Upwell Health Centre

Quality Report

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected Upwell Health Centre on 10 March 2015 as part of our comprehensive inspection programme. Upwell Health Centre is located in a building which is shared with a separate pharmacy and dentist and serves a population of approximately 9400. The overall rating for this practice is good. We found the practice was good in each of the domains safe, effective, caring, responsive and well led. We found the practice provided good care to older patients, patients with long term conditions, patients in vulnerable circumstances, families, children and young patients, working age patients and patients experiencing poor mental health. Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Staff took account of changes in national guidance when planning patient care.
- Staff had access to training to update their skills.
- Practice staff provided proactive and tailored services to vulnerable patients
- The practice had a robust governance structure in place with a designated quality lead, alongside a range of different regular meetings for staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- There was a clear leadership structure and staff felt supported by management. Three members of staff had been developed and promoted internally to lead role positions.

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

Importantly the provider should:

- Improve the arrangements for the security of blanks prescription forms
- Improve the security of the storage of vaccines.

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 safe. There were systems and processes in place for managing and responding to safety alerts. Staff learnt from any incidents and events that occurred in the practice and we found changes had been made as a result. Patients, staff and visitors were protected against the risk of health care associated infections. Arrangements were in place to manage emergencies. Staffing levels were appropriately managed and maintained and there were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that overall patient outcomes were either in line or above average for the locality. The practice had completed a scheme of clinical audit cycles, covering a broad range of clinical areas. There was evidence that this had led to improvements in outcomes for patients. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely, to ensure care pathways reflected best practice. Patients' needs were assessed and care was planned and delivered in line with current legislation. Arrangements were in place to promote patient health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. Staff worked with multidisciplinary teams. Some improvements were needed around appraisals and personal development plans for all staff but the practice manager was developing this.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients were very satisfied with the care they received from the practice. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We saw that the practice had taken steps to ensure information was accessible to patients. During our inspection we saw that staff treated patients with kindness and respect and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had good facilities and was well equipped to treat patients and meet their needs. Considering the need for expansion, they

Summary of findings

made good use of the existing space. The practice provided rooms cost free for other health services and charities to avoid the local population having to travel. The practice offered onsite phlebotomy to avoid those requiring this having to travel elsewhere. 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 was evidenced.

Are services well-led?

Good

The practice is rated as good for well-led. Staff strived to achieve the common goal of patient focused quality care. The practice had a number of policies and procedures to govern activity and held regular governance meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, performance reviews and attended staff meetings and events. The practice recently internally promoted three members of staff to more senior positions.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Weekly multi-disciplinary meetings were held to identify the best ways to provide care to palliative care patients and, where appropriate, to avoid them going into hospital. Continued monitoring helped to ensure that older patients received the right treatment and care when they needed it.

We spoke with a representative from one nursing home who told us that the practice offered effective care to their residents. A designated GP provided care to a local care home and held weekly visits there.

Older people we spoke with told us that they could get an appointment on the same day if they needed it and that they were satisfied with the care provided.

People with long term conditions

Good

he practice is rated as good for the care of patients with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly.

Nursing staff had lead roles in chronic disease management and the practice employed a full time specialist long term conditions nurse. Longer appointments and home visits were available when needed.

For those patients with the most complex needs, the practice worked with relevant health and care professionals to support patients. The practice supported patients to manage a range of long term conditions in line with best evidence based practice.

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, vulnerable children and those under the care of the local authority (in foster or other care arrangements). Immunisation

Summary of findings

rates were generally 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.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with health visitors, especially around safeguarding elements.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice provided extended hours on Mondays and Saturdays.

The practice provided the option of online booking for appointments. Health promotion and screening that reflected the needs for this age group was taking place.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks and offered longer appointments for people with a learning disability.

The practice looked after patients from several fixed traveller sites and had improved the health issues through vaccinations and advice in lifestyle choices

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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). Clinicians provided empathetic and responsive care to patients with poor mental health. Patients experiencing poor mental health were invited to attend the practice for different physical health checks.

Summary of findings

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 told patients experiencing poor mental health about how to access various support groups and were involved in a CCG led scheme to devote extra funding to Admiral Nurses through Norfolk and Suffolk NHS Foundation Trust (NSFT) for the enhanced care for dementia patients. 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

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We received 14 completed comment cards all of which were positive. We spoke with five patients during our inspection, including three members from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

The patients we spoke with told us that they trusted staff at the practice and that they felt that they received a good level of care. Four patients expressed their opinion that the practice provided an outstanding service and that GPs and nurses went the extra mile to ensure that patients were seen and that their needs were met as conveniently and quickly as possible. The comment cards reflected these views, all with very positive comments. Two patients told us that they sometimes had to wait up to two weeks to see the GP who knew them best, but they confirmed that they could always get an urgent appointment with another doctor if this was necessary and were prepared to wait if need be.

We spoke with three representatives of the PPG. We were told that they felt listened to by the practice and that the standard of care they received was of a high quality. They provided evidence that the practice had taken their comments and suggestions on board in the past. They were able to evidence support from the practice with the organisation of information events for patients.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the security of blanks prescription forms.
- Improve the security of the storage of vaccines.

Upwell Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector. The team included a GP specialist advisor, a practice manager specialist advisor, a medicine optimisation inspector and a second CQC inspector.

Background to Upwell Health Centre

Upwell Health Centre in Townley Close, Upwell provides services centred to patients living in Upwell and Outwell as well as the surrounding villages in the area covering over 180 square miles.

The practice is a partnership of five GPs. One GP partner holds the role of registered manager within the practice. Of the five GP partners, two are female. The practice also employs two salaried GPs, a nurse practitioner, a long term conditions specialist nurse, a nurse sister, three staff nurses and two healthcare assistants. The clinical team is supported by a practice manager, an assistant practice manager, a quality manager and an office manager as well as a team of administrators and receptionists.

The practice has a patient population of approximately 9400. GP appointments are available every weekday between 09:00 and 11:30 and then from 14:00 until 17:30. Extended hours are provided on Saturday mornings from 08:00 until 11:00 and on Monday mornings from 07:00 until 08:30 or Monday evenings 18:00 until 20:00, depending on GP availability.

The practice website clearly details how patients may obtain services out-of-hours. The practice has a registered pharmacy attached providing dispensing services to patients.

Why we carried out this inspection

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

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

Detailed findings

We also looked at how well services are provided for specific groups of patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local Clinical Commissioning Group (CCG) and the NHS England Area Team. The CCG and NHS England are both commissioners of local healthcare services.

We carried out an announced inspection on 10 March 2015.

During our inspection we spoke with a range of staff: reception, administrative and clinical staff. We also spoke with patients who used the service, and three representatives of the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care.

We reviewed comment cards which we had left for patients and members of the public to share their views and experiences of the service. We also reviewed a range of different records held by the practice.

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 practice had implemented systems for reporting and responding to incidents. We reviewed records in respect of each of the significant events identified and recorded in the previous year. We found a number of incidents had been reported including issues relating to medicines prescribing, dispensing and clinical decision making. The notes included actions that had been taken in response to the incidents to reduce future recurrence and improve patient safety.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. We saw evidence that the practice had managed these consistently over time and so could demonstrate a safe track record over time. Staff were aware of their responsibilities and the system for reporting significant events; we saw changes as a result of incidents arising. Staff attended regular meetings where the outcome of significant events and any learning was discussed. Learning from complaints was also discussed as these were treated as significant events in all cases.

Learning and improvement from safety incidents

The practice had systems in place for reporting, recording and monitoring significant events. The practice kept records of significant events that had occurred and these were made available to us. A significant events meeting was held monthly. We saw minutes and evidence that the practice had reviewed actions from past significant events and complaints. There was evidence that appropriate learning had taken place where necessary and that the findings were disseminated to relevant staff. For example, a recent incident involving double dispensing to one patient of a drug which needs to be closely monitored by specialists had led to a review and adjustment of processes to reduce the risk of recurrence.

All clinical and non-clinical staff we spoke with were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so. Staff used incident forms on the practice intranet and sent completed forms to the management. We tracked 29 incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, out of date eye drops were found in a treatment room, following this the practice removed the out of date eye drops, thoroughly checked all other stock for expiry dates and ensured the stock check list included every item required; leading to an improvement in the stock checking process.

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. The practice had taken the approach to treat all complaints as significant events (SE), thus ensuring information sharing with staff around complaints. National patient safety alerts were disseminated electronically to practice staff and discussed in person. 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 meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. A register was in place evidencing which alerts had been disseminated.

Reliable safety systems and processes including safeguarding

Systems were in place to safeguard children and adults. A designated GP partner was the practice lead for safeguarding children and vulnerable adults. Safeguarding policies and procedures were consistent with local authority guidelines and included local authority reporting processes and contact details.

The GP partners had undertaken training appropriate to their role. All staff had received training in the safeguarding of children and vulnerable adults at a level appropriate to their roles. Staff we spoke with demonstrated a good understanding of safeguarding children and vulnerable adults and the potential signs to indicate a person may be at risk. Staff described the open culture within the practice whereby they were encouraged and supported to share information within the team and to report their concerns. Information on safeguarding and domestic abuse was displayed in the patient waiting room and other information areas.

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. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

A chaperone policy was in place and information was clearly displayed in the waiting room, at reception and in consulting and treatment 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). Chaperone training had been undertaken by nursing staff and health care assistants who acted as chaperones when nursing staff were unavailable. Non-clinical staff did not act as chaperones.

Medicines management

The practice had a registered pharmacy attached providing dispensing services to patients. We spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels. The pharmacist told us that members of staff involved in the dispensing process were appropriately qualified and their competence was checked regularly. We found records to support this.

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We saw that procedures were updated regularly to maintain standards. The dispensary provided a medicines delivery service to housebound patients.

There were arrangements in place to record and follow up medicine related incidents and drug safety alerts. These were discussed in monthly meeting and recorded as significant events.

Patients were offered a choice of methods for requesting repeat prescriptions. Staff identified in advance when patients were due for a review before the next prescription was issued, and contacted patients to remind them. We found that the storage of blank prescription forms in consulting rooms was not in line with national guidance. However there was a good record keeping system in place so we were assured that if prescriptions were lost or stolen they could be promptly identified and investigated.

The practice held a stock of medicines in a brief case for use by doctors on home visits. We found that this stock was regularly checked to ensure it was in date and suitable for use.

The practice had arrangements for the storage of vaccines. While these were stored in appropriately locked refrigerators, these were within a patient accessible area and we found the keys were in the lock. This meant that they could be accessible to unauthorised persons. We found that the temperatures of the refrigerators used to store vaccines were monitored and recorded regularly to ensure their quality was maintained.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. 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 had undertaken further training to enable them to provide advice on the practice infection control policy. They demonstrated a good understanding of their role. Infection control policies and procedures were in place. The majority of staff had received training in infection control processes in November 2014 and all staff were aware of infection control practices. The practice manager informed us that staff not yet received up to date training would receive this in the (near) future but would have received this training previously in their role specific education.

Auditing of infection control processes was carried out regularly and appropriate action plans had been instigated upon the findings. For example, we saw audits had been completed in November 2014 on sharps handling, in February 2015 on waste management and in January and February 2015 on cleanliness of practice areas.

Minutes of practice meetings showed that infection prevention and control was discussed. 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. Personal protective equipment (PPE) 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. For example, we encountered a member of staff using PPE and cleaning materials for dealing with a leg ulcer incident, the member of staff was able to explain actions and reasoning behind the use of the PPE appropriately.

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. Spillage kits were available in clinical rooms and in the reception area.

We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor operations they performed. The practice had a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings). There were records that confirmed the practice's quality manager had performed monthly and annual checks with support and advice available form an external company. Checks were documented and being undertaken to reduce the risk of infection to staff and patients.

A survey was performed in March 2013 which found there was asbestos in the boiler room, but this was safe providing it was not disturbed. No other concerns regarding asbestos were raised. We saw that the practice had arrangements and notices in place for the segregation of clinical waste at the point of generation. Sharps containers were available in all consulting rooms and treatment rooms, for the safe disposal of sharp items, such as used needles.

During the inspection we found records of staff immunisation against Hepatitis B. We found that this was monitored to ensure staff were protected.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance 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; the practices' quality manager was qualified to perform these checks and this was last done in February 2015.

We saw evidence of calibration of relevant equipment was not due until May 2015. Additional medical testing equipment for patients, for example blood pressure machines, was made available for patients through the Hunter Rowe Trust, of which the GP partners were trustees.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We were not shown evidence of current DBS checks for non-clinical staff; this is not a requirement unless staff are left alone with patients, which we were informed they were not. There was, however, no risk assessment in place for this. We were also informed that renewal of all staff DBS checks was currently on-going.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. There was an arrangement in place for members of nursing and administrative staff to cover each other's roles. Staff we spoke with confirmed that this happened and these arrangements worked well. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring safety and responding to risk

The practice had considered the risks of delivering services to patients and staff and had implemented systems to reduce risks. We reviewed the comprehensive range of risk assessments in place. These included assessment of risks associated with moving and handling, fire safety, medical emergencies, health and safety of the environment and control of Legionella bacteria. All risk assessments had been recently reviewed and updated. We spoke with both

Good

Are services safe?

clinical and non-clinical staff about managing risks and found that they had the skills to safeguard patient safety. We observed that the practice environment was organised and tidy. Safety equipment such as fire extinguishers and defibrillators were checked and sited appropriately.

Health and safety information was displayed for staff to see and CCTV was active within communal areas of the premises. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. The practice employed a dedicated long term conditions nurse who was able to deal with, or refer, patients whose health deteriorated suddenly.

Staff gave examples of how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment. Whilst we were on the premises an emergency occurred and we witnessed that the practice undertook thorough steps to ensure efficient patient safety and care until the point of handover to the ambulance service. Some of the clinical staff in the practice provided their personal phone numbers to patients in special circumstances to improve access, for example palliative care patients or patients requiring support with first time prescribed insulin.

Staff described an example of the GPs commitment to supporting and responding to patient needs. One GP had to pull over whilst driving to assist patients acting strangely in public. This was confirmed by the PPG and showed us that the GPs have the best interest for patients in mind at all times.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including defibrillators and oxygen were available for use in the event of a medical emergency. The equipment was checked daily to ensure it was in working condition. All staff had received training in basic life support and defibrillator training to enable them to respond appropriately in an emergency. Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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 loss of access to the clinical computer system, loss of telephone system, loss of utilities, adverse weather, incapacity of staff and response to a major incident. 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 and records showed that all staff were up to date with fire training. Four members of staff on duty during our inspection were active fire marshals, each responsible for their own zone in the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice ensured they kept up to date with new guidance, legislation and regulations. The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance, accessing guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of monthly educational meetings where new guidelines were discussed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given 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 lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. The nurse manager was a specialist for chronic obstructive pulmonary disease (COPD – severe shortness of breath caused by chronic bronchitis, emphysema, or both). The practice employed a prescribing advanced nurse practitioner and a prescribing specialist long term conditions nurse who specialised in the on-going care and support for patients with long term conditions, with support from the GPs, 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. Our review of the clinical and educational meeting minutes confirmed that this happened.

We were told that all patients received appropriate treatment and regular review of their condition. The practice used computerised tools to identify and review registers of patients with complex needs. For example, patients with learning disabilities or those with long term conditions. The practice supported patients to manage a range of long term conditions in line with best evidence based practice. For example, we saw the practice had previously pre-empted changes to NICE guidance relating to the correct referral processes of cancer patients. The practice had retrospectively identified affected patients and whether the referrals were in line with NICE guidelines. Good practice and the meeting of the national standard of cancer referrals was confirmed following this audit, which led to certain cases being discussed at significant events meetings. This would be revisited when new NICE guidelines were issued.

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

Management, monitoring and improving outcomes for people

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 practice achieved 85.7% of the maximum Quality and Outcomes Framework (QOF) results 2013/14 in the clinical domain. The QOF is part of the General Medical Services (GMS) contract for general practices. It is a voluntary incentive scheme which rewards practices for how well they care for patients. The practice used QOF to assess its performance. QOF data showed the practice performed just below average in comparison to the national and local figures.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included retrospective audit of cancer diagnosis, assessing cardiovascular risk in patients with gout, on-going metformin and B12 deficiency, injectable treatment for diabetic control for those patients unable to control it with tablets (GLP1 Mimetic) and waiting times. We saw the results of audits had been shared with the clinical GP and nursing team within regular clinical meetings.

Staff spoke of a culture of quality improvement and continuous learning within the practice. The practice routinely collected information about patient care and treatment outcomes. The practice used a rota system of reviewing these in the case of a GP's absence. The office manager within the practice managed this process with the duty GP reviewing the blood results on the day of receipt.

Good

Are services effective?

(for example, treatment is effective)

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 mandatory training such as annual basic life support. We noted a good skill mix among the management team, with two members having additional qualifications in data processing/management and business management.

All GPs were up to date with their yearly continuing professional development requirements and all, either had 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).

Most staff undertook annual appraisals that identified learning needs from which action plans were documented. For those staff whose appraisals were due, plans were in place to complete these. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example practice nursing advanced training courses.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

The practice nurses had been provided with appropriate and relevant training to fulfil their roles. For example, the practice had appointed a specialist long term conditions nurse and a lead nurse for respiratory conditions. Both had undertaken advanced training.

Reception and administrative staff had undergone training relevant to their role. For example, records evidenced they had received training in customer care excellence and information governance. Staff described feeling well supported to develop further within their roles.

Three members of staff, clinical and administrative, had been developed and promoted internally to lead role positions. For example, a former receptionist was now working as quality manager, a practice nurse was promoted to nurse manager and a former member of the administration team was promoted to assistant practice manager.

Working with colleagues and other services

We found the practice worked with other service providers to meet patient needs and manage complex cases. The practice effectively identified patients who needed on-going support and helped them plan their care. For example, the practice demonstrated they had developed effective working relationships with a local residential care home. One of the GPs visited this home on a weekly basis, and more frequently if required; all the residents had care plans in place. Anticipatory care planning for those patients reflected the patients' wishes relating to hospital admission avoidance and palliative care.

Blood results, hospital discharge summaries, accident and emergency reports and reports from out of hours services were seen and acted upon by a GP on the day they were received. In the absence of a patient's named GP, the duty GP within the practice was responsible for ensuring the timely processing of these reports. We were told the practice's office manager followed these up to ensure completion.

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

The practice participated in all the enhanced service from the clinical commissioning group (CCG), Public Health and NHS England (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patient care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Care plans were shared with patients to ensure their full involvement in decision making and to facilitate sharing of information with other services, such as out of hours

Good

Are services effective?

(for example, treatment is effective)

services. The practice used information received to ensure patient care was being planned effectively. For example, the practice received hospital data on admissions and A&E attendances daily. This information was disseminated to the patient's named or duty GP by an administrator within the practice. Patients were contacted by their named GP or the specialist long term conditions nurse within three days following discharge from hospital to explore future admission avoidance.

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. 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

Patients we spoke with told us that the GPs and nurses always obtained consent before any examination took place. 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. The practice had drawn up a consent policy to help staff with highlighting how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they and / or their carers were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

A local home for people with learning disabilities had recently closed and four patients from this home were moved to a local residence, all four patients had an annual health check done. 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 we spoke with 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, Expressed consent (written or verbal) would be obtained for any procedure which carries a risk that the patient would likely consider as being substantial. A note would be made in the medical record detailing the discussion about the consent and the risks. The practice consent policy gave clear guidelines to staff in obtaining consent prior to treatment. The policy also gave guidance about withdrawal of consent by a patient. A form was available to record consent where appropriate. The GPs we spoke with told us they always sought consent from patients before proceeding with treatment. GPs told us they would give patients information on specific conditions to assist them in understanding their treatment and condition before consenting to treatment.

Health promotion and prevention

GPs we spoke with told us that regular health checks were offered to those patients with long term conditions, learning difficulties and those experiencing mental health concerns. We saw that medical reviews for those patients took place at appropriately timed intervals. 2013/14 data showed that 87% of people with severe mental health problems registered at the practice had a comprehensive care plan in place. This was above average for the CCG as well as nationally.

There was a variety of information available for health promotion and prevention throughout the practice, in the waiting area and on the practice website. Seasonal flu vaccinations were available to at risk patients such as patients aged 65 or over, patients with a serious medical condition or those living in a care home. The nurses we spoke with us told us there were a number of services available for health promotion and prevention. These included child immunisation, family planning, diabetes, chronic obstructive pulmonary disease (COPD), asthma, spirometry, cervical screening, smoking cessation support and travel vaccination appointments.

It was practice policy to offer a health check with a 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 smoking cessation advice to smokers. The practice also offered NHS Health Checks to all

Good

Are services effective?

(for example, treatment is effective)

its patients aged 40 to 75 years, these were performed by the nursing team. The practice manager informed us that a total of 181 out of 3422 patients in this age group, to date and since April 2014, took up the offer of the health check. A GP showed us how patients were followed up if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice's performance for cervical smear uptake in 2013/2014 was 78%, which was slightly better than others in the CCG area. There was a policy to send letters with reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. After three non-attendances the patient would be taken off the list, but could come back on again after their first test.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice offered a named GP to all patients aged over 75 and accommodated external health services, free of rent charge, so that patients did not have to travel to larger care facilities away from their area. For example, midwives, dermatology, audiology, dietician and physiotherapy services. The specialist long term conditions nurse worked closely with secondary care for diabetic patients and was supported in this by the local clinical commissioning group. The specialist long term conditions nurse also offered home visits for all long term condition patients that were unable to attend the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP patient open survey last updated in January 2015, and a survey of 78 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated higher than the CCG average for patients who would recommend this surgery to someone new to the area. The practice was also well above CCG average (73% versus 62%) for its satisfaction scores on respondents with a preferred GP who usually get to see or speak to that GP, with 96% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment card, despite being positive mentioned occasional queues at the dispensary as a slight negative, but there was no common theme to this. We spoke with five patients on the day of our inspection including three representatives of the patient participation group (PPG). All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

GPs and staff had received training on information governance and signed a confidentiality agreement at the start of their employment. Staff had a good understanding of confidentiality and how it applied to their working practice. For example, reception staff spoke discretely to avoid being overheard and a sign on the reception desk politely requested that patients waiting to speak with a receptionist stood away from the desk to allow the patient before them some privacy. Staff respected patients and preserved their dignity and privacy. Privacy curtains were in place in every consultation room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a separate room which helped keep patient information private.

In response to patient suggestions, name tags were introduced for all staff. 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. The practice manager told us he would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The GP 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 93% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Patient feedback on the comment cards we received was also positive and aligned with these views. Staff told us that translation services were available for patients who did not have English as a first language. There was a hearing loop available for patients with hearing aids and the practice's website informed patients that they could make use of a sign language interpreter if so required.

Patient/carer support to cope emotionally with care and treatment

The practice had a system for ensuring that all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. The GPs told us they would visit bereaved families and often provided their personal mobile

Good

Are services caring?

numbers to patients in end of life circumstances so that they could be contacted out of hours if so required to provide care and support to the patients and their families. This 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.

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. The practice offered annual health checks to carer and worked closely with the Norfolk Carers Service.

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.

Care and support was offered on site at a local learning disability residence and local care home for the elderly to ensure that the needs of these patients were identified and met. Joint working arrangements were in place with the Norfolk Carers Service to support carers. The practice had told patients experiencing poor mental health about how to access various support groups and were involved in a CCG led scheme to devote extra funding to Admiral Nurses through Norfolk and Suffolk NHS Foundation Trust (NSFT) for the enhanced care for dementia patients. Staff had received training on how to care for people with mental health needs and dementia.

There was a clinical lead for different areas of care, reflecting the Quality and Outcomes Framework (QOF). The Quality Outcomes Framework (QOF) provides a set of indicators against which practice are measured and rewarded for the provision of quality care.

The patient participation group (PPG) is proactive and had challenged and supported the practice to improve. As a result, nametags for staff were introduced and a more personal approach to answering the telephone by the call takers was implemented. This improved patients' experiences in reception and booking appointments. The PPG had organised health promotion events to support and educate patients around conditions and to promote a healthier lifestyle. PPG members attend monthly meetings with the practice manager and at least one GP.

One of the practice's GPs was a member of the clinical commissioning group (CCG) governing body and was prescribing and education lead for the CCG. This promoted the practice to regularly engage with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. One of the changes that had recently happened was the ceasing of employing district nurses by the practice; this was commissioned for the practice by the CCG at the time of our inspection. This meant the practice had to implement, at short notice, cover for some of the gaps left by this change. For example, the introduction of INR clinics, providing checks and reviews for those patients that are on Warfarin.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, including patients from several local fixed traveller sites. The practice told us that over the years they had built up trust and improved health issues by inclusion of vaccination and healthy lifestyle promotion.

The practice held weekly multi-disciplinary meetings, which included a health visitor on a monthly basis, that partly focussed on dealing with patients whose circumstances make them vulnerable, including vulnerable children.

The practice had access to translation services and a sign language interpreter if required. An induction loop was provided at the practice for patients who were hard of hearing or deaf. The premises and services were accessible for patients with disabilities. One of the entrance doors was not electronically operated but the receptionist told us that the member of staff working on the front desk would always provide assistance opening the door if required. 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. Accessible toilet facilities were available for all patients attending the practice.

We were not provided with evidence that equality and diversity training had been provided to staff but all staff we spoke with were able to explain the core principles. The practice provided a wheel chair loan service to help patients manage interim periods whilst they are sourcing or repairing their own.

Access to the service

Appointments were available from 09:00 am to 17:30 pm on weekdays. Extended hours appointments were offered on Mondays, either in the morning from 07:00 am to 08:30 am, or in the evening from 18:30 pm to 20:00 pm (dependent on GP availability) and Saturday mornings from 08:00 am to 11:00 am. All GPs offered 10 minute appointments. The trainee GPs offered 20 minute appointments. Longer appointments were available to those patients who needed them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice offered home visits which were shared by the GPs. A fixed on call rota was in place to ensure a duty GP was available daily. Urgent appointments were available on the day. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. Appointments with a named GP or nurse were available, a specialist long term conditions nurse allowed for better access for those suffering with a long term condition.

Home visits were made to a local care home on a specific day each week, by a named GP and to those patients who needed one. Patients were generally satisfied with the appointments system. 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 Saturday and Monday morning or evening was particularly useful to patients with work commitments. This was confirmed by the PPG. The practice offered on site phlebotomy (blood taking for testing) so that patients who needed this did not need to travel elsewhere to get this done.

The practice offered free space to external services so that patients requiring these did not need to travel elsewhere. For example, midwives, dermatology, audiology, dietician and physiotherapy services.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice treated all its complaints as significant events (SE) and as such were all discussed during SE meetings with an evidence trail of actions taken. As a result lessons learned from individual complaints had been recognised and acted on. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England; it was available on the intranet for all staff to access at any point.

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. This was displayed in the practice, in the practice leaflet and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at six complaints received in the last 12 months and found these were dealt with in an open and transparent manner, providing explanations or apologies when 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

The practice staff shared the guiding principle for the practice which included provision of a safe, high quality service; facilitation and engagement with other health services; positive clinical commission group (CCG) engagement; a teamwork approach; acting in the best interest of the patient; fostering a culture of learning and development and to maintain a relaxed, trusting efficient and professional practice culture. This philosophy was not yet shared in the business plan but the practice manager explained that this was currently in an editorial stage. Staff we spoke with all knew and understood the aforementioned principles and knew what their responsibilities were in relation to these.

As the business plan was still in editorial stage we saw no evidence of consideration for future risks recorded in any risk register, for example new local housing that could potentially increase practice demand.

Governance arrangements

The practice had a number of protocols, 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 nine of these protocols, policies and procedures and all nine had been reviewed annually 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 one of the GPs was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing slightly below national standards in some areas. Staff told us that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes but we were only shown one set of meeting minutes that could evidence this.

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, a retrospective audit of cancer diagnosis and referrals, assessing cardiovascular risk in gout, metformin and B12 deficiency and a waiting time audit. The practice had arrangements for identifying, recording and managing risks.

The quality manager showed us risk assessments had been carried out where risks were identified and action plans had been produced and implemented. The risks were not accumulated on a risk log. We saw that the risk assessments were performed regularly and updated in a timely way. Amongst others these included: disability risk assessment, security risk assessment (in cooperation with the police), window blind cord risk assessment, asbestos risk assessment and regular COSHH assessments (Control Of Substances Hazardous to Health).

The practice held monthly governance meetings. We looked at minutes from one of last year's meetings and found that quality and risks had been discussed. The practice we unable to provide us with minutes from recent governance meetings. The practice also held monthly significant events (SE) meetings, available for all staff to attend, in which the SEs were discussed and actions were highlighted and reviewed.

Leadership, openness and transparency

We saw from minutes that team multi-disciplinary team (MDT) meetings were held weekly. 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 team educational meetings were held every month.

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

It was clear from our interviews with the management team, the GPs and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. This was reflected in the GP newsletter that was posted on the practice web-site. Staff members we spoke with told us they felt their contribution to providing

Are services well-led?

Good

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

good quality care was valued. They told us that they welcomed the opportunity to raise issues with the GPs and the management team. This was also reflected in the arrangements for training staff.

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

The practice had an active patient participation group (PPG) which had steadily increased in size to fourteen regular members ("ideally two representing each nearby village"). The PPG included representatives from various population groups: working age people, older people, people with long term conditions, but struggled to attract younger families. The PPG was predominantly female (12 out of 14) and met every month. The PPG had produced a patient participation report from 2013/2014 and 2014/2015. The 2013/2014 report included a patient satisfaction survey, the results showed, amongst others, that 75% of patients rated the practice as "good" or above for the level of satisfaction with the appointment system and 94 % of patients rated the practice as "good" or above for the level of overall satisfaction with this practice. The results and actions agreed from these surveys are available on the practice website. We saw as a result of PPG feedback the practice had introduced nametags for staff and a more personal approach to answering the telephone by the call takers was implemented. We reviewed a report on comments from patients from the 2013/2014 survey, which had a common theme of satisfaction with the service provided but difficulties in obtaining appointments with a GP of choice and occasional long waiting times.

Acknowledgements were made about access to urgent appointments. The practice was in the process of a implementing a new appraisal process, we saw evidence of this but not all staff had yet received timely appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had been provided with specific training around practice nurse management and this had happened. 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 in the staff handbook and electronically on any computer 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. Staff told us that the practice was very supportive of training and that they had monthly training meetings. The practice was a GP training practice for GP registrars, training to become GPs. Two of the partners were GP trainers and one of the salaried GPs was an associate trainer.

The practice had completed reviews of significant events (SE) and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, we saw minutes of a SE meeting from December 2014 which detailed summaries and current status of actions on SE's. This was attended by members of the GP team, the nursing team and the management team.

The practice was effective in ensuring its staff performed well and developed within a learning culture. The emphasis in this process was on development, promoting opportunities to learn and improve and on maintaining good clinical practice. This was mirrored in the practice's approach to recently internally promote three members of staff to more senior positions.