Canterbury Medical Practice

Quality Report

Bridge Health Centre
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Bridge
Canterbury
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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?	Outstanding

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Canterbury Medical Practice on 13 December 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system for reporting and recording significant events. There was a positive attitude towards reporting events with substantial numbers of reported events from across all the teams working in the practice.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the experience, and had been trained to provide them with the skills and knowledge, to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

We saw areas of outstanding practice:

- There was a small but increasing contingent of refugees and asylum seekers with on the practice list. There was a lead GP and lead nurse appointed to manage their needs which were recognised as being both physical and psychological.

Summary of findings

- All correspondence of any patient less than 18 years old was scrutinised by the lead GP for safeguarding to help promote an holistic approach to family care. The practice had developed a contraceptive template for prescribing for patients aged under 18. This included an assessment of competence.
- There was a quarterly governance report. It summarised significant events, complaints, changes to national and local guidance (including changes to referral pathways) and audits.
- Patients with care plans, in addition to a named GP, had a named nurse and a named administrator. The latter was a point of contact for the patient, and being typically more readily available to the patients, than clinicians, they passed on messages and arranged clinical contacts or reviews.

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.

- There was an effective system for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to help prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes was at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice was a member of a "Vanguard" called Encompass. Vanguard sites are being developed as part of implementing the NHS Five Year Forward View. Part of the objective is to support improvement and integration of services.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Summary of findings

- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local patient population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it. The practice recognised future challenges and plans to address them were well advanced.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The practice had a systematic approach to working with other organisations, particularly as part of an NHS Vanguard site, to improve care outcomes, tackle health inequalities and obtain best value for money.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for managing notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. There were high levels of staff satisfaction. Staff were proud of the practice and spoke highly of the culture. Staff were engaged with the practice and encouraged to raise concerns or ideas for improvement.The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice had patients at a number of care and nursing homes and designated GPs carried out regular, usually weekly, ward rounds to help promote continuity of care.

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.
- There are 11 indicators for the management of diabetes, these can be aggregated. The aggregated practice score for diabetes related indicators was between 99% and 100% compared with the clinical commissioning group (CCG) average of 94% and the national average of 90%.
- Longer appointments and home visits were available when needed.
- There were named clinical leads for the more common long-term conditions and these staff had had additional training to suit them for the role.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for

Summary of findings

example, children and young people who had a high number of accident and emergency (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.
- The percentage of the practice's female patients aged 25 to 64 years whose notes recorded that a cervical screening test had been performed in the preceding five years was between 80 and 81 percent. This was comparable to the CCG and local average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The referral of any patient less than 18 years old was scrutinised by the lead GP for safeguarding to help promote an holistic approach to family care.
- The practice had developed a contraceptive template for prescribing for patients aged under 18. This included assessment for Gillick and Fraser competence.

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 patient 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.
- On-line services included booking and cancelling appointments, requesting prescriptions and accessing medical records.
- The practice offered a full range of health promotion and screening that reflected the needs of 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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Patients with Learning Disability are offered an annual check in their own home. The practice offered longer appointments for these patients.
- The practice regularly worked with other healthcare professionals, social services and social prescribing via the voluntary sector in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- There was an increasing number of registered patients who were asylum seekers or refugees. The practice had a designated GP and nurse to provide continuity of care for them, in recognition that this group had emotional and psychological needs as well as physical health needs.
- 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).

- Between 82% and 89% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months which was comparable to the national average of 84%.
- Performance for mental health related indicators was better than the CCG and national average. For example, the percentage of patients with schizophrenia and other psychoses who had had a comprehensive care plan in the preceding 12 months, agreed between individuals, their family and/or carers was between 92% and 95%. This was better than the CCG at 90% and the national average at 89%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system to follow up patients who had attended A&E where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice provided care to a local service for patients with severe mental health problems. This was provided by a GP who was a member of the Royal College of Psychiatry.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. This inspection is of a recently merged practice. It was created so recently that much of the data publicly available relates to the separate practices. Sometimes it has been possible to aggregate the data sometimes it has not. Where it has not we have said so and the data appears under the title of either "former Canterbury Medical Practice" or "former Cossington House Practice".

The results showed the former Cossington House Practice was performing significantly better than the national averages. Two hundred and fifty five survey forms were distributed and 117 were returned. This represented approximately 2% of the practice's patient list.

- 96% of patients found it easy to get through to this practice by telephone compared to the national average of 73%.
- 98% were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 98% described the overall experience of this GP practice as good compared to the national average of 85%.
- 88% said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

The results for the former Canterbury Medical practice, published at the same time, showed it was performing in line with national averages. Two hundred and twenty three survey forms were distributed and 105 were returned. This represented approximately 1% of the practice's patient list.

- 88% found it easy to get through to this practice by telephone compared to the national average of 73%.
- 93% were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 85% described the overall experience of this GP practice as good compared to the national average of 85%.
- 86% said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 22 comment cards all but one of which were positive about the standard of care received. One was negative about care and also about diagnosis. The general themes were that the practice was friendly, caring and offered an excellent standard of clinical care.

We spoke with seven patients during the inspection. All the patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The NHS friends and family test showed that of the 22 responses received 100% would recommend the practice.

Outstanding practice

- There was a small but increasing contingent of refugees and asylum seekers with on the practice list. There was a lead GP and lead nurse appointed to manage their needs which were recognised as being both physical and psychological.
- All correspondence of any patient less than 18 years old was scrutinised by the lead GP for safeguarding to help promote an holistic approach to family care. The practice had developed a contraceptive template for prescribing for patients aged under 18. This included an assessment of competence.
- There was a quarterly governance report. It summarised significant events, complaints, changes to national and local guidance (including changes to referral pathways) and audits.

Summary of findings

- Patients with care plans, in addition to a named GP, had a named nurse and a named administrator. The latter was a point of contact for the patient, andbeing typically more readily available to the patients, than clinicians, they passed on messages and arranged clinical contacts or reviews.

Canterbury Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser, a CQC pharmacy inspector and a practice manager specialist adviser.

Background to Canterbury Medical Practice

Canterbury Medical Practice is a GP partnership. It consists of two merged practices, the Cossington House Surgery and the Canterbury Medical Practice. This was formalised in April 2016.

Before the merger the Canterbury Medical Practice was located in the village of Bridge approximately four miles from the centre of Canterbury and three miles from the Cossington House practice. It had two branch surgeries, London Road, in Canterbury and Littlebourne surgery, Littlebourne. Its patient population, of approximately 13000, reflected its less urban setting with more patients over the age of 65 years through to over 85 years.

The Cossington House Practice was located in the city of Canterbury and comprised some 7200 patients. It had a patient population which was much younger than the national average and the number of patients in age ranges from 40 to 79 was less that that nationally, reflecting its location in a university city.

The newer larger Canterbury Medical Practice, still located in the village of Bridge, has a practice population therefore of approximately 20500. This is spread over a wide geographical area and its population, though now closer to the national average in age is diverse geographically, with both urban and quite rural environments. The practice as a whole is not in an area of deprivation though there are pockets of urban and of rural deprivation within it. The majority of the patients describe themselves as white British but the student population is drawn from a wide range of nationalities.

The practice holds a General Medical Services contract (a contract between NHS England and general practices for delivering general medical services). The practice is a partnership of eight GPs. The practice employs other GPs and has trainee GPs working under supervision. There are eight male GPs and seven female GPs. There are two nurse practitioners, one nurse manager and a senior nurse. There are eight practice nurses. All the nursing staff are female. There are three healthcare assistants and a phlebotomist, all female.

As a training practice, alongside their clinical roles, the GPs and nurses provide training and mentorship opportunities for trainee GPs, student nurses and allied healthcare professionals.

The GPs and nurses are supported by a management team and a team of administration, dispensary and reception staff.

The practice is a member of a “Vanguard”. Vanguard sites are being developed as part of implementing the NHS Five Year Forward View. Part of the objective is to support improvement and integration of services. Canterbury Medical Practice’s particular Vanguard site is called Encompass.

The practice is open 8am to 6.30pm Monday to Friday. There are extended hours with both GP and nursing staff appointments from 6.30pm to 8.30pm Tuesdays and Thursdays.

Detailed findings

The practice does not provide out of hours services to its patients and there are arrangements with another provider, Primecare, to deliver services when the practice is closed. Details of how to access this service are available at the practice and on the website.

Main site (the Bridge Surgery)

Bridge Health Centre

Patrixbourne Road

Bridge,

Canterbury

Kent

CT4 5BL

London Road Surgery

49 London Road

Canterbury

Kent

CT2 8SG

Littlebourne Surgery

The Corn Stores

Nargate Street

Littlebourne

Canterbury

Kent

CT3 1UH

Cossington Road

51 Cossington Road

Canterbury

Kent

CT1 3HX

We visited all the premises except the London Road surgery on the day of the inspection. The branch surgery at Littlebourne is dispensing, that is, it is able to provide pharmaceutical services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises.

The merged practice was created so recently that much of the data publicly available relates to the separate practices. Sometimes it has been possible to aggregate the data sometimes it has not. Where it has not we have said so and the data appears under the title of either "former Canterbury Medical Practice" or "former Cossington House Practice".

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 13 December 2016. During our visit we:

- Spoke with a range of staff including GPs, trainee GPs, nurses, reception staff and administrators. We spoke with patients who used the service.
- We saw how patients were looked after both in the reception and over the telephone
- Reviewed comment cards where patients shared their views and experiences of the service
- Reviewed an anonymised sample of the personal care or treatment records of patients.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

We also looked at how well services were provided for specific groups of people and what good care looked 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).

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system for reporting and recording significant events.

- Staff told us they would inform their line manager of any incidents and there was a recording form available on the practice's computer system. There was a short cut, on staff's visual display unit to take them directly to the reporting form. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice.
- National patient safety alerts were dealt with by a nominated member of the dispensary team and there was a system to help ensure they were dealt with if received when the team member was absent. They were sent on to the GPs and nurses for clinical matters and other staff as necessary. Alerts were discussed at clinical meetings.
- There was evidence that the whole team were engaged in reporting events, as reports came from all areas of the practice. There had been reports concerning, prescribing, administration, record keeping, clinical issues, referrals, district nursing and unexpected deaths. There had been 57 reports during the previous 12 months.
- We saw reports had been discussed at clinical meetings and had resulted in changes. For example there were changes to the appointment template after a telephone consultation had been missed. There had been changes to the system for checking that medical reports were reviewed by the relevant GP before being sent to the patient, following a case where this had not happened.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to help keep patients safe and safeguarded from abuse, which included:

- Arrangements to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. We looked at anonymised cases and saw that the staff identified occasions when a safeguarding referral might be appropriate and made the referral promptly.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We saw that the premises were clean and tidy. The practice nurse was the infection control clinical lead. They had attended a two day accredited course to train them for the role. They liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements. For example the practice had stopped using disposable cases on pillows and now used wipe clean equipment and sample collection baskets had

been replaced with lidded boxes. A new protocol instructed reception staff not to handle samples which were now placed in box by the patient and checked by clinical staff.

- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes for handling repeat prescriptions included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- There were nurses who had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient group directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary. All members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).
- Dispensary staff acted as a resource for the GPs and nurses. For example where a GP or nurse wished to check whether a particular medicine or dosage was appropriate to a case they could seek the advice of the dispensary staff who researched the issues and responded.
- The practice held stocks of controlled drugs (CDs) (medicines that require extra checks and special storage because of their potential misuse) and had procedures to manage them safely. There were also arrangements for the destruction of controlled drugs. However there was a small stock of CDs which, though secure, had been awaiting destruction for four months. We saw evidence that this had been done within two days of our inspection.
- We reviewed five personnel files and found 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures for monitoring and managing risks to patient and staff safety. There was a health and safety policy available to all staff. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota for all the different staffing groups to help ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All relevant staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Good

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had been called to at least one emergency in the last year. After the incident there had been a debriefing for those involved, they found that the emergency medicines and kit, that had been used, had worked well.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. Guidance was discussed at clinical meetings and was summarised in a quarterly governance report circulated to all staff.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- Examples of using national best practice included the use of the Cardiff care plan for patients with a learning disability

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice).

The merged practice was created so recently that much of the data publicly available relates to the separate practices. It has not been possible to aggregate the data. Therefore there are two sets of data, appearing as the "former Canterbury Medical Practice" or "former Cossington House Practice". Both practices were high achievers.

The Canterbury Medical Practice.

The most recent published results were 100 % of the total number of points available with 9% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The clinical commissioning group (CCG) exception reporting rate was 11% and the national rate was 9%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015 - 2016 showed:

- There are 11 indicators for the management of diabetes, these can be aggregated. The aggregated practice score for diabetes related indicators was 100% compared with the CCG average of 94% and the national average of 90%.
- The percentage of patients on the diabetes register, with a record of a foot examination and a risk classification within the proceeding twelve months was 94% compared to a national average of 89%. The practice had outperformed the national average by between 1% and 9% every year over the last ten years.
- Eighty two percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months which was comparable to the national average of 84%.
- The percentage of patients with chronic obstructive pulmonary disease ((COPD) - a long-term respiratory condition) having an annual check by a healthcare professional was 94%. This was better than the CCG and national averages at 90%.
- Performance for mental health related indicators was better than the CCG and national average. For example, the percentage of patients with schizophrenia and other psychoses who had had a comprehensive care plan in the preceding 12 months, agreed between individuals, their family and/or carers was 92%. This was better than the CCG at 90% and the national average at 89%. The practice had outperformed the national average by between 3% and 16% every year over the last ten years

The former Cossington House Practice

The most recent published results were 100 % of the total number of points available with 8% exception reporting. The clinical commissioning group (CCG) exception reporting rate was 11% and the national rate was 9%.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2016 - 2016 showed:

- There are 11 indicators for the management of diabetes, these can be aggregated. The aggregated practice score for diabetes related indicators was 99% compared with the CCG average of 94% and the national average of 90%.
- The percentage of patients on the diabetes register, with a record of a foot examination and a risk classification

Good

Are services effective?

(for example, treatment is effective)

within the proceeding twelve months was 97% compared to a national average of 89%. The practice had outperformed the national average by between 2% and 8% every year over the last ten years.

- Eighty nine percent of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months which was comparable to the national average of 84%.
- The percentage of patients with chronic obstructive pulmonary disease ((COPD) - a long-term respiratory condition) having an annual check by a healthcare professional was 92%. This was better than the CCG and national averages at 90%.
- Performance for mental health related indicators was better than the CCG and national average. For example, the percentage of patients with schizophrenia and other psychoses who had had a comprehensive care plan in the preceding 12 months, agreed between individuals, their family and/or carers was 95%. This was better than the CCG at 90% and the national average at 89%. The practice had outperformed the national average by between 3% and 14% every year over the last ten years

There was evidence of quality improvement including clinical audit.

The practice had an holistic approach, focussed on the patient rather than the condition. For example patients saw the diabetic nurse, whose had already received the results of their blood tests. Patients then had an appointment straight afterwards with a GP who made any necessary medication changes and undertook annual reviews for other co-morbidities. Patients with care plans, in addition to a named GP, had a named nurse and a named administrator. The latter was a point of contact for the patient, being typically more readily available to the patients, their carers and other healthcare professionals, than the clinicians. They passed on messages and arranged clinical contacts or reviews.

We looked at seven audits of which two were completed cycles. Improvements had been made and monitored.

- There was a completed audit, comprising two cycles, of handover and recording for paramedic visits. These were completed in December 2015 and February 2016. The first audit showed that seven out of 13 notes did not show consent and sufficient handover details. The practice updated the protocol, created new computer shortcut links to improve access to the documentation and informed all those involved. The second audit showed improved documentation and improved recording of consent. The changes were shared with the vanguard, Encompass, who were the employers of the paramedics.
- The second completed clinical audit concerned renal function in patients who were prescribed the newer anticoagulants (NOACs). This two cycle audit noted an increase in kidney function screening from 47% initially to 91% after learning and discussion at clinical meetings. A further audit is set for June 2017.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example there had been additional training for those reviewing patients with long-term conditions such as asthma, COPD diabetes and coronary heart disease. The practice also saw that staff needed training when they undertook an enhanced role, for example when a nurse became a nurse manager the practice ensured that they received management training.
- There were named clinical leads for the more common long-term conditions and these staff had had additional training for the role.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included support, coaching, mentoring and clinical supervision. We saw that there was a structured approach to mentoring which was available to staff for as long as they felt it was necessary

Good

Are services effective?

(for example, treatment is effective)

and permanently for advanced nurse practitioners. There was support for revalidating GPs. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

This included care and risk assessments, care plans, medical records and investigation and test results.

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital.
- The practice was a member of a "Vanguard" site called Encompass. Vanguard sites are being developed as part of implementing the NHS Five Year Forward View. Part of the objective is to support improvement and integration of services through working together with other providers. The benefit to patients is care designed to meet local people's needs and ensure patients receive more services close to their homes, rather than having to travel to hospital.
- Staff recognised the importance of involving others. For example, a complaint had led the practice to review some of the referral pathways, it became clear that they were open to more than one interpretation and the practice ensured that the CCG were involved so that future instructions were clearer.
- Meetings took place with other healthcare and social care professionals on a weekly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance. The practice had developed a template for contraceptive prescribing for patients aged under 18. This includes assessment for Gillick and Fraser competence.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.

- Care plans for those receiving end of life care had quality markers embedded in the palliative care templates in patients' records for example diagnosis, resuscitation status, just in case medication and carers. This allowed the practice to audit the plans for quality, which they did regularly, and allowed clinicians to access important information easily.
- Patients were signposted to the relevant service. .

The practice's uptake for the cervical screening programme was 81% which was comparable to the CCG and the national averages of 82% The practice telephoned patients who did not attend for their cervical screening test to remind them of its importance. The practice ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 86% to 91% and five year olds from 84% to 95%. The national averages were 89% 94% and 97% to 96% respectively..

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Twenty one out of 22 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One comment card was negative about care and diagnosis.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The merged practice was created so recently that much of the data publicly available relates to the separate practices. It has not been possible to aggregate the data, so it appears under the title of either "former Canterbury Medical Practice" or "Former Cossington House Practice".

The results showed the former Canterbury Medical Practice was performing in line with the national averages.

- 87% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and national average of 89%. When asked the same question about nursing staff the results were 89% compared to the CCG average of 93% and national average of 91%.
- 88% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%. When asked the same question about nursing staff the results were 96% compared to the CCG average of 95% and national average of 92%.
- 97% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%. When asked the same question about nursing staff the results were 97% compared to the CCG and national average of 97%.
- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%. When asked the same question about nursing staff the results were 89%compared to the CCG average of 92% and national average of 91%.
- 93% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

The results for the former Cossington House Practice were significantly higher than the national averages.

- 92% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%. When asked the same question about nursing staff the results were 99% compared to the CCG average of 93% and national average of 91%.
- 91% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%. When asked the same question about nursing staff the results were 99% compared to the CCG average of 95% and national average of 92%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%. When asked the same question about nursing staff the results were 99% compared to the CCG and national average of 97%.
- 92% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and national average of 85%. When asked the same question about nursing staff the results were 98%compared to the CCG average of 92% and national average of 91%.
- 96% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. The results showed the former Canterbury Medical Practice was performing in line with the national averages.

- 83% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%. When asked the same question about nursing staff the results were 90% compared to the CCG average of 92% and national average of 90%.
- 80% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%. When asked the same question about nursing staff the results were 82% compared to the CCG average of 87% and national average of 85%.

The results showed the former Cossington House Practice was performing better than the national averages.

- 92% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%. When asked the same question about nursing staff the results were 99%compared to the CCG average of 92% and national average of 90%.
- 98% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 82%. When asked the same question about nursing staff the results were 92% compared to the CCG average of 87% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- There were translation services and we saw notices in the reception areas informing patients of this.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified approximately 150 patients as carers 1% of the practice list). There was a small but increasing contingent of refugees and asylum seekers with on the practice list. There was a lead GP and lead nurse appointed to manage their needs which were recognised as being both physical and psychological. Patients from this group were provided with face to face (as opposed to telephone) interpreters. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a 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. When a patient died the practice closed the patient record but also informed any other providers who were involved with that patient. This helped to prevent the family receiving letters, such as appointments, for the deceased which could cause further distress. There was a policy to follow up patients who had suffered a bereavement two to three weeks after the event as it was recognised that it was often at this time that people needed support rather than in the immediate aftermath.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice 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. For example the practice provided or hosted acupuncture, physiotherapy and reflexology services. There were consultant led cardiology services, echocardiograms, ultrasound scans and hearing clinics.

- The practice offered evening surgeries from 6.30pm to 8.30pm on three or four evenings a week.
- Appointments for influenza clinics, physiotherapy and some complimentary therapy clinics were run on Saturday mornings.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. Additionally there was a paramedic practitioner home visiting service. Paramedics only visited when and if the GP felt the case was appropriate, or if an urgent visit was required and no GP was immediately available
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- There were services to support the homeless, and those with drug and/or alcohol dependency for example a local charity for the homeless had provided walk in clinics which had been promoted by, and held at, the branch surgery in the city centre.
- On-line services included booking and cancelling appointments, requesting prescriptions and accessing medical records.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open between 8am to 6.30pm Monday to Friday. There were extended hours with both GP and nursing staff appointments from 6.30pm to 8.30pm three to four evenings a week. Appointments were dependent upon individual GPs but could be available during any time that the practice was open. Appointments could be booked up to six weeks in advance and there were urgent appointments available on the day.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages. The merged practice was created so recently that much of the data publicly available relates to the separate practices. It had not been possible to aggregate the data, so it appears under the title of either "former Canterbury Medical Practice" or "former Cossington House Practice".

The results for the former Canterbury Medical Practice showed

- 81% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 88% said they could get through easily to the practice by telephone compared to the national average of 73%.

The results for the former Cossington House Practice showed

- 90% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 96% said they could get through easily to the practice by telephone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency for medical attention.

There was a duty doctor to whom such calls were directed. In cases where the urgency was so great that it would be inappropriate for the patient to wait for a GP home visit, there was a paramedic home visiting service. Paramedics would only visit when and if the GP felt the case was appropriate, or if an urgent visit was required and no GP was immediately available. This service was provided

Good

Are services responsive to people's needs?

(for example, to feedback?)

collaboratively through the vanguard, Encompass. Encompass had carried various reviews of the service and we were told that there was strong support for it from the public and GPs. We were told that when admission to accident and emergency was necessary having paramedics involved improved the speed and process of admission for the patient.

Listening and learning from concerns and complaints

The practice had an effective system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance. 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 in the practice leaflet and on the practice website.

We looked at the 10 complaints that had been received in the last 12 months. They had been recorded, investigated and responded to within the timeframes demanded by the practice policies. Responses were honest and addressed the issues raised. Complainants received a written apology where appropriate.

Lessons were learnt from individual concerns and complaints and also from analysis of trends. Action was taken to as a result to improve the quality of care. For example, there had been an error in how a referral to secondary was managed. The practice investigated. There were faults with the practice's system and human error was identified as the cause, the mistake and the cause were discussed with the individuals, for their learning. Later the incident was discussed at a team meeting for general learning. Analysis of complaints had identified that communication and how patients perceived staff actions was an issue. This had been discussed and there had been formal training to improve staff's communication skills.

Are services well-led?

Outstanding ☆

(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 care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. The statement included; providing safe and high quality care, maintaining a motivated workforce and working with collaboration with others.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored. For example it recognised the difficulty of maintaining services across multiple sites and was well advanced with planning for a main site, co-located with the local general district hospital.
- The practice supported the vision with actions. For example the practice committed substantial clinical and non-clinical time to promote good outcomes for patients. Patients with care plans, in addition to a named GP, had a named nurse and a named administrator. The latter was a point of contact for the patient, and being more readily available to the patients, than clinicians, they passed on messages and arranged clinical contacts or reviews.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- There were practice specific policies that were available to all staff.
- There was a comprehensive understanding of practice's performance. Partners had responsibility for different areas such a finance, infection control and safeguarding.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example the practice used a register to record risks and their potential impact on the patients and the practice.
- The practice produced a quarterly governance report. It was widely circulated amongst staff. It summarised significant events, complaints, changes to national and local guidance (including changes to referral pathways) and audits.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

- There were partners meetings every other month to decide strategic direction.
- There was an executive management team which met each week. This team comprised both clinical and managerial leaders. Working closely together to provide high quality clinical care whilst at the same time innovating and developing services.

This objective of closer working was evidenced by the range of services provided which included;

- cardiology (through a GP with a special interest in the subject).
- echocardiogram service
- anticoagulation monitoring
- musculoskeletal services including physiotherapy, osteopathy and acupuncture
- reflexology services
- schools' medical officers
- and to hosting a wide range of therapy services as well as counselling, pain clinic and podiatry
- ultrasound
- hearing tests

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour and we saw an example of this. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included training for staff on

Are services well-led?

Outstanding ☆

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

communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held regular team meetings. This included meetings of the nursing team, reception team, dispensary team and administration team.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice. For example, the group were currently involved in designing improvements to the extended hours services to better support those who were working full time and found it difficult to get to the practice during normal working hours. Other initiatives, proposed by the PPG and adopted by the practice included, the provision of a disabled parking bay at one of the branches and new patient booking in screens.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw three examples where they had done so namely; changes to how prescriptions were managed, helping to bid for a new anticoagulation monitoring service and designing new QOF templates that supported staff in getting patients the right reviews within the right timescales.
- There was an annual general meeting for whole practice (the practice comprises 86 staff). The practice provided a buffet. Staff learned about the strategic direction of the practice. They had the opportunity to make suggestions and discuss ideas, both in an open forum and anonymously, via feedback cards.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The practice was one of the three pilot sites selected for the development of a new model of integrated care particularly for those at risk of emergency admission to hospital. The pilot was recognised in the CCG and Encompass (the multispecialty community provider (MCP)) as leading in the development of this new model of care. The pilot has attracted a number of external agencies who have emulated the methods used by the practice. As part of this the practice developed detailed clinical templates to help populate clear care plans for sharing with both the patients and health and social care providers. The plans recognise the value of social and emotional needs as well as health needs. Many of these templates have been adopted across the CCG.
- A patient was so appreciative of how this new model of care had changed the quality of life, for themselves and their partner that they helped to make in a short film about what the practice and Encompass were trying to achieve. It was planned that the film be posted on social media to a enable wider sharing of this initiative.
- The practice was subject to scrutiny by Health Education Kent, Surrey and Sussex (called the Deanery) as the supervisor of training. There was a strong training ethos within the practice with three GP trainers, practice nurse mentors as well as opportunities for non-clinical staff to develop and progress. One of the GPs was a programme director for the Deanery so was involved in training at the strategic level. GP trainees and FY2

Are services well-led?

Outstanding ☆

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

doctors were encouraged to provide feedback on the quality of their placement to the Deanery and this in turn was passed to the GP practice. GPs' communication and clinical skills were therefore regularly under review.