

# Bridge Street Surgery

## 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 carried out an announced comprehensive inspection at Bridge Street Surgery on 3 November 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 in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience 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 one area of outstanding practice:

- The practice had organised annual health road shows for two consecutive years. These were held in the local Town Hall providing easy access. Multiple charities were invited to provide stalls offering information and

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advice to patients and clinicians alike. The PPG attended these running a refreshment stall with the aim to raise funds for patient improvement at the practice. In 2016 the practice held a small flu clinic during the road show to further encourage flu vaccine uptake. This was supported by the attendance of nursing and reception staff.

The areas where the provider should make improvement are:

- Ensure patients waiting for their appointments in all areas of the practice can be clearly seen by reception staff to ensure patients whose health might deteriorate can be seen by staff.

- Ensure the process for security of dispensary keys is reviewed and monitored.
- Improve the recording of references for new members of staff and ensure that staff are risk assessed prior to undertaking chaperone duties.
- Continue to develop methods used to proactively identify carers.
- Ensure that the learning from complaints and significant events is shared and disseminated with the appropriate staff within the practice.

**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?

The practice is rated as good for providing safe services.

- There was an effective system in place 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 prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse. The practice proactively monitored for children that were not brought to their appointment and followed up on these for potential safeguarding reasons. The practice had also undertaken a two cycle audit on the details recorded of who accompanied a child at consultation.
- Risks to patients were assessed and well managed.

Good



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally higher than the clinical commissioning group (CCG) and national averages.
- 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.

Good



### Are services caring?

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in July 2016 showed patients rated the practice generally higher than others for aspects of care. For example, 95% of patients said the GP was good at listening to them compared to the clinical

Good



# Summary of findings

commissioning group (CCG) average of 91% and the national average of 89%, 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%, 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 91% and 96% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

- Feedback from patients about their care was consistently positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 71 patients as carers (1% of the practice list).

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local 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.
- Data from the national GP patient survey publishes July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages. For example; 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and the national average of 76%, 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 80% and the national average of 73%.
- 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.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good 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.
- 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.
- The provider was aware of and complied with the requirements of the duty of candour. The GPs and practice manager encouraged a culture of openness and honesty.
- The practice proactively sought feedback from staff and patients, which it acted on. There was a strong focus on continuous learning and improvement at all levels. The practice was a teaching and research ready practice.

Good



# 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

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 worked closely with the multi-disciplinary team, out-of-hours and the nursing team to ensure proactive palliative care planning.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis and heart failure were above local and national averages.
- The practice looked after patients living in local nursing homes. GPs undertook regular visits and visited patients as and when required.
- The practice had administered flu vaccinations to 20% of patients aged over 65 years old during the 2015 to 2016 flu vaccination clinics.

Good



### People with long term conditions

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.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that the performance for diabetes related indicators was better than the local and national averages with the practice achieving 99%; this was one percentage point above the local average and three percentage points above national averages. The rate of exception reporting was above the local and national averages, with the practice percentage of 15% across all indicators; this was four percentage points above local averages and five percentage points above national averages.

Good



# Summary of findings

- Longer appointments and home visits were available when needed.
- 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.
- The practice had administered flu vaccinations to 4.3% of patients on the practice at risk register during the 2015 to 2016 flu vaccination clinics.

## Families, children and young people

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Childhood immunisation rates for the vaccinations given were high when compared to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69% to 99% which was above the CCG average of 64% to 96% and five year olds from 75% to 99% which is above the local average of 69% to 95%.
- 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 practice's uptake for the cervical screening programme was 78%, which was above the CCG average of 84% and the national average of 82%. There was a policy to offer written and telephone reminders for patients who did not attend for their cervical screening test.
- 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.

Good



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

The practice is rated as good for the care of working-age people (including those recently retired and students).

Good





# Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The bowel cancer screening rate for the past 30 months was 62% of the target population, which was above the CCG average of 60% and above the national average of 58%. The breast cancer screening rate for the past 36 months was 81% of the target population, which was also above the CCG average of 71% and the national average of 72%.
- 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. The practice reported an uptake for NHS health checks for the year 2015/2016 had been 153 completed health checks. Of the 1,458 patients on the practice over 75 years register 1,398 had received an annual health check in the previous 12 months. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

## People whose circumstances may make them vulnerable

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 homeless people, travellers and those with a learning disability. The practice had identified 42 patients with a learning disability on the practice register. Twenty-seven of these patients had received a health check, 13 had been seen for other reviews with invitations sent to the remaining two patients.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Good



# Summary of findings

- 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)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally higher than the clinical commissioning group (CCG) and national averages.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2015 to 31/03/2016) was 92%; this was above the CCG and the national average of 84%. The practice referred patients to various support services as required with a 15% exception reporting rate which was one percentage points above the CCG average and three percentage point above the national average.
- The percentage of patients experiencing poor mental health who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 82% this was below the CCG average of 91% and above the national average of 88%. Of the 30 patients identified as experiencing poor mental health on the practice register, 27 has received a health check in the past twelve months with appointments scheduled for the remaining patients.
- 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.
- The practice had a system in place to follow up patients who had attended accident and emergency 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.

Good



# Summary of findings

## What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice was performing generally above local and national averages. 219 survey forms were distributed and 129 were returned. This represented a 59% response rate.

- 74% of patients found it easy to get through to this practice by phone compared to the CCG average of 80% and the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 90% of patients described the overall experience of this GP practice as good compared to the CCG average of 88% and the national average of 85%.

- 84% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards which were very positive about the standard of care received. Patients felt that practice staff treated them very well and were friendly, kind and caring. Patients commented that they were treated with dignity and respect.

We spoke with five patients during the inspection and five patients who were members of the patient participation group (PPG). All ten patients said they were very satisfied with the care they received and thought staff were approachable, professional, committed and caring.

## Areas for improvement

### Action the service SHOULD take to improve

- Ensure patients waiting for their appointments in all areas of the practice can be clearly seen by reception staff to ensure patients whose health might deteriorate can be seen by staff.
- Ensure the process for security of dispensary keys is reviewed and monitored.
- Improve the recording of references for new members of staff and ensure that staff are risk assessed prior to undertaking chaperone duties.
- Continue to develop methods used to proactively identify carers.
- Ensure that the learning from complaints and significant events is shared and disseminated with the appropriate staff within the practice.

## Outstanding practice

- The practice had organised annual health road shows for two consecutive years. These were held in the local Town Hall providing easy access. Multiple charities were invited to provide stalls offering information and advice to patients and clinicians alike. The PPG attended these running a refreshment stall with the aim to raise funds for patient improvement at the practice. In 2016 the practice held a small flu clinic during the road show to further encourage flu vaccine uptake. This was supported by the attendance of nursing and reception staff.

# Bridge Street Surgery

## 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 and a second CQC inspector.

## Background to Bridge Street Surgery

Bridge Street Surgery is located in Downham Market, Norfolk. The practice is run by six GP partners (four male and two female). The practice employs one female salaried GP, two female practice nurses, three female treatment room nurses and two female health care assistants. The clinical team is supported by a practice manager, a dispensary manager, a team of administrative, secretarial and reception, cleaning and dispensing staff. The practice is a dispensing practice and dispenses to approximately 42% of its patient population.

According to Public Health England information, the practice age profile has higher percentages of patients over 60 years compared to the practice average across England. It has lower percentages of patients aged 0 to 50 years. There are a high proportion of patients with chronic diseases on the practice register.

The practice is open between 8.15am and 6pm Monday to Friday. Telephone lines are open from 8am to 6pm. Extended hours appointments are offered with GPs from 7.30 to 8am Monday and 6pm to 7.45pm Wednesdays. In addition to pre-bookable appointments that can be booked up to seven weeks in advance, urgent appointments are also available for people that need them.

The building provides good access with accessible toilets and car parking facilities are available a short walk from the practice. The practice provides treatment and consultation rooms on the ground floor with lift access to the nurses' treatment rooms on the first floor.

The practice holds a General Medical Service (GMS) contract to provide GP services to approximately 8,667 registered patients, which is commissioned by NHS England. A GMS contract is a nationally negotiated contract to provide care to patients. In addition, the practice also offers a range of enhanced services commissioned by their local CCG: facilitating timely diagnosis and support for people with dementia and extended hours access.

Out-of-hours care is provided by Integrated Care 24 (IC24) through the NHS 111 service.

## 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 3 November 2016. During our visit we:

# Detailed findings

- Spoke with a range of staff including two GPs and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

We also looked at how well services 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.

# Are services safe?

## Our findings

### Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. 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 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 to identify trends and make changes when necessary.
- Practice staff were encouraged to reflect upon their involvement within a significant event, and we saw evidence of this within staff personal development plans and appraisals. This embedded learning from significant events. For example as a result of a significant event analysis the practice had amended the policy on blood pressure readings and where appropriate undertook ankle blood pressure readings.
- Significant events were discussed at clinical and whole team meetings.

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.

### Overview of safety systems and processes

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

- Arrangements were in place 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 nurses were trained to level two child protection or child safeguarding.

- A notice in the waiting room advised patients that chaperones were available if required. All clinical 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). However we found that there were no recorded risk assessments in place for two non-clinical staff who occasionally undertook chaperoning duties. The practice immediately undertook a risk assessment and following our inspection confirmed that DBS checks for these staff had been undertaken. The practice continued to ensure that staff were risk assessed prior to undertaking chaperone duties.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice health care assistant was the infection control lead and was supported by the practice nurses as clinical leads, who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place 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 identified as a result.
- We reviewed six personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service for clinical staff. However we found that only one reference had been obtained for new staff. We discussed this with the practice who confirmed they would be requesting two references in future.

# Are services safe?

## Medicines management

The dispensary was open from 8.15am until 6.00pm Monday to Friday. Prescriptions could be requested on-line, by fax, internet, post or in person. The practice had signed up to the Dispensing Services Quality Scheme (DQRS) which rewards practices for providing high quality services to patients in their dispensary. As part of this scheme the practice had to ensure that face to face reviews of 10% of patients were carried out to assess compliance and understanding of the medicines being prescribed, known as DRUMS (Dispensing Review of the use of Medicines).

The dispensary had air conditioning and there was a room temperature gauge which was checked daily. There was a temperature gauge on the refrigerator with a second temperature probe inside. The refrigerators were checked and stocks were in date with enough space around the medicines for air to circulate. All medicines were stored securely and in a clean and tidy manner and were within their expiry date. Annual stock checks were carried out of all drugs. Electronic scanning equipment was used which automatically re-ordered stocks that were getting low. The dispensing staff ensured that all prescriptions were signed by a GP prior to medication being dispensed.

There was an effective process in place for the dispensing of Methotrexate, (a drug used to treat certain types of cancer, severe psoriasis and rheumatoid arthritis) and Warfarin (an anticoagulant normally used in the prevention of thrombosis). All prescriptions for these medications were given to the GPs prior to dispensing, in order to check that the appropriate blood tests had been carried out.

Prescriptions that had not been collected by a patient were kept for two months. A code was then entered on the computer system indicating non-collection of medication, and a task sent to the GP advising that a patient had not collected medicines. The dispensary staff were able to evidence their Standard Operating Procedures (SOPs) which were dated and signed by the dispensary team (these are practice specific written instructions about how to dispense medicines safely). The practice also had a dispensary manual which included information on how to order medicines and protocols for replenishing stock. Members of staff who were involved in the dispensing process had achieved the appropriate national vocational qualification (NVQ) and Business and Technology Education Council (B.Tech) diplomas.

There was a named GP responsible for the dispensary, and informal meetings took place with the dispensary manager as and when required. Discussions included dispensing procedures, policies, concerns or incidents. Near misses were recorded as significant events, and records were evidenced of discussions that had taken place, lessons learnt and actions taken.

The dispensary held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and there were procedures in place to manage them safely. There was also a procedure for the destruction of controlled drugs and the relevant paperwork was completed, signed and witnessed as required. Controlled drugs were kept in a locked cabinet and regular monthly stock checks were made by two members of the dispensary team. However there was scope to improve or risk assess the storage of the key. Medicines required by the practice for use on their emergency trolley were obtained from the dispensary. Records were kept of what was being used or how often stocks were replenished.

All Medicines and Health Care Products Regulatory Agency alerts were received by the dispensary manager. (This is a government agency which approves and licenses medicines, allowing them to be prescribed in the UK. The principal aim of the agency is to safeguard the public's health). The MHRA alert was then actioned, signed, and dated by the dispensary manager and filed for future reference. There was a system in place for the practice manager to receive the alert, should the dispensary manager not be available in order to ensure that patient safety was not at risk.

Unwanted and expired medications were disposed of in line with waste regulations and confidential waste was appropriately handled.

Boxed computerised prescriptions were stored in the dispensary and a record of prescription numbers and where the prescriptions were being used was recorded.

A private area would be made available if patients wished to discuss any areas of concern or queries.

There was good communication between the dispensary and the GPs, and change to medication was always checked with a GP before dispensing.

Regular and varied medication meetings took place throughout the year, including clinical prescribing

## Are services safe?

meetings, medicine champion meetings and dispensary meetings. Topics for discussion included: signing prescriptions, DRUMS, prescribing issues: risk management: NICE guidelines (National Institute for Clinical Excellence which produce clinical guidelines and recommendation about the treatment and care of patients with specific diseases and conditions in the NHS in England and Wales), and cost effective prescribing. Quarterly prescribing and medicines management meetings also took place.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. 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 in place to monitor safety of the premises such as control of substances hazardous to health and infection control. The practice had a variety of other risk assessments in place 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).
- We noted there were waiting room areas in the practice that were not easily visible to staff. We saw that a patient

whose health may deteriorate while in these waiting room areas would not be visible to busy staff. We discussed this with the practice GPs and practice manager who agreed they would be reviewing patient safety in this area.

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty across the reception, administration and dispensary teams.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place 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 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.
- 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 a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



# 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.

GPs maintained personal lists to ensure continuity of care, there was an arrangement of job share amongst the GPs to ensure effective oversight of patient care.

The practice had systems in place 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.

### 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 most recent published results for 2015 to 2016 were 99% of the total number of points available with a 15% exception reporting rate which was four percentage points above the CCG average and five percentage point above the national average, (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).

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

- Performance for diabetes related indicators was better in comparison to the CCG and national average, with the practice achieving 99% across all indicators. This was six percentage points above the CCG average and nine percentage points above the national average. The rate of exception reporting was in line with local averages.
- Performance for mental health related indicators was also better in comparison to the CCG and the national averages. With the practice achieving 98% across each indicator, this was 0.3 percentage points above the CCG average and six percentage points above the national average. The rate of exception reporting was in line with local averages.

- Performance for asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disease, dementia, depression, epilepsy, heart failure, hypertension, learning disability, osteoporosis, palliative care, peripheral arterial disease, and stroke and transient ischaemic attack were all above or in-line with CCG and national averages with the practice achieving 100% across each indicator.

Due to the demographics of the practice population with over one third of patients over retirement age and high incidence of chronic diseases within the practice population the practice had in place cohesive and effective systems which ensured effective monitoring of patients. However where there were areas where exception reporting was above local and national averages, we saw systems ensured exception reporting was appropriate. The practice continued to promote and encourage patients to attend for health and medication reviews to ensure they were not overlooked.

The practice regularly monitored clinical data using a reflective review process and discussed and disseminated findings with clinical staff and relevant organisations.

High risk medications were monitored regularly by doing a search on the clinical computer system. The practice described and showed us how their recall system worked for various drug monitoring. There were recalls in place and the practice checked that patients had been in for their blood tests.

The practice participated in local audits, national benchmarking, accreditation, peer review and research. Clinical audits demonstrated quality improvement. Clinical audits had been completed in the last year; we looked at two cycle audits where the improvements made were implemented and monitored. For example, we looked at a two cycle audit of patients prescribed glucagon-like peptide (GLP-1) medicine used for patients with type two diabetes. Clinical data revealed that this treatment therapy improved diabetic control whilst reducing body weight and the patients systolic blood pressure. The practice undertook an audit in March 2014 to establish evidence of an appropriate medication review and an evaluation of therapeutic response had taken place for patients who were prescribed GLP-1, in addition where there was no clear therapeutic benefit, treatment should be stopped and an alternative considered. Following the first audit the practice established 75% of patients prescribed GLP-1 had

# Are services effective?

(for example, treatment is effective)

undergone such a review, this was below the practice target of 90%. The audit was repeated in September 2016 with the practice achieving 92% of appropriate reviews with an action plan for patients where action or alternatives were required.

The practice participated in non-clinical audits including data quality, patient feedback, and infection control, cervical screening uptake, cleaning standards, minor surgery outcomes and appointment schedules. The practice also took part in local audits, national benchmarking, accreditation, peer review and research.

## 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, for those reviewing patients with long-term conditions.
- 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 ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and 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.

The practice staff worked with other services to meet patients' needs and manage those patients with more complex needs. Such as the multidisciplinary teams (MDT), the community nursing teams and health visitors. The MDT meetings brought together the knowledge, skills and best practice from health and social care teams. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a three monthly basis with monthly interim meetings or sooner when required where care plans were routinely reviewed and updated for patients with complex needs.

There were a variety of formal and informal staff meetings undertaken by the practice to coordinate and share information. GPs met informally at daily coffee breaks which provided opportunities to discuss complex clinical cases or pressing administration issues. There were quarterly clinical governance meetings where attendance was mandatory for all staff with lunch provided by the practice. We were told this served as an open platform for all staff to raise issues and concerns. Where possible external health speakers attended for clinical updates.

## 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.

# Are services effective?

(for example, treatment is effective)

- 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.

## 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, drug and alcohol consumption, and smoking cessation. Patients were signposted to the relevant service. A dietician was available on the premises; the midwife attended weekly as did a continence advisor and smoking cessation advice was available from a local support group.

The practice's uptake for the cervical screening programme was 78%, which was below the CCG average of 84% and the national average of 82%. There was a policy to offer written and telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems in place 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.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The bowel cancer screening rate for the past 30 months was 62% of the target population, which was above the CCG average of 60% and above the national average of 58%. The breast cancer screening rate for the past 36 months was 81% of the target population, which was also above the CCG average of 71% and the national average of 72%.

The practice had identified 42 patients with a learning disability on the practice register. 27 of these patients had received a health check, 13 had been seen for other reviews with invitations sent to the remaining two patients. The percentage of patients experiencing poor mental health who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2015 to 31/03/2016) was 82%; this was below the CCG average of 91% and above the national average of 88%. The percentage of patients diagnosed with dementia whose care had been reviewed in a face-to-face review in the preceding 12 months (01/04/2015 to 31/03/2016) was 92%; this was above the CCG and the national average of 84%. The practice referred patients to various support services as required.

Childhood immunisation rates for the vaccinations given were high when compared to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 69% to 99% which was above the CCG average of 64% to 96% and five year olds from 75% to 99% which is above the local average of 69% to 95%.

The practice had administered flu vaccinations to 20% of patients aged over 65 years old and 4.3% of patients on the practice at risk register during the 2015 to 2016 flu vaccination clinics. 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. The practice reported an uptake for NHS health checks for the year 2015/2016 had been 153 completed health checks. Of the 1,458 patients on the practice over 75 years register 1,398 had received an annual health check in the previous 12 months. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

# 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 when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

We received 10 CQC comment cards which were all very positive about the standard of care received. Patients felt that practice staff treated them very well and were friendly, kind and caring. Patients commented that they were treated with dignity and respect.

We spoke with five patients during the inspection and five patients who were members of the patient participation group (PPG). All ten patients said they were very satisfied with the care they received and thought staff were approachable, professional, committed and caring.

Results from the national GP patient survey published in July 2016, showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 91%.

- 96% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

### 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 published July 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were also above local and national averages. For example:

- 93% of patients 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%.
- 89% of patients 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%.
- 95% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90% and the national average of 85%.

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

- Staff told us that translation services were available for patients who did not have English as a first language. However we were told there was little demand for this service at the practice.
- We saw information was available on the practice's website in other languages.
- Staff told us they had access to a number of information leaflets for patients at the practice in easy read format.

## Are services caring?

### **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 71 patients as carers (1% of the practice list). Written information was available to direct carers to the various avenues of support available to them.

The patient participation group (PPG) worked with the practice to provide health roadshows where support services and organisations provided information and awareness to patients, the public and staff. The practice charity of the month provided information from the

practice each month on a variety of topics including West Norfolk Carers, The Alzheimer's Society, West Norfolk Deaf Association and the local Wellbeing service. The practice supported a carers group which was held monthly from the practice. This was a drop in service where carers could access practical and financial advice and information.

Staff told us that if families had suffered bereavement, their usual GP contacted them and undertook a bereavement visit. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. The practice had made use of the Gold Standards Framework for end of life care. It had a palliative care register and had regular meetings to discuss the care and support needs of patients and their families with all services involved. The practice had recorded 16 patients on the palliative care register.

# 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.

- The practice offered late evening GP appointments at 7.30 to 8am Monday and 6pm to 7.45pm Wednesday for working patients who could not attend during normal opening hours.
- 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.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately. The practice was a registered Yellow Fever Centre.
- There were disabled facilities, a hearing loop and translation services available.
- A wide range of patient information leaflets were available in the waiting area including NHS health checks, services for carers, bereavement and promotion of mental health awareness. There were displays providing information on cancer and diabetes warning signs.
- The practice provided a range of nurse-led services such as management of asthma, weight management, diabetes and coronary heart disease, wound management, smoking cessation clinics and minor illness advice. Chronic disease appointments were available at a time that was convenient to patients.
- The practice offered in-house diagnostics to support patients with long-term conditions, such as blood pressure machines, electrocardiogram tests, spirometry checks, blood taking, health screening, minor injuries and minor surgery/joint injections.
- The practice supported the management of anti-coagulation monitoring, near patient testing, minor injuries, post-operative wound care and learning disability health checks.
- The practice ran a weekly international normalized ratio (INR) clinics, (a means of evaluating the coagulation rate of blood) with the aid of IT software. This was supported by the GPs. Patients care was taken over by the practice once they were discharged from the hospital anti-coagulation clinic. The practice had access to an on-site D-Dimer (D-Dimer tests are used to check for blood clotting problems) to avoid admission to hospital in suspected deep vein thrombosis patients.
- The practice offered minor surgery on site.
- The practice identified and visited the isolated, frail and housebound regularly. Chronic disease management was provided for vulnerable patients at home and the practice was active in developing care plans and admission avoidance strategies for frail and vulnerable patients.
- Telephone appointments were available for patients if required. The practice used a text message appointment reminder service for those patients who had given their mobile telephone numbers.
- The practice hosted other services from the surgery including a weekly midwifery service, a dietician, a twice monthly continence advisor clinic, the weekly wellbeing service to support patients who may be experiencing poor mental health and a carer support clinics. In addition there was a monthly hearing support clinic. This was a walk in service where patients could access practical advice, impaired hearing badges and reception staff were able to provide NHS hearing aid batteries upon request. One healthcare assistant was informed in the use of WANDA (an information technology system that improves the lives of individuals with chronic conditions), and had offered advice and support in setting up these clinics.
- The practice also facilitated the monthly services of the hospital based diabetic specialist nurse to review more complex diabetic patients.
- Services for children and young people included chlamydia testing kits for young people and access to the C Card scheme. This is a free condom scheme available to young people 24 years or younger who register, which provided free condoms from the practice or any other outlet which is part of the scheme.

# Are services responsive to people's needs?

## (for example, to feedback?)

- The practice was one of three practices in the town that provided general medical services to a four care/nursing homes in Downham Market. There were named GPs who undertook a ward round at the homes weekly and when required.
- The practice website provide links to on-line services such as; booking and cancelling appointments, prescription ordering, notifying changes to patients records, online access to records and electronic prescriptions.
- The practice also provided NHS Health Checks, sexual health advice, family planning and, smoking and drug misuse guidance.
- The practice offered a range of on-line services, which included; appointment bookings, prescription requests, Summary Care Records and on-line access to clinical records. The practice reported this was a popular service with almost 1000 patients accessing it. The practice social media page provided up to date practice and healthcare information for patients.
- The practice invited a variety of charity organizations on a monthly basis to attend for a coffee morning to meet with the GPs and to set up an information stall in the practice waiting room. This information was left for a month for patients to view. This included charities dealing with topics such as domestic violence, age concern and the Alzheimer's society.

### Access to the service

The practice was open between 8.15am and 6pm Monday to Friday. Telephone lines were open from 8am to 6pm. Extended hours appointments were offered with GPs from 7.30 to 8am Monday and 6pm to 7.45pm Wednesday. In addition to pre-bookable appointments that could be booked up to seven weeks in advance, urgent appointments are also available for people that need them. Double and fifteen minute appointments were available where required.

Results from the national GP patient survey published July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 76% of patients were satisfied with the practice's opening hours compared to the CCG average of 78% and the national average of 76%.

- 74% of patients said they could get through easily to the practice by phone compared to the CCG average of 80% and 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 in place to assess:

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

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice's website and in their information leaflet. Information about how to make a complaint was also displayed on the wall in the waiting area. Reception staff showed a good understanding of the complaints' procedure. We noted that verbal complaints had not been recorded and so the potential to achieve wider learning from these had been lost.

We looked at documentation relating to nine complaints received from January 2016 to August 2016 and found that they had been fully investigated and responded to in a timely and empathetic manner. We saw that as a result of one complaint the music playing in the reception area had been changed. However, we noted that not all complaints had been cascaded to all staff within the practice where appropriate or discussed at full team meetings to ensure learning outcomes, actions taken and improvements were reviewed by all staff.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement to provide a caring, friendly and efficient service and to be approachable and accessible; this was detailed in the statement of purpose with their aims and objectives. Staff we spoke with were aware and understood these values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The GP registered manager and practice manager were aware of the challenges for succession planning in the practice. The practice had clearly identified potential and actual changes to practice, and made consideration to how they would be managed.
- The practice had identified local challenges and responded to patient needs. For example by providing or hosting services from the practice to support patient's needs. For example the practice supported the management of patients prescribed warfarin, offering a finger prick blood test and computer analysis to determine a dosing regime and follow up requirements at the practice. In addition, the practice hosted a number of outreach service such as wellbeing service and continence advice to ensure patients did not have to travel.

### 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 in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.

- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

### Leadership and culture

On the day of inspection the GP registered manager 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 GPs and management were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of 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). This included support training for all staff on communicating with patients about notifiable safety incidents. The management team encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment;

- The practice gave affected people reasonable support 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 in place and staff felt supported by management.

- 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 management team in the practice. All staff were involved in discussions about how to run and develop the practice, and the management team 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.



# Are services well-led?

Good 

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. It proactively sought patients' feedback and engaged patients in the delivery of the service. There was a patient suggestion box in the waiting area for patients to add their views, compliments and concerns. The practice manager told us these were regularly reviewed by the PPG and practice manager.
- The PPG met regularly and submitted proposals for improvements to the practice management team. The practice had organised annual health road shows for two consecutive years. Both proving popular and successful events. These were held in the local Town Hall providing easy access. Multiple charities were invited to provide stalls offering information and advice to patients and clinicians alike. The PPG attended these running a refreshment stall with the aim to raise funds for patient improvement at the practice. With the funds gathered at the 2015 event the practice purchased a hearing loop to improve access for patients with reduced hearing. In 2016 the practice held a small flu clinic during the road show to further encourage flu vaccine uptake. This was supported by the attendance of nursing and reception staff. All proceeds raised go to the practice equipment fund with the practice raising £567.10 from the 2016 event. The PPG decided on where these funds were spent following review of patient feedback and practice priorities.
- The practice produced quarterly newsletters for patients. This included important information for patients such as flu clinic dates and practice information.
- Friends and Family survey results from May 2016 to August 2016 showed that of the 12 responses received from patients, ten were likely or extremely likely to recommend the practice to friends or family, with one neither likely or unlikely and one unlikely.

- The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they felt empowered by management to make suggestions or recommendations for the practice. There was a staff suggestion box for staff to add their views, compliments and concerns. The practice manager told us these were regularly reviewed.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice management team told us that the whole practice team would continue to develop new models of care that would meet and enhance patient care. For example, the practice recruited apprentices from a local college. We were told the practice had successfully recruited three apprentices following completion of their time at the practice, with one apprentice moving on to another practice.

The practice was a training practice and taught medical students, the practice was also a Royal College of General Practitioners research practice and took part in research activity such as chronic obstructive pulmonary research and asthma studies.

The practice were innovative with the staffing mix at the practice. The practice employed two practice nurses with a special interest in diabetes and one practice nurse who had undertaken training in respiratory conditions. They were supported by GP leads for both conditions, the diabetic GP lead having led multiple diabetes projects. One GP was an authority on multi-morbidities and prescribing for elderly patients. Another GP was a long term condition lead and board member for complex care. One GP was a member of the East Anglia Science Network diabetes project group, the chair of the West Norfolk Diabetes Network and held a national post as committee member for primary care diabetes.