment is effective)

alone undertaking many different dispensary tasks. A second member of the dispensary staff was working on the reception desk as well as providing double checks on dispensed prescriptions. We were told that dispensary staff covered the reception desk when the receptionist was not working. The dispensary staff worked professionally to ensure people's medicines were dispensed safely. However we observed that the amount of work that had to be dealt with safely by one member of staff on their own was a potential risk. We were told by the practice that they were aware of this situation and a new member of staff for the dispensary had been recruited.

The practice nursing team consisted of two qualified nurses. They both had an active role in providing care and treatment to patients. Both were able to describe their roles and responsibilities and demonstrate how their experience and training met the needs of patients. For example, one nurse had completed further training in diabetic care, cervical cytology, asthma and chronic obstructive pulmonary disease (COPD) management. COPD is a term for a number of lung diseases which affect the function of a person's breathing.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. We saw that the nurses' appraisals had not been held within the last 12 months, although these were due to be held in the near future.

### Working with colleagues and other services

The practice had an established system in place for handling and taking action on the information received from local hospitals, out-of-hours providers and the 111 service. The information received was both in an electronic and paper format. Communications included blood test results, hospital discharge summaries and letters from other health partners about the care and treatment of patients. We spoke with staff who were able to describe and demonstrate the system in place for managing communications. The system involved tasking of actions to individual members of staff and where appropriate patients were contacted with an appointment date to discuss results with a GP. The staff we spoke with felt the system worked well. We checked and saw that the management of communications was up to date. There had been no recorded incidents during the previous year where any communication item had not been followed up.

We were told that the practice had support and advice from a CCG pharmacist who visited the practice every two weeks. The doctors described the invaluable input the pharmacist provided in reviewing patients prescribed medicines. We also spoke with a pharmacist manager from the CCG who told us that the CCG pharmacist and the practice had developed an effective partnership working arrangement that encouraged discussion to improve outcomes for patients.

Meetings to discuss the needs of patients who were approaching the end of their life were held on a six weekly basis. The meetings were attended by a health visitor, specialist palliative care nurse, community nurses, GPs, practice nurses and others relevant to meeting the care needs of patients. All attendees could add individual patients for discussion. Records of the attendees and patients discussed were kept; actions were tasked to individuals to follow up on. A GP and both the dispensary and practice manager also met with the manager of each local nursing home on a regular basis to discuss any issues, concerns or to explore suggestions.

### Information sharing

Important information about patients was shared with the local out-of-hours provider via a computer system. For example, patients who were approaching the end of their life and those at high risk of unplanned admission to hospital.

Patients who were included in the enhanced service for avoiding unplanned admission to hospital had documented care plans at home and also scanned onto their computerised medical records. The practice manager told us this would help to provide other health professionals with information should they become involved in the patients' care at a time when the practice was closed.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

# Are services effective?

## (for example, treatment is effective)

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.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We saw care records that showed staff had applied the principles of the Mental Capacity Act 2005 when involving patients in decisions about the care they received. An example of this was that 100% of patients on the practice register for poor mental health had received an annual health check.

A GP told us that patients and those close to them were supported through decisions when their capacity may be impaired. For example, patients approaching the end of their life received guidance on recording their treatment wishes in the event of their health deteriorating. This information was recorded in patient notes and templates to nationally recognised standards.

### Health promotion and prevention

The practice provided care, advice and treatments to patients that may improve their general wellbeing and prevent any illnesses or conditions getting worse.

We saw that the most recent published QOF data from 2013/14 showed that vaccination rates for standard childhood immunisations were mostly in line or higher than the local average. For example, 100% of children aged one had received the pneumococcal vaccine (PCV) to help reduce the risk of acquiring the bacteria that can cause pneumonia, blood poisoning and meningitis. This was higher than the CCG average of 97.1%.

The 2013/14 practice rate for cervical cytology screening for female patients aged 25 to 64 years at the practice was 72.8%, this was lower than the CCG average of 78.8% and national average of 76.9%. A practice nurse showed us the system of following up patients who did not attend screening appointments, which involved multiple reminders. Practice supplied data showed that this performance had increased to 80% in 2014/15.

The practice had provided seasonal flu vaccination for 61% of patients aged 65 and over. This was higher than the national average of 53%. We saw that the practice was particularly effective at targeting groups of patients whose underlying medical conditions could result in more severe illness associated with seasonal flu. We saw that rates of seasonal flu vaccination in patients groups were high. For example, the following groups of patients had all received the vaccination:

- 96% of patients on the practice register for coronary heart disease.
- 95% of patients who had experienced a stroke (interruption of blood supply to the brain) or transient ischaemic attack (temporary interruption of blood supply to the brain).
- 100% of patients with chronic pulmonary obstructive disease (COPD).

New patients registering at the practice were offered an appointment with a GP for a health and medicines check.

Eighty-four per cent of patients aged 45 and over had received a recorded blood pressure check in the last five years. The practice referred patients for smoking cessation advice to a neighbouring practice for assistance.

National data from the published by Public Health England in 2014 showed the rates of practice patients attending, or participating in, screening to detect signs that may be suggestive of cancer were slightly lower than CCG average. For example, 57.1% of patients in the age range of 60 to 69 had participated in bowel screening in the last 30 months. This was slightly lower than the CCG average of 61.8% and national average of 58.3%.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP national patient survey published in January 2015. The survey was undertaken in January to March 2014 and July to September 2014 and was based on 250 surveys being sent to patients at the practice, of which 122 were returned.

The evidence from the GP national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated broadly in line with others for patients who rated the practice as good or very good. The practice was also average for its satisfaction scores on consultations with GPs and nurses. For example:

- 90.9% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 93.1% and national average of 88.6%.
- 88.1% said the GP gave them enough time compared to the CCG average of 91.9% and national average of 86.8%.
- 97.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 97.3% and national average of 95.3%.

Satisfaction scores in relation to the treatment provided by the practice nurses were also in line with local and national averages.

Patients completed Care Quality Commission (CQC) comment cards to tell us what they thought about the practice. We received nine completed cards. Most of the cards contained positive comments about the practice and staff. Seven contained comments that expressed care was excellent or very good. Four patients expressed that waiting times at the morning clinic could be lengthy. We also spoke with 13 patients on the day of our inspection. They all told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Modesty curtains and blankets were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system operated to allow only one patient at a time to approach the reception desk. Data from the GP national patient survey showed that 95.8% said they found the receptionists at the practice helpful compared to the CCG average of 89.6% and national average of 86.9%.

### Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded with average opinions to questions about their involvement in planning and making decisions about their care and treatment and rated the practice mainly in line or slightly below others in these areas. For example:

- 85.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 91.7% and national average of 89.7%.
- 86.1% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 81.5%.

Twelve out of the 13 patients we spoke with felt involved in decisions relating to their care and treatment. One patient said they felt a family members illness symptoms had been dismissed without timely investigation. Patient feedback on the comment cards we received was also mainly 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. We saw notices in the reception areas informing patients this service was available.

### Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients responded positively to questions about involvement in planning and making decisions about their care and treatment and rated the practice higher than others in these areas. For example:

Good

# Are services caring?

- 73.3% with a preferred GP usually get to see or speak to that GP compared to the CCG average of 63% and national average of 60.5%.
- 92.4% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.6% and national average of 90.4%.
- 93% described their experience at the practice as good compared with the CCG average of 89.7% and national average of 85.2%.

We received numerous positive comments from patients we spoke with and within comment cards about the emotional support provided by staff at the practice. We heard examples of occasions of when patients felt that they had received high levels of support at difficult times.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. One patient told us that a GP had provided their family with a high level of support during the illness and subsequent death of a member of the family. They also told us that the care provided by the GP and practice made their loss a little more bearable due to the kindness, warmth and compassion shown to them.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided.

The practice GPs visited three local nursing homes twice a week to review patients' care and treatment. We spoke with the registered manager of one of the nursing homes who told us that the GPs had provided this service regularly for many years. They also told us that the practice would always respond quickly to any telephone requests for advice or requests for home visits. The registered manager told us that they were invited on a regular basis to meet with the GPs, other nursing home managers, the practice manager and dispensary manager to discuss services at the practice. They felt this was a useful way of discussing the services provided and gave opportunity to share ideas.

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 spoke with two members of the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). They told us that although the group had recently been set up, they had plans to work in partnership with the practice to further enhance the services provided. For example, by conducting and acting upon in house surveys.

### Tackling inequity and promoting equality

All facilities at the practice were situated on a single level. Doorways and corridors were wide enough to allow prams and wheelchairs to turn and access all rooms. We saw patients with walking aids mobilising through the practice without hindrance. For patients whose spoken English was not strong, a telephone interpreter could be provided.

The practice was not aware of any patients that had circumstances that could present challenges to meeting the requirements of registering for GP services. For example, a person who was homeless. The practice manager told us that they aimed to be a fully inclusive practice and would assist anyone who required their services.

All of the staff at the practice had completed equality and diversity training. The practice staff we spoke with were all able to demonstrate they recognised the importance of treating all patients, carers and visitors with equality and respect for diversity

### Access to the service

The practice was open 8:30am to 1pm and 2pm to 6pm on Monday, Tuesday, Wednesday and Friday and 8:30am to 12:30pm on a Thursday. During 1-2pm on weekdays the practice reception was closed, urgent requests were still accepted by telephone and responded to as necessary. Out-of-hours and marginal cover was provided by Shropshire Doctors Co-Operative. Marginal cover relates to times when the practice is closed and is not in the out-of-hours period of 6:30pm until 8am on weekdays and all other times at weekends and bank holidays.

During morning opening, all appointments were available for urgent needs and non-bookable. Patients could be seen at the practice between 8:30am and 9:45am and would be seen in turn. There was the option to see a GP of choice, although this could not be guaranteed. We spoke with 13 patients about this system of appointment; they all told us that the system met their urgent health needs. We also received nine completed Care Quality Commission (CQC) comment cards. Four cards contained comments that waiting times could be long. One patient expressed via a comment card that the urgent appointment system did not meet their needs as a person who worked. Data from the GP national patient survey published in January 2015 in relation to waiting times showed:

- 41.7% said that they usually wait 15 minutes or less after their appointment time to be seen. This performance was lower than the CCG average of 65.3% and national average of 65.2%.
- 52% felt they didn't normally wait too long to be seen. This was lower than the CCG average of 58.9% and national average of 65.2%.

Other findings in the GP national patient survey about access to the practice were more positive. For example:

- 87.7% described their experience of making an appointment as good compared to the CCG average of 81.2% and national average of 73.8%.
- 93.7% found it easy to get through to the practice by telephone compared to the CCG average of 83.9% and national average of 74.4%.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

- 92.5% were able to get an appointment or speak to someone the last time they tried compared with the CCG average of 89.3% and 85.4%.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. The practice displayed clear information on how to raise a complaint in the waiting room and in the practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

The practice had received five written complaints in the previous year. We tracked the complaints and saw that all complaints had been responded to in an appropriate timescale. Those who complained were made aware that they could raise their concerns with the Parliamentary and Health Service Ombudsman (PHSO) if they remained dissatisfied following the practice findings after a complaint.

# Are services well-led?

Good

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

## Our findings

### Vision and strategy

The practice had a written aim to provide patients with "the best possible medical service". This would be achieved by ensuring "All members of the practice team work closely together and are committed to continuity of care". We spoke with staff and they all knew the essence of the practice aims and their role in achieving them.

### Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to each member of staff in the practice manager's office. We looked at four of these policies and procedures and saw that they had been reviewed annually and were up to date. All of the staff we spoke with knew of the existence of policies and procedures and where to access them.

The practice held meetings every month and governance was discussed as needed. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

The practice had a dedicated lead to monitor performance in the quality and outcomes framework (QOF). QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The practice performance in QOF had improved in most areas in 2014/15 from the previous year.

Areas of risk in the building had been identified and had been mitigated by the involvement of others with greater knowledge to act on behalf of the practice. For example, all fire alarm testing and drills were organised by an external company. We did see that the way medicines were stored could lead to increased risk. Our findings were shared with the practice team who told us they had already made a number of improvements and plan to act to improve further.

### Leadership, openness and transparency

The GPs were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. A GP told us about the strong family links within the practice staffing and it was clear from the patients we spoke with that they felt that the practice operated in an open and transparent way and as patients they felt valued and in return valued the practice staff.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Staffing levels were broadly stable and most staff members had been employed at the practice for a number of years. For example, four members of staff had 103 years' service at the practice between them. Action had and was being taken to address staffing issues within the dispensary. One additional member of staff had been recruited and one more was planned to be recruited. Staff told us that there was an open culture within the practice and that they felt respected, valued and supported.

All of the staff we spoke with knew the leadership structure and the scheme of responsibility for individual duties and tasks.

### Practice seeks and acts on feedback from its patients, the public and staff

We saw evidence that the practice had acted upon feedback from patients. For example, practice staff told us they had changed the opening direction of a window as a relative of a person who used a wheelchair highlighted that it could cause injury when open to a person who used a wheelchair. The practice was aware of their performance in the GP national patient survey and had planned to conduct an internal survey in partnership with the patient participation group (PPG). (PPGs are a way for patients to work in partnership with a GP practice to encourage the continuous improvement of services). The members of the PPG we spoke with told us practice staff were approachable and had shown enthusiasm in getting the group set up.

Staff met on a monthly basis. All of the staff we spoke with told us that they feel valued and that ideas could be shared. The practice manager told us that there was a staff suggestion box, although most staff raised any issues, concerns or comments directly.

# Are services well-led?

Good

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

We spoke with the registered manager of a nursing home within the practice area. They told us that the practice staff including dispensary staff were open to feedback and that the practice arranged and held meetings for services to be discussed.

### Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place and included a personal development plan.

Significant event and complaint learning outcomes were shared with staff. The practice manager told us this was to promote an open culture in which everyone could contribute to improving the care, treatment and experience of patients.

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<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>Care and treatment was not provided in a safe way as medicines were not always stored securely. Risks such as near misses, incidents and policies associated with the storage and dispensing of medicines were not recorded or not recorded adequately. Checks on medicines expiry dates were not detailed or recorded. Checks on high risk medicines were carried out by one person and not two.<br>Regulation 12 (2) (g) |