Dr Jaswant Rathore

Quality Report

Castle Meadows Surgery
100 Milking Bank
Dudley
DY1 2TY
Tel: 01384234737
Website: www.castlemeadowssurgery.nhs.uk

Date of inspection visit: 21 July 2015
Date of publication: 01/10/2015

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	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Castle Meadows Surgery on 21 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be 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; people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe care.

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

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- We saw a number of risk assessments and plans in place with regards to the absence of emergency equipment such as oxygen and the absence of Disclosure and Barring Service checks (DBS checks) for those who chaperoned.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, reviewed and addressed.
- Information about services and how to complain was available and easy to understand.
- There was a clear leadership structure and staff felt supported by management. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

Summary of findings

- The practice was continuing to attract new patients and to help with this the practice had plans in place to move to larger purpose-built premises. We noticed carpet was in place within the room used to perform minor surgery. The practice explained how the move would help to provide a bigger waiting room to cater to all patients during busy periods and to provide more suitable rooms for clinical staff to carry out consultations and treatments such as minor surgery.
- The practice was above average across areas of the quality outcomes framework (QOF) for 2014 and the practice was above average on results from the national gp patient survey, published in July 2015. 100% of the respondents described their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses.

We saw an area of outstanding practice:

- The practice had a patient services team in place; this was a unique service consisting of a patient services manager and two coordinators. The team provided a personal assistant service for patients to discuss things like tests results and referrals with a named manager or co-ordinator in the practice. Patients who contacted the practice with concerns or queries were put through to the patient services department which improved phone-line access for those wishing to book appointments. Staff told us that this was a contributing factor in the success of their telephone access. The patient survey information we reviewed showed that 99% of the respondents said they found it easy to access the surgery by phone, compared to the CCG average of 68% and national average of 73%.

However there were areas of practice where the provider should make improvements:

- Ensure risk assessments are robust with regards to the absence of emergency medical equipment
- Ensure DBS checks are completed for those staff who are left alone with patients when acting as a chaperone

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 providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice had a number of risk assessments and plans in place with regards infection control prevention, including legionella risk. The practice had not carried out a risk assessment to consider if Disclosure and Barring Service checks (DBS checks) were required for staff that carried out chaperone duties. We raised this with the practice during the inspection and this prompted them to complete risk assessments for each member of staff who acted as a chaperone. The practice had started the DBS application with one member of staff and shared plans to make the relevant DBS applications at the end of July 2015; for the rest of the team who chaperoned. The practice did not have oxygen on site, we raised this with the practice during the inspection and this prompted them to assess the risk of not having oxygen. The risk assessment highlighted that the practice had plans to approach the CCG to request a local contract with an oxygen provider. The practice was continuing to attract new patients and to help with this the practice had plans in place to move to a larger purpose-built premisis.The practice explained how the move would help to provide more suitable rooms for clinical staff to carry out consultations and treatments such as minor surgery. There were enough staff to keep patients safe.Patients' needs were assessed and care was planned and delivered following best practice guidance.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were in line with the CCG average for the locality. For example, performance for diabetes related indicators was 86% compared to the CCG average of 85%. Overall performance for mental health related indicators and dementia diagnosis rates were 100% (with an exception rate of 0%). The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Childhood immunisation rates for the vaccinations given to under twos ranged from 97% to 100% and five year olds also from 97% to 100%. These were above the CCG averages which ranged from 25% to 98% for under twos and from 94% to 100% for five year olds. Flu vaccination

Summary of findings

rates for the over 65s were 49%, compared to the national average of 52% and vaccination rates for at risk groups were 80%, compared to the national average of 73%. Staff referred to guidance from the National Institute for Health and Care Excellence 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. The practice had a patient services team and the patient services manager was heavily involved in identifying, monitoring and coordinating care for patients who were at high risk of admission to hospital. This helped to ensure patients were reviewed regularly and that multidisciplinary care plans were documented in their records.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 a caring service. The practice was above average on their results from the national GP patient survey, published in July 2015.One hundred percent of the respondents described their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We 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. The practice had a patient services team in place; this was a unique service which was made up of a patient services manager and two coordinators. This team was described as a personal assistant service for patients where patients could discuss things like tests results and referrals with a named manager or co-ordinator in the practice. Patients who contacted the practice with concerns or queries were put through to the patient services department which opened up the phone lines for those wishing to book appointments. Staff told us that the patient services role worked well and that this was a contributing factor in the success of their telephone access. The patient survey information showed that 99% of the respondents said they could get through easily to the surgery by phone compared to the CCG average of 68% and national average of 73%. Patients said they found it easy to make an appointment with a

Summary of findings

named GP and that there was continuity of care, with urgent appointments available the same day. The practice responded to the needs of their practice population by offering Saturday morning consultations and telephone consultations which were also scheduled during lunch time hours to suit the practices working population. The practice was continuing to attract new patients and to help with this the practice had plans in place to move to a larger purpose-built premesis.The practice explained how the move would help to provide a bigger waiting room to cater to all patients during busy periods.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff gave positive feedback with regards to working at the practice and described the practice as a brilliant place to work. All staff said they felt respected, valued and supported. The trainee we spoke with had many positive things to say about the practice, the trainee told us how the practice had developed a specific learning plan in line with their personal and professional development needs which included their interest in women's health. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The patient participation group (PPG) was active. 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

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. 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 dementia and end of life care. The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Vaccination rates for at risk groups were 80%, compared to the national average of 73%. Patients could request prescriptions over the phone, online and at the practice. Prescriptions could also be ordered by the local pharmacy and the practice also offered a prescription delivery service for older patients.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The patient services manager was also heavily involved in identifying, monitoring and coordinating care for patients who were at high risk of admission to hospital. This helped to ensure patients were reviewed regularly and that multidisciplinary care plans were documented in their records. Ninety five percent of the patients on the practices unplanned admissions register consented to having a care plan in place, all patients on the register were given the option to have a care plan. The GPs specialised in clinical areas including diabetes care .The practices performance for diabetes care was above average with QOF results from 2014 for diabetes related indicators as 86% compared to the CCG average of 85%. The practice shared data with us which showed that 91% of their patients with diabetes had received an annual review and a medication review in 2014. 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 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

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. The practice offered a full range of immunisations

for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average in areas for immunisations, where comparative data was available. Childhood immunisation rates for the vaccinations given to under twos ranged from 97% to 100% and five year olds also from 97% to 100%. These were above the CCG averages which ranged from 25% to 98% for under twos and from 94% to 100% for five year olds. Appointments were available outside of school hours and on Saturdays. The premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice were exploring ways of communicating with their younger population and had developed a practice social media page which contained information about the practice, opening times, updates and key topics such as health promotions. The practice showed us how they were also encouraging younger representation within their PPG, via the use of their social media page. PPGs are a group of patients registered with a practice who work with the practice to improve services and the quality of care.

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 practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, by smoking cessation advice to smokers. There was evidence that the practices smoking cessation clinics were having some success as the number of patients who had stopped smoking in the last 12 months was 42%. The practice's performance for the cervical screening programme was 83%, which was above the national average of 81%. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 40% of patients in this age group took up the offer of the health check. The practice responded to the needs of their practice population by offering Saturday morning consultations and telephone consultations which were also scheduled during lunch time hours to suit the practices working population. 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. It had carried out annual health checks for people with a learning disability and offered longer

appointments for people with a learning disability. The practice shared reports with us to demonstrate that care plans were in place for 56% of their patients with a learning disability, the practice had a total of 15 patients on their learning disability register; all of which had annual health checks in place. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had 10 patients with dementia on their register, all of the practices patients with dementia had received an annual review and a medication review in 2014. The practice carried out advance care planning for patients with dementia, all of these patients had care plans in place. The practice's QOF data from 2014 highlighted that the practices dementia diagnosis rate was 100% (with an exception rate of 0%) and overall performance for mental health related indicators was 100% (with an exception rate of 0%). The practice had 25 patients on their mental health register, 95% of their patients experiencing poor mental health had care plans in place. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We also spoke with 14 patients on the day of our inspection. Patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients completed 48 CQC comment cards to tell us what they thought about the practice. Patients said they found the clinical staff to be caring and the reception staff were described as friendly and helpful. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in July 2015. The data from the national patient survey showed that 100% of the respondents described their overall experience of the practice as good.

Areas for improvement

Action the service SHOULD take to improve
However there were areas of practice where the provider should make improvements:

- Ensure risk assessments are robust with regards to the absence of emergency medical equipment
- Ensure DBS checks are completed for those staff who are left alone with patients when acting as a chaperone

Outstanding practice

The practice had a patient services team in place; this was a unique service consisting of a patient services manager and two coordinators. The team provided a personal assistant service for patients to discuss things like tests results and referrals with a named manager or co-ordinator in the practice. Patients who contacted the practice with concerns or queries were put through to the patient services department which improved phone-line access for those wishing to book appointments. Staff told us that this was a contributing factor in the success of their telephone access. The patient survey information we reviewed showed that 99% of the respondents said they found it easy to access the surgery by phone, compared to the CCG average of 68% and national average of 73%.

Dr Jaswant Rathore

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included GP specialist advisor, a practice nurse specialist advisor and an expert by experience. An expert by experience is a person who has experience of using this particular type of service, or caring for somebody who has.

Background to Dr Jaswant Rathore

Castle Meadows Surgery is situated in the town of Dudley. Services to patients are provided under a General Medical Services (GMS) contract with NHS England. The practice has expanded its contracted obligations to provide enhanced services to patients. An enhanced service is above the contractual requirement of the practice and is commissioned to improve the range of services available to patients. The increased range of services provided included offering extended hours, avoiding unplanned admissions and minor surgical procedures.

There are approximately 5,170 patients of various ages registered and cared for at the practice. The practice building is purpose built with all treatment and practice office areas on one floor. The building has car parking, with allocated spaces and access for those with a disability.

The practice team consists of a five GPs, two are male GPs, one of which is the lead GP and the other is a long term locum GP employed by the practice. A locum GP is a fully qualified doctor who can provide temporary cover to fill a vacancy or cover sick leave, staff holidays or training commitments. There are three female GPs, one of which is a deputy lead GP who is due to become a partner at the practice. During the inspection we were informed that the lead GP was on long term leave from the practice and the practice had made arrangements for the deputy lead GP to deputise as part of the management arrangements they had in place. A statutary notification was sent to CQC on 27 July 2015 to support this arrangement. The practice also employs a practice nurse. The practice manager works collaboratively with the lead GP and is supported by an assistant practice manager to take care of the day to day running of the practice. The management team is supported by a team of seven receptionists as well as a practice secretary who covers secretarial, administration and reception duties.

The surgery is open from 8:45am to 6:30pm Monday to Friday with consultations available from 09:00 to 11:30 and 4pm to 6:30pm with the GP and from 9am to 1pm and from 3pm to 6:30pm with the nurse. Saturday consultations are also available from 9am to 11:45am. During the week, the practices phone line directed patients to the on call GP if patients need to see a GP between the hours of 8am to 8:45am and 11:30am to 4pm. When the practice is closed outside of core hours patients are referred to the out-of-hours service.

Patients can book appointments over the phone, online and in the practice. The practice does not provide an out-of-hours service to their own patients but they have alternative arrangements for patients to be seen when the practice is closed.

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 the 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.

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)

We carried out an announced inspection on 21 July 2015 at the practice. During our inspection we spoke with two GP's, one nurse, two reception staff, a secretary and an assistant practice manager. Prior to the inspection the lead GP informed us that they would be absent on the day of the inspection and we were also informed that the practice manager would be on annual leave. Arrangements were made for the deputy lead GP and the assistant practice manager to deputise throughout the inspection. During the inspection we were informed that the lead GP was on long term leave from the practice and the practice had made arrangements for the deputy lead GP to deputise as part of the management arrangements they had in place. A statutory notification was sent to CQC on 27 July 2015 to support this arrangement.

We also spoke with 17 patients, three of which were members of the participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We reviewed 48 comment cards where patients and members of the public shared their views and experiences of the service.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used information from a variety of sources such as national patient safety alerts, complaints and significant events to help them to identify and manage risk, learn from reported incidents and improve patient safety. We reviewed safety records, incident reports and minutes of meetings dating back to January 2015 where these were discussed. We saw that the practice had managed these consistently and demonstrated a safe track record over time. A significant events meeting was held in the practice once a significant event was raised, we saw minutes to support that actions were discussed and learning points were applied during these meetings. We also found that the practice encouraged one person from each department to attend the significant events meeting so that learning was consistent across the practice. Additionally, significant events was a standing item on the practice meeting agenda and a practice meeting was held every two months to review actions from past significant events, incidents and complaints.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used incident forms and sent completed forms to the practice manager. We reviewed records of four significant events that had occurred during the last 12 months and saw this system was followed appropriately. We saw evidence of action taken as a result and that the learning had been shared. For example, we saw how the practice had reported that the machine used for glucose testing had broken. The practice arranged for clinical training and coaching for non-clinical staff on what to look out for in the absence of the testing machine. The induction pack was also altered so that new clinical staff were trained on how to monitor glucose.

The lead GP would email national patients safety alerts to practice staff and a hard copy of the alerts was added to the alerts folder which was kept in reception. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for and we saw examples where alerts had been communicated effectively including alterations in prescribing for clinical staff and medical device alerts for practice staff.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding, with a deputy lead also in place. Staff were aware of who the safeguarding leads were and all staff had been trained in both adult and child safeguarding at the required levels. Staff understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect and knew where to find information about safeguarding on the practice's computer system. The practice also kept a backup folder containing policies and safeguarding protocols and the safeguarding contact details were easily accessible.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a system to highlight vulnerable patients on the practice's electronic records. This included patients receiving end of life care as well as children who had a child protection plan in place. The practice shared a report with us to demonstrate that those with child protection plans in place were regularly reviewed.

The GPs took part in monthly multi-disciplinary meetings with district nurses and the health visitors to discuss children and young people known to be living in vulnerable circumstances, including those with child protection plans or in the care of the local authority. The practice also had regular contact with other agencies including social services, school nurses, midwives and the local authority to actively engage in local safeguarding procedures and ensure key information on safeguarding was shared. We also saw that individual cases including missed appointments and attendances at accident and emergency were monitored and discussed with the relevant safeguarding organisations.

Reception staff would act as a chaperone if nursing staff were not available. 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. There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. Receptionists had also undertaken

training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had a number of risk assessments and plans in place with regards infection control prevention, including legionella risk. The practice had not carried out a risk assessment to consider if Disclosure and Barring Service checks (DBS checks) were required for staff that carried out chaperone duties. We raised this with the practice during the inspection and this prompted them to complete risk assessments for each member of staff who acted as a chaperone. The practice had started the DBS application with one member of staff and shared plans to make the relevant DBS applications at the end of July 2015; for the rest of the team who chaperoned.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were 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. We saw records of room temperature and fridge temperature checks which ensured medication was stored at the appropriate temperature. All the medicines we checked were within their expiry dates and processes were in place to check medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that the nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms for use in printers and those for hand written prescriptions were kept securely at all times. The practice had a system of tracking prescriptions throughout the practice however the numbers held on site were not included on their log. We fed this back to the practice on the day and they took immediate action to include prescriptions in stock as well as prescriptions issued on their log. The practice had established a service for patients to pick up their dispensed prescriptions from the pharmacy which was located next door to the practice and they had systems in place to monitor how these medicines were collected. The practice had a system in place to alert them whenever a patient required an annual medication review; the practice managed this by attaching an alert to the patient's electronic record. Prescriptions would not be issued for any out of date reviews and only when the patient completed their medication review would a prescription be re-issued. Patients could request prescriptions over the phone, online and at the practice. Prescriptions could also be ordered by the local pharmacy and the practice also offered a prescription delivery service for older patients.

Cleanliness and infection control

Patients we spoke with told us they found the practice to be clean and had no concerns about cleanliness or infection control. We observed the premises to be clean and tidy. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. We noticed carpet was in place within the treatment room used to perform minor surgery. Guidance by the Department of Health notes that carpets should not be used in minor surgery rooms due to probability of body fluid contamination. We highlighted this during our inspection and the practice shared specific cleaning schedules in relation to this along with historical cleaning records where risk was assessed. The practice advised that minor surgery had not been carried out since approximately May 2015. The practice had also received funding to move to a purpose built premises and had started to view properties. We were advised that carpets would not be in the treatment room used for minor surgery within the new building once the practice moved.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw evidence that the lead had carried out annual infection control audits and that any improvements identified for action were completed on

Requires improvement

Are services safe?

time. The practice had scheduled in a risk assessment for legionella through an accredited organisation. Legionella is a bacterium which can contaminate water systems in buildings. The practice shared information with us to show that the risk assessment was booked for 27 July 2015.

Equipment

Staff we spoke with confirmed that they had the equipment they needed for the care and treatment they provided. 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 last testing date which was May 2015. We saw evidence that the equipment used by staff was calibrated in May 2015, this included blood pressure measuring devices and a spirometer, used to measure lung function including the volume and speed of air that can be exhaled and inhaled and is a method of assessing lung function.

Staffing and recruitment

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks 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.

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. These included regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and the practice manager was the health and safety representative. The practice manager had also completed a series of health and safety risk assessments and an annual health and safety audit as part of this role. One of the completed actions from the most recent risk assessment included a checklist for the first aid box to ensure it was always fully stocked and a future action included resurfacing areas of the practice car park.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. The practice had carried out a fire risk assessment in March 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We also saw that staff had received training in basic life support.

Emergency equipment was available including access an automated external defibrillator (AED).This is a portable electronic device that analyses life threatening irregularities of the heart and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The practice did not have oxygen on site, we raised this with the practice during the inspection and this prompted them to assess the risk of not having oxygen. The risk assessment highlighted that due to the practice's distance from the local ambulance service and ambulance response times, the practice felt that oxygen was not necessary. However, the risk assessment highlighted that the practice had plans to approach the CCG to request a local contract with an oxygen provider. The practice also planned to continually assess the risk on a three monthly basis until oxygen was in place.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac

Requires improvement

Are services safe?

arrest and anaphylaxis. Processes were also in place to check whether 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. 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 a heating company to contact if the heating system failed.

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. The GPs specialised in clinical areas such as diabetes, heart disease and asthma and the practice nurse supported this work. Discrimination was avoided when making care and treatment decisions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice implemented a patient services team consisting of the practice manager, assistant practice manager and practice secretary. These staff members covered the roles of patient services manager and patient service coordinators. The patient services team were described as a personal assistant to patients who had been admitted to hospital and they were heavily involved in identifying, monitoring and coordinating care for patients who were at high risk of admission to hospital. This helped to ensure patients were reviewed regularly and that multidisciplinary care plans were documented in their records. Ninety five percent of the patients on the practices unplanned admissions register consented to having a care plan in place, all 110 patients on the register were given the option to have a care plan.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. The practice showed us two clinical audits that had been undertaken in the last two years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw audits were completed in July 2013 and October 2014 regarding the prescribing of medicines used to treat asthma. Following the audit, the GPs carried out medication reviews for patients under the age of 16 who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. In addition, the practice implemented a policy to notify the local safeguarding team if a child with asthma missed two asthma reviews. The practice had also completed a number of minor surgery audits which highlighted zero complications and a success rate of 92% in January 2014.

The practice achieved 96% of the total QOF target in 2014, which was above the national average of 94%. 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.

- Performance for diabetes related indicators was 86% compared to the CCG average of 85%
- The percentage of patients with hypertension having regular blood pressure tests was 81% compared to the CCG average of 80%
- Overall performance for mental health related indicators was 100% (with an exception rate of 0%)
- The dementia diagnosis rate was 100% (with an exception rate of 0%)

The practice's prescribing rates were similar to national figures and there was a protocol for repeat prescribing which followed national guidance. The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had bi-monthly palliative care meetings and monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Structured annual reviews were also undertaken for people with long term conditions. The practice shared data with us which showed that 91% of their patients with diabetes had received an annual review and a medication review in 2014. Other reviews were carried out for patients with Chronic Obstructive Pulmonary Disease (COPD). COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Ninety two percent of the practice's patients with COPD had received an annual review and 100% had received a medication review in 2014. All of the practice's patients with dementia had received an annual review and a medication review in 2014.

Effective staffing

Practice staffing included medical, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending essential courses such as annual basic life support. All GPs were up to date with their yearly continuing professional

Good

Are services effective?

(for example, treatment is effective)

development requirements and all had been revalidated. 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. 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 development for staff, examples included protected learning time for online training and providing funding external training courses such as medical terminology courses for non-clinical staff. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. The lead GP and deputy lead GP also provided regular tutorials.

Working with colleagues and other services

The practice worked with other service providers to meet patient's 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. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. Emergency hospital admission rates for the practice were relatively low at 8% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract. We saw that the policy for actioning hospital communications was working well in this respect. The patient services manager would make regular contact with the patients who were at risk of hospital admission to make sure their needs were being met and to reduce the need for them to go into hospital. Staff told us how this worked well and we saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw that the practice had systems in place to share the appropriate information for patients with complex needs with the ambulance and out-of-hours services. For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours. 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 evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. 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. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures

Good

Are services effective?

(for example, treatment is effective)

and all staff were clear about when to obtain written consent. 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.

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. These care plans were reviewed annually and had a section stating the patient's preferences for treatment and decisions. The practice shared reports with us to demonstrate that care plans were in place for 56% of their patients with a learning disability, the practice had a total of 15 patients on their learning disability register; all of which had annual health checks in place. Ninety five percent of their patients experiencing poor mental health had care plans in place, out of 25 patients on their register. All of the practices patients with dementia and patients receiving palliative care had care plans in place.

Health promotion and prevention

It was practice policy to offer a health check 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. The practice offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 40% of patients in this age group took up the offer of the health check. A follow up appointment was immediately processed for the GP on duty if risk factors for disease was identified at the health check.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, by smoking cessation advice to smokers. There was evidence that the practices smoking cessation clinics were having some success as the number of patients who had stopped smoking in the last 12 months was 42%. The practice's performance for the cervical screening programme was 83%, which was above the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and the practice nurse had responsibility for following up patients who did not attend. The practice offered a full range of

immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average in areas for immunisations, where comparative data was available. For example:

- Childhood immunisation rates for the vaccinations given to under twos ranged from 97% to 100% and five year olds also from 97% to 100%. These were above the CCG averages which ranged from 25% to 98% for under twos and from 94% to 100% for five year olds.
- Flu vaccination rates for the over 65s were 49%, compared to the national average of 52% and vaccination rates for at risk groups were 80%, compared to the national average of 73%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. The evidence from the national patient survey published in July 2015 showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 100% of the respondents described their overall experience of the practice as good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 99% said the GP was good at listening to them compared to the CCG average of 88% and national average of 89%.
- 97% said the nurse was good at listening to them compared to the CCG average of 92% and the national average of 91%.
- 99% said the GPs and the nurse gave them enough time, compared to the CCG and national averages of 87% for GPs and the CCG average of 93% and national average of 92% for nurses.
- 100% said they had confidence and trust in the last GP they saw compared to the CCG and national averages of 95%.
- 99% said they had confidence and trust in the practice nurse compared to the CCG and national averages of 97%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 48 completed cards which were positive about the service experienced. Patients said they found the clinical staff to be caring and the reception staff were described as friendly and helpful. They said staff treated them with dignity and respect. Additionally, 95% of the national patient survey respondents said they found the receptionists at the practice helpful, compared to the CCG and national averages of 87%.

We also spoke with 14 patients on the day of our inspection. Patients 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. Disposable curtains were provided in treatment rooms so that patients' privacy and dignity was maintained during examinations. Consultation room doors were closed during consultations and conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

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

- 98% said the last GP they saw was good at explaining tests and treatments compared to the CCG and national averages of 86%.
- 97% said the nurse was good at explaining tests and treatments compared to the CCG average of 91% and the national average of 92%.
- 96% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%.
- 95% said the nurse was good at involving them in decisions about their care compared to the CCG average of 87% and national average of 85%.

Patients we spoke with on the day of our inspection told us that 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. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information:

Good

Are services caring?

- 99% said the last GP they spoke to was good at treating them with care and concern compared to the CCG and national averages of 85%.
- 97% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90%.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice had a higher than average caring population, the practice identified that 0.4% of their patients had caring responsibilities. The practice's computer system alerted GPs if a patient was also a carer. We were shown a carers folder which contained information for carers to ensure they understood the various avenues of support available to them. The practice promoted information on carers direct throughout the practice and on the practice website. The practice also offered flexible appointments for those with caring responsibilities. Staff told us that if families had suffered 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. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. These systems included providing extended hours and telephone consultations which would also be carried out during lunch hours for the working population. The practice were exploring ways of communicating with their younger population and had developed a practice social media page which contained information about the practice, opening times, updates and key topics such as health promotions. The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPGs are a group of patients registered with a practice who work with the practice to improve services and the quality of care. One of these improvements included installing automatic doors in order to improve access to the building for people with mobility difficulties. The practice showed us how they were also encouraging younger representation within their PPG, via the use of their social media page. The 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.

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 with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and 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 doctor.

The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The practice informed us that space in the waiting room was a problem during busy periods and staff told us that sometimes patients would need to stand and wait due to the waiting area being full. Although we found the waiting area to be of a reasonable size, on the day of our inspection we saw how busy it became as patients arrived for appointments and we could see how it was possible for the area to become fairly crowded. During busy periods limited space in the waiting could potentially make it difficult for wheelchair users and people with prams to move around. The practice were aware of the need to move to a bigger site and had started to view alternative premises to move to and had received support and funding from the CCG (Clinical Commissioning Group). GPs also told us that sometimes they need to 'hot desk' and work in different rooms, depending on what room was available on the day of their shift. Staff told us that this was another contributing factor towards the practices plans to move.

Access to the service

The surgery was open from 8:45am to 6:30pm Monday to Friday with consultations available from 09:00 to 11:30 and 4pm to 6:30pm with the GP and from 9am to 1pm and from 3pm to 6:30pm with the nurse. Saturday consultations were also available from 9am to 11:45am. During the week, the practices phone line directed patients to the on call GP if patients needed to see a GP between the hours of 8am to 8:45am and 11:30am to 4pm. The practice explained how on call duties rotated across the GPs at the practice.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. The practice had opted out of providing out-of-hours services to their own patients. When the practice was closed outside of core hours the answerphone message informed patients to call the either the emergency service 999 or the NHS 111

Good

Are services responsive to people's needs?

(for example, to feedback?)

service which assessed and referred patients to the out-of-hours services. Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and rated the practice well in these areas. For example:

- 92% were satisfied with the practice's opening hours compared to the CCG and national averages of 75%.
- 99% described their experience of making an appointment as good compared to the CCG average and national averages of 87%.
- 92% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 63% and national average of 65%.
- 99% said they could get through easily to the surgery by phone compared to the CCG average of 68% and national average of 73%.

The assistant practice manager shared the role of patient services coordinator with the practice secretary. The patient services role was a unique service for patients to discuss things like tests results and progress on secondary care referrals with a named manager or co-ordinator in the practice. Staff told us that the patient services role worked well and that this was a contributing factor in the success of their telephone access. Patients who contacted the practice with concerns or queries were put through to the patient services department which opened up the phone lines for those wishing to book appointments. We saw this service being used during our inspection and we saw that it worked well as patients enquiries were dealt with efficiently.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. Routine appointments were available for booking up to eight weeks in advance. All of the comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

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 to help patients understand the complaints system was on display in the practice and on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at seven complaints received in the last 12 months and found that they were satisfactorily handle and dealt with in a timely way. The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

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 clear vision to deliver high quality primary medical services. We found details of the vision and practice values were part of the practices strategy and also outlined in their practice charter. The practice vision and values included respect of patient choice, religion and culture; and to offer good access with high quality services to all patients. We spoke with seven members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and found that they had been reviewed and were up to date. The practice manager was responsible for human resource policies and procedures. We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice. The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a lead GP and a deputy lead GP who were leads for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

Leadership, openness and transparency

Staff told us that the GPs were approachable and always take the time to listen to them. All staff were involved in discussions about how to run the practice and how to develop the practice. We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff gave positive feedback with regards to working at the practice. All staff said they felt respected, valued and supported.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The practice had an active PPG which included 16 representatives who met approximately every six weeks. We met with three members of the PPG; the PPG members told us how they had recently rolled out a practice survey and were in the process of collating the completed questionnaires to review areas for improvement from patient's perspectives. The PPG were very positive about the role they played and told us they felt engaged with the practice.

The practice had also gathered feedback from patients and staff through use of a suggestions box where suggestions could also be made anonymously, the practice advised that they had not received any suggestions via the box and were open to keeping it in place for future suggestions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 six staff files and saw that regular appraisals took place which included a personal development plan. The practice was a GP training practice for doctors who were training to be qualified as GPs. The trainee we spoke with had many positive things to say about the practice, the trainee told us how the practice had developed a specific learning plan in line with their personal and professional development needs which included their interest in women's health.

Are services well-led?

Good

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.