# Dr Robinson & Partners

## Quality Report

Mount Road
Kidsgrove
ST7 4AY
Tel: 01782 777991
Website: www.kidsgrovegps.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? | Good |
| 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 Dr. Robinson and Partners practice on 02 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, responsive and caring services. It was also rated as good for providing services for all population groups.

Our key findings were as follows;

- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice offered extended opening hours every Wednesday from 6pm to 8pm.
- The practice linked with the Clinical Commissioning Group and other local providers to enhance services and share best practice.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.

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

Importantly the provider should:

- Strengthen their record keeping to ensure that decisions relating to identified risks are considered and assessed; for example in respect of legionella and fire drills.
- Ensure prescribers on home visits before leaving the practice premises; record the serial numbers of any prescription forms/pads they are carrying.
- Consider ways of improving the systems in place to enable the practice to receive and act on patient feedback.

**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?**

Good

The practice is rated as good 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. Only nursing staff and healthcare assistants acted as patient chaperones and they were provided with chaperone service training. Information about safety was recorded, monitored, appropriately reviewed and addressed, as an example there was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We saw that improvement was needed in record keeping in respect of legionella risk assessments and fire drills. There were enough staff to keep patients safe. Risks to patients were assessed and well managed.

**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 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. We also noted that only 9% of patients on the practice unplanned admissions register had had a hospital admission in 2014- 2015. 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.

The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. We saw as an example of this the audits completed in respect of antipsychotic medicine use. The repeat audit demonstrated the improvements made in antipsychotic medicine monitoring and their use as a direct result for their patients.

**Are services caring?**

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with

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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.

The National GP Patient Survey completed in 2015 found the percentage of practice patients who said the last appointment they got was convenient was comparable to the local Clinical Commissioning Group (CCG)average. We found that the practice was aware that their patient feedback was lower than the CCG average in respect of telephone and preferred GP access. The practice demonstrated they were in the process of deciding on how to best improve the service for their patients.

The practice ensured 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 who had suffered bereavement confirmed this support was offered by the practice.

**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 said they found it easy to make urgent same day appointments. The practice were aware of the feedback from patients regarding telephone access and preferred GP access and were considering how to best improve the service. We saw evidence of how the practice had developed new pathways and flowcharts regarding female urinary continence and sleep apnoea. These were discussed at the practice locality meetings and shared with their CCG peer groups. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

**Are services well-led?**

Good

The practice is rated as good for being well-led.

Staff were clear about the practice vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The staff felt they were valued and their views about how to develop the service were acted upon. The practice had a number of policies and procedures to govern activity

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and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. We reviewed the practice risk log, which addressed a wide range of potential issues, such as fire and loss of electricity. These were updated in a timely way. The practice proactively sought feedback from staff via meetings appraisals and training events. The practice sought feedback from patients via comments, compliments and complaints the National GP Patient Survey. The practice was considering setting up a patient participation group (PPG). The practice acted on feedback received for example complaints and were considering their response to the National GP Survey results for example patient telephone access. Staff had received inductions although documentation was not seen regarding the inductions for the most recent recruits. Staff had 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 which included enhanced services in dementia and end of life care. The practice invited all patients eligible for the Shingles vaccine and the majority of those invited attended. They noted patients who were invited who chose to decline and their reason for declining to ensure that appropriate health promotion information was available to them. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

**People with long term conditions**

Good

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

Nursing staff had lead roles 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. We saw that emergency Chronic Obstructive Pulmonary Disease (a lung disease) patient admissions on their disease register was lower that the local Clinical Commissioning Group average figures. For those people with the most complex needs, their 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. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. For example we saw that the practice had a specific confidentiality policy for teenagers that aimed to ensure children and young people were treated in an age-appropriate way and recognised as

# Summary of findings

individuals with their preferences considered. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. We saw that the practice's performance for cervical smear uptake was amongst the best in the CCG area.

**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 offered a range of vaccination services including travel vaccinations. The practice offered evening appointments until 8pm each Wednesday with a GP or nurse practitioner. 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 offered longer appointments for people with a learning disability.

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.

A follow up of bereaved patients was offered after their bereavement to assess their needs. This was initially a call and 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.

**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).

# Summary of findings

We found that the majority of patients experiencing poor mental health had agreed care plans in place at the time of the inspection, demonstrating patients' involvement in the decisions about their care and treatment. All had received an annual health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had been proactive in the reduction of antipsychotic drug use in dementia care patients. One of the partner GPs had completed a clinical audit about the usage of antipsychotic medicine for patients with Dementia in 2012. Following a repeat audit in 2014 the improvements made from the first audit had had a positive impact on patients with dementia, demonstrated by the reduced use of antipsychotic medicines in patients with dementia and that all patients on antipsychotic medicine had received regular medicine reviews.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, for patients experiencing poor mental health the practice offered telephone consultations during morning and afternoon surgeries for patients who did not wish to attend the surgery to talk to a GP over the telephone.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. These are mental health support charities which aim to provide advice and support to empower anyone experiencing mental health problems. 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 spoke with 12 patients during the inspection and received six completed CQC comments cards. The majority of the patients we spoke with said they were happy with the service they received overall. Five patients said the service was excellent. Nine of the 12 patients said they had experienced difficulties getting through to the practice by telephone, however once they gained access they could make an appointment the same day if required. Patients' comments were overwhelmingly positive in respect of the care, treatment provided by the GP and nurses and of the attitude and approach of the practice reception staff.

The National GP Patient Survey completed in 2015 found that 95% of patients said the last appointment they made was convenient. These were results from 258 surveys sent to patients with 122 surveys returned, a 47% completion rate. The percentage of patients that would recommend their practice was 71.5%. We saw that 93% of patients had confidence and trust in the last GP they saw or spoke to and 84% said the last GP they saw or spoke to was good at explaining tests and treatments. The survey highlighted areas in which the practice could improve, for example 45% described their experience of making an appointment as good compared to the local Clinical Commissioning Group (CCG) average of 77%; that 43% of patients found it easy to get through to the practice by phone compared with the CCG average of 75%. Twenty-nine per cent of patients with a preferred GP usually got to see or speak to that GP. The practice staff were aware of the feedback from patients regarding telephone and preferred GP access and were deciding on how to best improve the service.

Patients were aware they could ask to speak to the reception staff in another room if they wanted to speak in confidence.

Patients we spoke with told us they were aware of chaperones being available for examinations. They told us staff were helpful and treated them with dignity and respect. We were told that the GP, nurses and reception staff explained processes and procedures in great detail and were always available for follow up help and advice. They were given printed information when this was appropriate.

## Areas for improvement

**Action the service SHOULD take to improve**

• Strengthen their record keeping to ensure that decisions relating to identified risks are considered and assessed; for example in respect of legionella and fire drills.

• Ensure prescribers on home visits before leaving the practice premises; record the serial numbers of any prescription forms/pads they are carrying.

• Consider ways of improving the systems in place to enable the practice to receive and act on patient feedback.

# Dr Robinson & Partners

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector. The team included a GP and an Expert by Experience. Experts by Experience are members of the inspection team who have received care and experienced treatment from a similar service.

## Background to Dr Robinson & Partners

Dr Robinson and Partners is located in Kidsgrove, Staffordshire and is part of the NHS North Staffordshire Clinical Commissioning Group (CCG). The total patient population is 6967. The practice is in an area considered as one of the least deprived nationally.

The staff team currently comprises of two male partner GPs and two female salaried GPs. The partners each work four full time days per week and the salaried GPs provide between them a total of 11 practice sessions, each session being either a full morning or afternoon. The practice team includes a practice manager, deputy practice manager, two nurse practitioners, a practice nurse, two health care assistants, reception staff and administration staff. There are 22 staff in total employed. The practice is also a training practice for trainee GPs.

Surgery opening times are Monday, Tuesday and Friday 8am -6pm, Thursday 8am-1pm and on Wednesdays the practice opens from 8am-8pm. The practice does not provide an out-of-hours service to its own patients but has alternative arrangements commissioned by the North Staffordshire CCG 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 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.

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:

# Detailed findings

• Older people

• People with long-term conditions

• Families, children and young people

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

• People living in vulnerable circumstances

• People experiencing poor mental health (including people with dementia),

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our request. We also asked other organisations to share what they knew, such as the local Clinical Commissioning Group (CCG). CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.

We carried out an announced visit on 02 February 2015. During our visit we spoke with 12 staff members including GPs, the deputy practice manager, nurses, and reception staff. We observed how patients were communicated with. We reviewed six CQC comment cards where patients and members of the public were invited to share their views and experiences of the service and spoke with 12 patients. The CQC comment cards had been made available at the practice of Dr. Robinson and Partners in advance of our inspection.

Good

# 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. For example when there was a needlestick injury all appropriate actions were taken and reported appropriately.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were maintained of significant events that had occurred and we were able to review these. Significant events were dealt with immediately and cascaded learning from these events relayed to the staff either on a one to one basis or via a practice meeting. Meetings were held regularly and would, where required, include reviewing actions from past significant events and any complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff were aware of how to report incidents and these were reported to the practice or deputy practice manager. We saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice meetings 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 vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained to an advanced level and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or should a child not attend for immunisations despite reminder letters. The practice also held a register of patients living in vulnerable circumstances including those with learning disabilities (LD).

There was a chaperone policy, which was visible in reception and in the 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). Only nursing staff and healthcare assistants acted as patient chaperones and they were provided with chaperone service training.

### 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

clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. We saw that medicine reviews took place appropriately. For example if a patient was on a blood thinning medicine, their medicine was reviewed following routine blood investigations and dosage altered accordingly. We found that 78% of the patients eligible for a medicine review had been in receipt of a review at the time of the inspection.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were securely handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. When making home visits, GPs took suitable precautions to prevent the loss or theft of forms, such as ensuring prescription pads were carried in a locked carrying case and not left on view in a vehicle. However, GPs did not record prescriptions serial number data which is suggested as best practice by the NHS Protect Security of prescription forms guidance, August 2013. The GPs assured us that this would be implemented.

### Cleanliness and infection control

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

The practice had a lead for infection control who was relatively new to the practice and the lead role. We were informed that plans were in place to undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw that three of the four nurses had completed infection control training within the past 12 months. We saw evidence that the previous infection control lead had carried out an infection control audit in March 2014 and action plans were in place, discussed with the practice team and any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

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.

There was no documented Legionella risk assessment completed by the practice. Legionella is a naturally occurring bacteria wide spread in nature. When the bacteria enter water systems in the built environment, conditions can often favour and encourage significant growth and reproduction to levels which can cause bacterial infection. All systems require a risk assessment, but not all systems will require elaborate control measures.

We found that literature to inform staff about the Control of Substances Hazardous to Health (COSHH) was available for staff to read. Cleaning products were stored in lockable cabinets in line with COSHH.

### Equipment

Staff we spoke with told us they had 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 last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer and oxygen saturation monitors.

### Staffing and recruitment

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 criminal records checks through the Disclosure and Barring Service (DBS). The deputy practice manager had systems in place to check clinicians maintained medical indemnity insurance. There was evidence to show qualifications claimed had been verified. We saw that if a locum GP joined the practice on temporary basis the practice made checks to ensure their registration with the GMC was valid and check NHS England's performers list. The practice did not have systems in place to routinely check the professional registration status of the practice nurses against the Nursing and Midwifery Council (NMC) each year to make sure they were still deemed fit to practice. We saw that measures were immediately put into place by the deputy practice manager to address this. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there 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. Newly appointed staff had a probationary period to complete with this expectation written in their contracts.

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 deputy practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

### 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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice meetings.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included for example, those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia as well as other emergency medicines. 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. The deputy manager was able to demonstrate that staff received fire training and staff confirmed that they practised regular fire drills. We saw that the practice had

Good

# Are services safe?

not maintained fire drill records including the names of the staff who had attended. The deputy practice manager and fire marshall assured us that they would implement and maintain appropriate fire drill and test records.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this in respect of a staff member's recent maternity leave and the mitigating actions that had been put in place to manage this.

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. We saw that practice meetings took place where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the nurse practitioners supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions management such as diabetes and respiratory disorders. Our discussions with the GP partners, salaried GP, GP trainees and nurses confirmed that this happened.

The GP partners showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was better than average when compared to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. We saw that emergency Chronic Obstructive Pulmonary Disease (COPD is a lung disease) patient admissions per 100 patients on their disease register numbered 5.9 which was lower that the CCG average figures of 10.3. We saw that the percentage of patients on the practices mental health register with an agreed comprehensive care plan was 71%. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw that staff regularly reviewed elective and urgent referrals made, and that improvements to practice were shared with all clinical staff.

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

### Management, monitoring and improving outcomes for people

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 and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last three years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example one of the partner GPs had completed a clinical audit about the usage of antipsychotic medication for patients with Dementia in December 2012. They found that 33% of the patients on antipsychotics were not being reviewed in secondary care, showing there was room for improvement. The GP shared the audit with colleagues and wrote to the psychiatrist who had prescribed the medication to request they review the usage. Following a repeat audit in June 2014 it was found that 100 % of the patients on antipsychotics were getting regular medication reviews and that only 10% of the patients with Dementia were on antipsychotics. This had a positive impact on patients with dementia. The practice had a system in place for completing clinical audit cycles. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved.

Good

# Are services effective?

## (for example, treatment is effective)

Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a 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 also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The practice met all the minimum standards for QOF in diabetes/asthma/ COPD. This practice was not an outlier for any QOF clinical targets.

The team made use of clinical audit tools, clinical support and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that 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. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice maintained a palliative care register and held regular palliative multidisciplinary meetings to discuss the care and support needs of patients and their families.

### Effective staffing

Practice staffing included medical, nursing, managerial 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 good skill mix among the doctors, for example one GP had an additional diploma in sexual and reproductive healthcare, another with a diploma in family planning and a GP with MRCS a professional qualification for surgeons in the UK and Ireland. 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).

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, for example a healthcare assistant had recently attended training in understanding mental capacity. 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. We received positive feedback from the trainee we spoke with. We saw that the practice had also received positive feedback letters from previous trainees.

Nurse practitioners and practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and minor illness. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

The deputy manager demonstrated that the practice had appropriate performance management policies in place and should poor staff performance be identified appropriate action would be taken.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those 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 both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP

Good

# Are services effective?

## (for example, treatment is effective)

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. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

### 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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a faxed copy of patients' summary records to A&E. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS web to coordinate, document and manage patients' care. The practice had changed to the EMIS web only the month before the inspection. This was used to support staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. 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.

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 (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. The practice kept records and showed us for example that all patients who were included in their unplanned admissions enhanced services were invited to attend the surgery to complete a care plan with one of their care co-ordinators or a GP. We saw that 87% of those patients had a care plan agreed and 66% to date had been reviewed. We also noted that only 9% of patients on the unplanned admissions register had had a hospital admission in 2014- 2015.

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 Gillick competencies. (These are used to help assess whether a child 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 relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

### Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice offered NHS Health Checks to patient eligible aged 40 to 75 years, exercise on prescription and referral to a weight management services.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in

Good

# Are services effective?

## (for example, treatment is effective)

offering additional help. For example, for patients experiencing poor mental health the practice offered telephone consultations during morning and afternoon surgeries for patients who did not wish to attend the surgery to talk to a GP over the telephone. There were systems in place to identify 'at risk' patients, for example those receiving end of life care and these groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 81.06%, which was amongst the best in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do 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 for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the nursing staff.

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 national patient survey January 2015 and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The data from the national patient survey showed that 72% of patients surveyed described their overall experience at the practice as good or very good. The survey showed that 81% said the last GP they saw or spoke to was good at treating them with care and concern, was good at giving them enough time and listening to them. The same survey showed that 93% of respondents had confidence and trust in the last GP they saw or spoke to

Patients completed CQC comment cards to tell us what they thought about the practice. We received six completed cards and all were positive about the service experienced. Patients commented they felt the practice offered a good service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with12 patients on the day of our inspection. 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. Curtains 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 / treatment room doors were closed during consultations and that 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. Patients we spoke with told us they were satisfied with the privacy offered in the reception area.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager or deputy practice.

There was policy information posted on the practice website regarding the practices zero tolerance of patient abusive behaviour. This assisted practice staff who could refer to this to help them diffuse potentially difficult situations.

### 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 generally rated the practice well in these areas. For example, data from the national patient survey showed 75% of practice respondents said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. A further 93% of respondents had confidence and trust in the last GP they saw or spoke to which was in line with the local Clinical Commissioning Group (CCG) average of 95%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

We saw that the practice had a specific confidentiality policy for teenagers that aimed to ensure children and young people were treated in an age-appropriate way and recognised as individuals with their preferences considered. We found that 71% of patients experiencing poor mental health had agreed care plans in place at the time of the inspection demonstrating patients involvement in the decisions about their care and treatment.

Staff told us that translation services were available for patients who did not have English as a first language. We found there were no notices in the reception areas informing patents that this service was available. However, the practice staff informed us that all of the patients currently registered at the practice spoke excellent English.

Good

# Are services caring?

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

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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 suffered bereavement confirmed they had received this type of support but had chosen not to take up the offer but that others may find 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.

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 saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. An example was given whereby the practice had developed new pathways and flowcharts regarding female urinary continence and sleep apnoea. These were discussed at the practice locality meetings and shared with their CCG peer groups.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from their staff, from any complements or complaints made and from the National GP Patient Surveys. The practice had awareness that patients wanted longer appointments with their GP to be able to discuss multiple concerns. In response they instigated 15 minute appointments with the GP partners in order to facilitate this. This initiative had yet to be evaluated by the practice.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

For example patients with a learning disability and carers. The practice had access to online and telephone translation services.

The deputy practice manager advised that to date the practice had not provided equality and diversity training. However the staff we spoke with had awareness of equality and diversity. We spoke with one of the nurse practitioners who confirmed that they had completed equality and diversity training in their previous role.

The premises and services had been adapted to meet the needs of patients with disabilities. For example there was level access to the practice and disabled car parking and accessible toilets were available. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms.

All the patients registered at the practice were English speaking. Although the practice could cater for other languages through translation services.

### Access to the service

The practice opened Monday, Tuesday and Friday 8am -6pm, Wednesday from 8am-8pm and Thursday 8am-1pm. The practice did not provide an out-of-hours service to its own patients but had alternative arrangements for patients to be seen when the practice was closed. The practice provided patients with information and contact details for the out of hours provider. Appointments times to see the partner GPs were 15 minutes apart and the salaried GPs and locum GPs normally 10 minutes.

Comprehensive information was available to patients about appointments on the practice website. They operated an 'on the day' booking system for the majority of appointments but some pre-bookable appointments were available. Patients could express a preference for a particular GP at the practice and staff informed us they would endeavour to comply with any reasonable request. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Patients rang the practice in the morning for a same day appointment, if there were no further appointments available and the request was not urgent patients then had to ring again the following day. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. The practice's extended opening hours on Wednesday until 8pm was particularly useful to patients with work commitments. This was confirmed by some of the staff and patients we spoke with.

Longer appointments were also available for patients who needed them and those with long-term conditions. Home visits were made to local care homes on by the named GP for those patients who needed one.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice were aware that recently their patients had found it problematic to access the service by phone. This was reflected in the January 2015 National GP Survey which showed that only 45% of respondents described their experience of making an appointment as good, compared to the local CCG average of 77%. Forty three per cent found it easy to get through to the practice phone compared to the local CCG average of 75%, and 29% saw or spoke with their preferred GP compared to the local CCG average of 55%. The partner GPs informed us they had been deciding how they could improve the service they provided in respect of patient access within the constraints of the consulting and treatment rooms available to them. They were also considering options regarding Thursday afternoon appointments. There had been no resolution to these discussions, which were still on-going at the time of the inspection.

### 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; posters were displayed in the waiting room, a summary leaflet was available as well as information on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. Two of the patients we spoke with had needed to make a complaint and found that it had been generally dealt with to their satisfaction.

We looked at 15 complaints received in the last 12 months and found these were both clinical and non-clinical. They had been handled and dealt with in a timely way, with openness and transparency and the outcome and communication with the complainant was clearly documented.

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. Staff informed us that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

# 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

Discussions with staff and evidence we reviewed identified that the management team had a clear vision and purpose. The GPs and nurses we spoke with demonstrated a clear understanding of their responsibilities and they took an active role in ensuring that a quality service was provided on a daily basis. There was a clear team working ethos that demonstrated all staff worked to and had contributed towards a common goal. Four new staff had been recruited to the practice within the past 12 months. They told us that a quality service for patients was the practice ethos. Most GP's, reception and administration staff had been working at the practice for a number of years and had been part of the development of the service.

All staff were clear of their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon.

### 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 seven of these policies and procedures. All seven policies and procedures we looked at had been reviewed and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. We spoke with 12 members of staff who 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.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. The GPs informed us that they had the opportunity to measure its service against others and identify areas for improvement.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example audit findings for the 2012-13 period were presented to colleagues and discussed with respect to the British Medical Journal review of Lateral Epicondylitis (tennis elbow) management. In a one year period the practice had 20 tennis elbow presentations. The audit findings were that patients were appropriately treated and advised.

The practice had arrangements for identifying, recording and managing risks. The deputy practice manager showed us their risk log, which addressed a wide range of potential issues, such as fire and loss of electricity. These were updated in a timely way. We saw systems in place for monitoring all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audit and infection control. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example an infection control audit had been conducted in 2014 and action plans were implemented to address identified risk areas.

### Leadership, openness and transparency

We saw from minutes that practice and treatment room meetings were held regularly and palliative care multidisciplinary meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that the GPs attended locality meetings four times a year, CCG educational days twice a year and attended GP hot topic meetings and courses.

The practice manager and deputy practice manager were responsible for human resource policies and procedures. We reviewed a number of policies, for example staff performance procedures, training policy and management of sickness which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through the GPs individual feedback for their appraisals, the national patient surveys, compliments and complaints received. The GPs and deputy practice manager had informed us that they were considering setting up a Patient Participation Group (PPG). A PPG is a group of patients registered with the practice who have an interest in ensuring the needs and interests of all patient groups are

# Are services well-led?

Good

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

taken into consideration and to work in partnership with the surgery to improve common understanding. They informed us they had tried in the past to encourage patient interest but had little success.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. 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.

The practice had a whistleblowing policy which was available to all staff within the practice.

### 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 five staff files and staff told us that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and they accessed training and training days where guest speakers and trainers attended. We saw that the most recent recruits were subject to an appraisal during their probationary period.

The deputy manager informed us these were planned for February and following the inspection confirmed the dates they were planned to take place. We did not see evidence of the induction programme the new recruits completed. However staff informed us that they had received a staged approach induction with learning and support from the whole practice team both clinical and non-clinical.

The practice was a GP training practice involved in the teaching of doctors, medical students and student nurses. At the time of the inspection the practice were supporting a Foundation year 2 (F2) doctor on a four month rotation, (An F2 doctor remains under clinical supervision, as do all doctors in training, but take on increasing responsibility for patient care). The GP supervising the F2 doctor ensured they had supervision times made available for guidance on any patients care. A debrief meeting was held at the end of each surgery between the F2 doctor and the supervising GP. The practice approved trainers had been in receipt of very positive feedback from their trainees.

The practice completed reviews of significant events and other incidents and shared results and findings with staff at staff meetings to ensure the practice learned from and took action, which improved outcomes for patients.