

Bungay Medical Practice

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

Requires improvement



Are services safe?

Inadequate



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires improvement



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 Bungay Medical Practice on 9 May 2017. Overall the practice is rated as requires improvement.

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

- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Patients we spoke with 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.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff demonstrated that they understood their responsibilities in relation to safeguarding children and vulnerable adults. However, some staff we spoke with were unclear about whom the local or regional leads were.
- There was a system for reporting and recording significant events; however learning outcomes from events were unclear. Significant events were not always discussed at meetings in a timely manner.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns but learning outcomes were not always recorded.
- ECCH had a clear vision and set of values and but some staff at the practice were not aware of these. Whilst staff felt supported by local leadership, they recognised that ECCH were still in the process of developing those relationships and support structures.

Summary of findings

The communication between the provider and the location had not always been effective. This had resulted in delays in information being shared and recommendations being acted upon.

- The training matrix for staff showed training had not always been completed in areas such as basic life support and safeguarding relevant to their role.
- We found out of date medicines and devices in GP bags.
- The practice was signed up to receive some, but not all Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The practice had a record of alerts they had received and these were actioned appropriately. The practice signed up to receive all remaining alerts on the day of the inspection.
- Some standard operating procedures for the dispensary had not been reviewed since 2013.
- The infection control lead had not received training specific to the role and a sharps bin was out of date.
- The practice had identified less than 1% of the practice population as carers and had not offered these patients carer health checks.

We saw two areas of outstanding practice:

- East Coast Community Healthcare (ECCH) were actively implementing new models of care; for example they employed a physiotherapist, health trainer and community matron to work at the practice. The physiotherapist saw patients with musculoskeletal pain. Patients could book directly with this service ensuring they had timely advice in the management of conditions such as back pain. This benefitted the patient who did not have to be referred to other services which often incurred protracted delays and the risk of their condition deteriorating. The physiotherapist would triage patients and refer back to the GP if inappropriate. The physiotherapist was available to the GPs and nurses for immediate advice if they needed their specialist skills. Between March and April 2017, the physiotherapist saw 86 patients. Of these, only 1% was referred to a GP and 93% were managed with exercises and advice alone.
- The practice offered a 'same day team' which included clinical led triage, same day appointments

for vulnerable patients and same day home visits by a primary care practitioner for patients who had conditions making it difficult to attend the practice. The emergency care practitioner was a trained paramedic who liaised with the GP after or during every visit. The community matron was also part of this team and offered same day appointments for acute social problems. The nurse team also had 30 appointments available daily for patients with minor illness.

The areas where the provider must make improvements are:

- Implement an effective process to ensure that medicines kept in GP's bags are checked routinely and are safe to use.
- Ensure all safety alerts are received, actioned and shared.
- Ensure there is an effective system in place to monitor that actions from significant events are completed and recorded and learning is shared with staff, including dispensary significant events.
- Ensure standard operating procedures for the dispensary are reviewed and updated.
- Implement an effective system for monitoring staff training to ensure staff are up to date for mandatory training including safeguarding and basic life support.

The areas where the provider should make improvement are:

- Continue to identify carers and consider the need for health checks and additional support for this patient group.
- Continue to work towards effective communication to ensure staff understand their roles in relation to incident reporting and complaints.
- Consider the need for additional training for the infection prevention and control lead and ensure infection prevention and control audits are always effective.
- Ensure actions taken in response to complaints are always documented.

Summary of findings

- Ensure all equipment is calibrated to ensure it is safe and effective for use.

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 inadequate for providing safe services.

Inadequate



- Staff demonstrated that they understood their responsibilities in relation to safeguarding children and vulnerable adults. We found that not all clinicians were not trained to the relevant level of safeguarding for their role. However, training was taking place on the evening of our inspection.
- From the sample of documented examples we reviewed, we found there was a system for reporting and recording significant events; however this needed to be improved as outcomes from events were unclear. When things went wrong patients were informed as soon as practicable, received reasonable support, detailed information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again. We noted that not all actions detailed were carried out. Significant events were not always discussed at meetings in a timely manner.
- We found medicines and devices in GP bags that were out of date.
- The practice had a system in place to deal with alerts received from Medicines and Healthcare products Regulatory Agency (MHRA), however they were not signed up to receive all alerts as they were missing from the distribution list. The practice had a record of alerts received and actions taken to ensure monitoring of patients who were at risk. The practice took immediate action to receive the remaining alerts and undertook a review of past alerts.
- Some standard operating procedures for the dispensary had not been reviewed since 2013 and the practice could not evidence dispensary specific audits.
- The infection control lead had not received training specific to the role and a sharps bin was out of date.
- The training matrix for staff showed training had not been completed in areas such as basic life support.
- The practice had arrangements to respond to emergencies and major incidents; however as some medicines were out of date, we could not be assured these arrangements were effective.

Are services effective?

The practice is rated as good for providing effective services.

Good



Summary of findings

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were in line with local and national averages.
- Clinical audits demonstrated quality improvement in areas such as diabetes and asthma.
- Staff had the skills and knowledge to deliver effective care and treatment and were aware of current evidence based guidance.
- 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 such as midwives, a community matron and a health visitor.
- End of life care was coordinated with other services such as the MacMillan nurses, palliative care nurses and a palliative care consultant.
- East Coast Community Healthcare employed a 'health coach' that carried out healthy living and smoking cessation advice to patients.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients, such as coil implant fitting.

Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey, published in July 2016, showed patients rated the practice in line with others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had identified less than 1% of the practice population as carers and did not offer carer health checks. Information for support groups was available in the waiting room.
- Information for patients about the services available was accessible. Translation services and a hearing loop were available for patients who needed them.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- Practice staff reviewed the needs of its local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified.

Summary of findings

- The practice offered extended hours on Mondays from 7am to 8am and on Thursdays from 6.50pm to 8.20pm.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice offered telephone consultations for those patients who wished to access advice this way.
- East Coast Community Healthcare employed a physiotherapist, a pharmacist, a health coach and a primary care practitioner to meet patient needs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from four examples reviewed showed the practice responded quickly to issues raised. There was some evidence that action plans for complaints were completed, however this was not always documented and learning outcomes were not always clear or recorded.

Are services well-led?

The practice is rated as requires improvement for being well-led.

- ECCH and the practice had a clear vision and set of values, however, some staff were not aware of these and their responsibilities in relation to this.
- ECCH had a governance framework which supported the delivery of good quality care within the practice. This included arrangements to monitor and improve quality and identify risk. However we found this needed to improved. For example, we found not all staff had completed training required by the provider and there were out of date medicines in GP bags.
- Staff felt supported by local leadership; but told us support from the provider, ECCH, required further improvement.
- There was evidence of a number of initiatives which had either been implemented or planned by ECCH in order to address the needs of the patients and staff at the practice.
- The provider was aware of and complied with the requirements of the duty of candour.
- ECCH proactively sought feedback from staff and patients, which it acted on. The practice engaged with the patient participation group; however the group did not feel ECCH engaged with them.

Requires improvement



Summary of findings

- Staff had received inductions, annual performance reviews and attended staff meetings.
- There was some focus on continuous learning and improvement at all levels. However, gaps in training had been identified. This had been identified by the practice and some action had been taken.

There were local leadership systems within the practice and each department had a manager. There were monthly meetings for each department and staff commented positively on leadership within the practice.

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 requires improvement for the care of older people. The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The practice staff were flexible with the appointment system to enable patients to use the community transport to get to the practice.
- The practice had a paramedic trained primary care practitioner who undertook acute home visits three days per week, ensuring patients who may be vulnerable received prompt assessment.
- The practice were proactive in identifying patients who may need palliative care as they were approaching the end of life. Patients were involved in planning and making decisions about their care, including their end of life care. All GPs were trained in palliative care.
- The practice followed up patients discharged from hospital and ensured their care plans were updated to reflect any extra needs. Receptionists telephoned patients who were discharged and offered a follow up appointment.
- Where older patients had complex needs, the practice shared summary care records with local care services such as community nurses. The practice held monthly multidisciplinary team meetings and invited social care staff, ambulance staff and community workers.
- Older patients were provided with health promotional advice and support to help them maintain their health and independence for as long as possible. The practice employed an in-house community matron who offered daily appointments for new referrals such as hospital discharges, falls and dementia care.

Requires improvement



Summary of findings

- Care homes supported by the practice received weekly ward rounds by a named GP or nurse for continuity. The local rehabilitation ward received a daily ward round and a GP attended the multidisciplinary meetings.

People with long term conditions

The practice is rated as requires improvement for the care of people with long term conditions. The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

- Nursing staff had lead roles in long-term disease management and were able to review multiple conditions in one appointment. The practice ensured blood tests were completed prior to appointments so results could be discussed during the appointment.
- Performance for diabetes related indicators from the Quality and Outcomes Framework (QOF) was 92%. This was comparable to the local clinical commissioning group (CCG) and national averages of 90%. The prevalence of diabetes was 8% which was the same as the CCG average and comparable to the national average of 7%. Exception reporting of diabetes indicators was 10% which was below the CCG average of 17% and in line with the national average of 12%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured their care plans were updated to reflect any additional needs.
- The practice had in-house spirometry, urine testing, 24 hour ambulatory BP monitoring and 24 hour heart monitoring devices.
- All these patients had a named GP and there was a system to recall patients for 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.

Requires improvement



Families, children and young people

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

Requires improvement



Summary of findings

- There were systems 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 accident and emergency (A&E) attendances. These children were discussed at quarterly multidisciplinary team meetings with health visitors and the safeguarding team and safeguarding was on the standing agenda for monthly clinical meetings. The practice also telephoned non-attendees of practice and hospital appointments.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for pregnant women and offered an appointment at 26 weeks gestation, as well as offering six week checks for new mothers and babies.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice had same-day appointments available in the nurse led clinic for children with acute problems and young people seeking sexual health advice.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications. For example, receptionists were trained to fast-track any child or pregnant woman who may be acutely ill to the clinical triage team.

Working age people (including those recently retired and students)

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours on Mondays and Thursdays.
- The practice was proactive in offering online services as well as a range of health promotion and screening that reflects the needs for this age group, such as health checks for over 45s, weight management advice and smoking cessation.

Requires improvement



Summary of findings

- The practice offered a flexible triage approach, which included phoning patients back at times that suited them, such as during lunch breaks during the patient's working day.

People whose circumstances may make them vulnerable

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability. The practice offered same day appointments for those in the traveller community.
- 58% of patients with a learning disability had attended annual health checks. The practice ensured the records were flagged and double appointments were offered to patients with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice flagged patients with a sensory impairment so all staff were aware and clinicians would come to the waiting area to call these patients in for an appointment.
- The practice regularly worked with other health and care professionals in the case management of vulnerable patients, including the community nursing team.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations, including information in the waiting room.
- Staff we spoke with knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.

Requires improvement



People experiencing poor mental health (including people with dementia)

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

Requires improvement



Summary of findings

The provider was rated as inadequate for safety and requires improvement for well-led. The issues identified as requiring improvement overall affected all patients including this population group. However there were examples of good practice:

- The practice carried out advance care planning for patients living with dementia.
- 86% of patients experiencing poor mental health had a comprehensive care plan, which was comparable with the CCG average of 85% and the national average of 89%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia. The practice regularly referred patients with dementia high level needs to the local Dementia Intensive Support Team and offered a Mini Mental State Examination for those with concerns about memory.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia and had effective communication with local care homes.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff we spoke with had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing in line with and above local and national averages. 220 survey forms were distributed and 115 were returned. This represented a 52% response rate.

- 93% of patients described the overall experience of this GP practice as good which was comparable with the CCG average of 89% and higher than the national average of 85%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area which was higher than the CCG average of 82% 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 nine comment cards which were all positive about the standard of care received. There were comments relating to the caring nature of staff, quick referrals to other organisations and how the practice were responsive to accommodating different appointment times for people of working age.

We spoke with five patients during the inspection. All four patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. However, some patients reported dissatisfaction with the approach of some non-clinical staff.

Areas for improvement

Action the service **MUST** take to improve

- Implement an effective process to ensure that medicines kept in GP's bags are checked routinely and are safe to use.
- Ensure all safety alerts are received, actioned and shared.
- Ensure there is an effective system in place to monitor that actions from significant events are completed and recorded and learning is shared with staff, including dispensary significant events.
- Ensure standard operating procedures for the dispensary are reviewed and updated.
- Implement an effective system for monitoring staff training to ensure staff are up to date for mandatory training including safeguarding and basic life support.

Action the service **SHOULD** take to improve

- Continue to identify carers and consider the need for health checks and additional support for this patient group.
- Continue to work towards effective communication to ensure staff understand their roles in relation to incident reporting and complaints.
- Consider the need for additional training for the infection prevention and control lead and ensure infection prevention and control audits are always effective.
- Ensure actions taken in response to complaints are always documented.
- Ensure all equipment is calibrated to ensure it is safe and effective for use.

Summary of findings

Outstanding practice

- East Coast Community Healthcare (ECCH) were actively implementing new models of care; for example they employed a physiotherapist, health trainer and community matron to work at the practice. The physiotherapist saw patients with musculoskeletal pain. Patients could book directly with this service ensuring they had timely advice in the management of conditions such as back pain. This benefitted the patient who did not have to be referred to other services which often incurred protracted delays and the risk of their condition deteriorating. The physiotherapist would triage patients and refer back to the GP if inappropriate. The physiotherapist was available to the GPs and nurses for immediate advice if they needed their specialist skills. Between March and April 2017, the physiotherapist saw 86 patients. Of these, only 1% was referred to a GP and 93% were managed with exercises and advice alone.
- The practice offered a 'same day team' which included clinical led triage, same day appointments for vulnerable patients and same day home visits by a primary care practitioner for patients who had conditions making it difficult to attend the practice. The emergency care practitioner was a trained paramedic who liaised with the GP after or during every visit. The community matron was also part of this team and offered same day appointments for acute social problems. The nurse team also had 30 appointments available daily for patients with minor illness.

Bungay Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Bungay Medical Practice

Bungay Medical Practice provides services to approximately 11,000 patients in a semi-rural area in Suffolk. The practice has eight GPs; seven female and one male. There is a practice manager and an assistant practice manager on site. The practice employs three practice nurses, a trainee practice nurse, two trainee advanced nurse practitioners and a nurse manager. The practice also employs three health care assistants. East Coast Community Healthcare also provides a primary care practitioner, a community matron, a physiotherapist and a health coach. Other staff include eight receptionists, four secretaries, three admin assistants and five dispensers. The practice holds a GMS contract with NHS England. The practice is able to offer dispensing services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy. We visited the dispensary as part of this inspection. Bungay Medical Practice is a training practice for GP Registrars (qualified doctors who are undertaking training to become GPs) and nurse students.

In August 2015, Bungay Medical Practice formed a partnership with East Coast Community Healthcare Community Interest Company (ECCH), who are the provider for the practice. ECCH is a provider of over 30 community

services, which includes four GP practices and has been established for five years. Staff employed by Bungay Medical Practice were due to transfer their employment to ECCH, however there had been delays with this. Therefore at the time of the inspection staff remained employed by Bungay Medical Practice.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are available between 7am and 8am on Mondays and between 6.50pm and 8.20pm on Thursdays. Appointments can be booked up to three weeks in advance for extended hour's appointments only and GPs booked follow ups as required. Urgent appointments are available for people that need them, as well as telephone appointments. Online appointments are available to book up to one month in advance.

When the practice is closed patients are automatically diverted to the GP out of hour's service provided by Integrated Care 24. Patients can also access advice via the NHS 111 service.

We reviewed the most recent data available to us from Public Health England which showed the practice has a smaller number of patients aged 20 to 39 years old compared with the national average. It has a larger number of patients aged 60 to 84 compared to the national average. Income deprivation affecting children is 15%, which is lower than the CCG average of 26% and national average of 20%. Income deprivation affecting older people is 12%, which is lower than the CCG average of 17% and national average of 16%. Life expectancy for patients at the practice is 80 years for males and 84 years for females; this is comparable to the CCG and England expectancy which is 80 years and 83 years.

Detailed findings

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 such as the CCG and three care homes to share what they knew. We carried out an announced visit on 9 May 2017. During our visit we:

- Spoke with a range of staff, including GPs, nurses, admin staff and dispensary staff and spoke with patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and family members of patients.
- Reviewed a 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.

- Looked at information the practice used to deliver care and treatment plans.

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 living 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 a system 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).
- The practice manager recorded significant events onto a Datix reporting system which alerted East Coast Community Healthcare (ECCH). ECCH monitored the practice response and discussed significant events at provider level meetings to monitor trends.
- From the sample of four documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable. They received reasonable support, detailed information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. However, we found that not all action plans were completed and that learning was not always shared with the local practice team in a timely way.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings of heads of departments where significant events were discussed. The practice reported they discussed significant events at whole team meetings, but could not produce meeting minutes to confirm this. Some minutes of team meetings were seen but these lacked sufficient details to demonstrate learning had been shared.
- The practice had a system in place to deal with alerts received from Medicines and Healthcare products Regulatory Agency (MHRA). The practice had a record of alerts received and actions taken to ensure monitoring of patients who were at risk. We conducted searches and found actions had been taken where appropriate. During our discussions the practice became aware that they did not receive all types of alerts as they did not

appear on the distribution list. The practice took immediate action to receive the alerts and undertook a review of past alerts. After the inspection, the practice provided information relating to any alerts they had not received and any action taken in response to these.

- The practice could not provide evidence of monitoring trends in significant events at a local level. However, ECCH monitored trends at monthly provider meetings, but this was not always shared with the practice.

Overview of safety systems and processes

The practice had some systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance at provider level if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding at ECCH level and practice level. However, the policy contained contact details for ECCH, and not the safeguarding lead at the practice. Staff we spoke with were unclear about whom the leads were at local and regional levels. After the inspection, ECCH provided us with updated safeguarding policies, which clearly identified who to contact at the practice and ECCH. We found the practice held safeguarding meetings with GPs and other agencies, including the health visitor and midwife.
- Staff we spoke with demonstrated they understood their responsibilities regarding safeguarding. Prior to the inspection, the provider had acknowledged that not all staff had relevant safeguarding training for their role and had booked training for the evening of our inspection.
- A notice in the waiting room and all clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained basic standards of cleanliness and hygiene.

Are services safe?

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. Cleaning services were employed by the ECCH.
- The advanced nurse practitioner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice and regularly attended local IPC meetings. The IPC lead had not received additional training to undertake this role. There was an IPC protocol and most staff had received up to date training. Annual IPC audits were undertaken by the IPC lead and an external company and we saw evidence that action was taken to address any improvements identified as a result. On the day of inspection, we found a sharps bin to be out of date. The practice took immediate action to remove these.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security, and disposal) needed to be improved.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. We reviewed medical records of patients taking medicine such as Methotrexate or Lithium; we found that patients had received regular monitoring in a timely manner.
- Dispensary staff identified when a medicine review was due and told us they would alert the relevant GP to reauthorise the medicine before a prescription could be issued. This process ensured patients only received medicines that remained necessary for their conditions.
- The practice carried out regular medicines audits, with the support of the local CCG medicine management teams, to ensure prescribing was in line with evidence based guidelines for safe prescribing. 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. On the day of the inspection the staff were unable to show that the practice had completed dispensary audits to help ensure dispensing processes were suitable and the quality of the service was maintained.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training, or were fully supervised in apprenticeship roles, and had undertaken continuous learning and development. Competencies were regularly checked by the dispensing lead GP. We noted the practice did not have oversight of the mandatory training that staff had undertaken.
- There was limited evidence to show the system and process for reporting and learning from medicines incidents and errors was effective. Practice staff we spoke with told us they reported incidents and these were logged. When asked, dispensary staff were not able to access the log or minutes of meetings where learning was shared. The minutes of dispensary meetings we saw lacked detail to demonstrate that learning had been shared with all dispensary staff or that actions required to prevent further incidences had been completed or discussed in a timely manner. For example, a significant event was recorded in August 2016 but was not discussed at a meeting until May 2017. In March 2016 a significant event was logged and a subsequent complaint was received by the practice. We saw an investigation and reply to the patient had been completed, but there was insufficient evidence to be assured learning had been shared and all actions such as additional training had been completed.
- Dispensary staff showed us standard operating procedures (SOPs) which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). However, we found that a significant number of SOPs had not been reviewed for a significant period of time; we were told by staff that the SOPs should be updated annually. For example the SOP titled Safe and Secure Handling of Controlled Drugs policy was last reviewed 29 May 2013. We did not see clear evidence of regular reviews of these procedures in response to incidents or changes to guidance in addition to annual review.
- Dispensary Review of Medicines Use (DRUMS) were completed by the dispensers and referred to GPs as required.
- Dispensary staff described a process for ensuring second checks by another staff member or GP when dispensing certain medicines; for example, controlled drugs.
- The dispensary staff were able to offer weekly blister packs for patients who needed this type of support to

Are services safe?

take their medicines and we saw the process for packing and checking these was effective. Staff knew how to identify medicines that were not suitable for these packs and offered alternative adjustments to dispensing where possible.

- Records showed fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature and staff were aware of the procedure to follow in the event of a fridge failure.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential for misuse) and had procedures in place to manage them safely. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys were held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns with the controlled drugs accountable officer in their area.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. Medicines we checked in the dispensary were within their expiry date. However, we found medicines and devices in three GP bags which were not within their expiry date. These included medicines such as a diazepam rectal tube which had expired in February 2017 and paracetamol suppositories which had expired in March 2017. Staff were unable to evidence that checks were regularly undertaken. The practice took immediate action and removed these medicines and devices. After the inspection, the practice provided evidence of a log of medicines in the GP bags.
- Blank prescription forms and pads were securely stored and there were systems to monitor their use.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. These were signed and up to date and the clinical staff using them could access them easily.

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence

of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and had carried out regular fire drills. There were four designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- Most electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. However, on the day of inspection we found two pulse oximeters had not been calibrated. The practice took immediate action on the day and provided evidence of a booking made to have these calibrated.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Not all staff had completed basic life support training.
- The practice had three defibrillators available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines stored securely on the emergency trolley were in date; however, we found out of date medicines in GP bags used for home visits.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) evidence based guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk audits and discussion at monthly clinical meetings.

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 from 2015/16 showed the practice had achieved 98% of the total number of points available compared with the CCG average of 95% and national average of 96%.

The overall exception reporting rate for the practice was 9% which was lower than the CCG average of 14% and comparable to the national average of 6%. (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).

Data from 2015/2016 showed:

- Performance for diabetes related indicators was 92%. This was comparable to the local CCG and national averages of 90%. The prevalence of diabetes was 8% which was the same as the CCG average and comparable to the national average of 7%. Exception reporting of diabetes indicators was 10% which was below the CCG average of 17% and in line with the national average of 12%.
- Performance for mental health related indicators was 95%. This was higher than the local CCG average of 90%

and comparable to the national average of 92%. The prevalence of mental health was 1% which was equal to the local CCG and national averages of 1%. Exception reporting for mental health was 9% which was below the CCG average of 19% and comparable to the national average of 11%.

- Performance for chronic obstructive pulmonary disease was 91%. This was below the local CCG and national averages of 96%. The prevalence of chronic obstructive pulmonary disease was 3% which was equal to the CCG average and comparable to the national average of 2%. Exception reporting for chronic obstructive pulmonary disease was 8% which was below the CCG average of 15% and the national average of 13%.

There was evidence of quality improvement including clinical audit:

- There had been 17 clinical audits commenced in the last two years, nine of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, an audit completed in March 2016 was undertaken to monitor steroid doses and inadequate monitoring of patients with asthma. Results showed that additional reviews and monitoring had achieved a reduction in the number of patients with high salbutamol use.
- Another audit had been completed on type two diabetic patients with abnormal blood test results that were not on treatment. Information about patients' outcomes was used to make improvements such as improved documentation in this group of patients and more effective follow up of diabetic patients.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered topics such as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality, as well as role specific training.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term

Are services effective?

(for example, treatment is effective)

conditions and those fitting contraceptives could evidence up-to-date training and courses completed. However, this excluded the lead role for infection control.

- 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. This included ongoing support, one-to-one meetings, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff reported they received training and could demonstrate they understood topics including: 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. However, not all staff could evidence that mandatory training had been completed. The practice reported training had been completed, but could not evidence this; for example, not all staff had completed basic life support training or safeguarding training relevant to their role.

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.
- From the sample of 10 documented examples we reviewed, we found the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients

moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. This included meetings with health visitors, midwives, MacMillan nurses, palliative care nurses and a palliative care consultant.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

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.
- 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 and signposted them to relevant services. For example:

- Patients receiving end of life care and those at risk of developing a long-term condition.
- East Coast Community Healthcare (ECCH) employed a 'health coach' for the practice for those requiring advice on their diet, smoking cessation and safe alcohol levels.
- A musculoskeletal physiotherapist was available on the premises and patients could book appointments directly with them. The physiotherapist triaged these patients and referred on to the GP if needed. Same day appointments were available for patients requiring this service.

Are services effective?

(for example, treatment is effective)

The practice's uptake for the cervical screening programme was 79%, which was higher than the CCG average of 74% and the national average of 73%. Exception reporting for the cervical screening programme was 13% which was comparable to the CCG average of 10% and above the national average of 7%. There was a policy to offer written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme for those with a learning disability and they ensured a female sample taker was available. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

- 74% of females aged 50-70 were screened for breast cancer in the last 36 months which was comparable with the CCG average of 72% and the national average of 73%.

- 65% of persons aged 60 to 69 were screened for bowel cancer in the past 30 months which was above the CCG average of 60% and national average of 58%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG and national averages. For example, rates for the vaccines given to under two year olds ranged from 94% to 97% and five year olds averaged at 95% which was above the national target of 90%.

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

Are services caring?

Our findings

Kindness, dignity, respect and compassion

During our inspection we observed that 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.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. There was a sign at reception to advise of this and another sign to encourage privacy and dignity of patients at the reception desk.
- Patients could be treated by male or female clinicians.

All nine Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One card commented positively on the practice being responsive to working times and amending an appointment time to reflect this.

We spoke with five patients including two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. However, two patients commented negatively on the approach of a non-clinical member of staff.

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 comparable to, or above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 98% of patients said the GP was good at listening to them which was above the CCG average of 90% and the national average of 89%.

- 94% of patients said the GP gave them enough time which was above the CCG average of 89% 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 96% and the national average of 95%.
- 94% of patients said the last GP they spoke to was good at treating them with care and concern which was above the CCG average of 87% and the national average of 85%.
- 98% of patients said the nurse was good at listening to them compared with the CCG average of 94% and this was above the national average of 91%.
- 99% of patients said the nurse gave them enough time which was comparable with the CCG average of 95% and this was above the national average of 92%.
- 97% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern which was comparable with the CCG average of 94% and this was above the national average of 91%.
- 87% of patients said they found the receptionists at the practice helpful compared with 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 clinical 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 to meet patients' needs. Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey, published in July 2016, showed patients responded positively to

Are services caring?

questions about their involvement in planning and making decisions about their care and treatment. Results were in line with and above local and national averages. For example:

- 94% of patients said the last GP they saw was good at explaining tests and treatments which was above the CCG average of 89% and the national average of 86%.
- 97% of patients said the last GP they saw was good at involving them in decisions about their care which was above the CCG average of 86% and the national average of 82%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 93% and the national average of 90%.
- 94% of patients said the last nurse they saw was good at involving them in decisions about their care compared to 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 interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available in different languages. Longer appointments were available for these patients.
- There was a hearing loop available.
- A chaperone service was offered to patients. There were signs in the waiting rooms and all clinical rooms advising patients of this.

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 such as memory problems, cancer support groups and smoking cessation. Information about support groups was also available on the practice website. There were signs in all patient toilets signposting patients to domestic abuse charities. There was support for isolated or house-bound patients, including signposting to relevant support and volunteer services. The practice pro-actively offered transport services for vulnerable patients and those receiving chemotherapy and radiotherapy to get to appointments. This was funded by an external charitable trust fund which helped to fund services for the local population including Bungay Medical Practice.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 96 patients as carers (less than 1% of the practice list); this register was not actively monitored and therefore these patients were not offered health checks. Written information was available to direct carers to the various avenues of support available to them, including advice for young carers.

Staff told us that if families had experienced bereavement, their usual GP contacted the family and/or carer to offer their condolences and to see if any further support was needed. 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.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Mondays from 7am to 8am and on Thursdays from 6.50pm to 8.20pm for working patients who could not attend during normal opening hours. These appointments were pre-bookable.
- There were longer appointments available for patients with a learning disability, multiple problems and mental health conditions. The practice offered same day appointments for the traveller population.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning. The practice also held meetings with the MacMillan nurse, palliative care nurse and palliative care consultant to ensure a multi-disciplinary approach to care. The practice also adopted the 'yellow folder' system for advanced care planning and offered anticipatory prescribing.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS.
- There were accessible facilities, which included a portable hearing loop and interpretation services available.
- A pharmacist was available to see or telephone patients to give medicines advice.
- The practice had employed a mental health practitioner who would be available each day; this member of staff had not commenced employment at the time of our inspection. The practitioner planned to see patients with acute mental health issues and offer assessment, diagnosis and treatment, as well as referral to secondary services. The practitioner also planned to offer a 'drop in' clinic for patients for group support.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours appointments were offered from 7am to 8am on Mondays and from 6.50pm to 8.20pm on Thursdays. Appointments can be booked up to six weeks in advance for a nurse and three weeks in advance for extended hour's appointments only. GPs will book pre-bookable appointments for patients if required. Urgent appointments were also available for patients that needed them.

The practice operated a triage system, patients' details were collated by the reception team and a GP called the patient back and appointments were offered to those as appropriate. Appointments could be booked in person, by telephone or online.

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

- 83% of patients were satisfied with the practice's opening hours compared with the CCG average of 79% and the national average of 76%.
- 82% of patients said they could get through easily to the practice by telephone compared to the CCG average of 81% and the national average of 73%.
- 84% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 87% and the national average of 85%.
- 95% of patients said their last appointment was convenient compared with the CCG average of 95% and the national average of 92%.
- 73% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.
- 56% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 64% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them and most patients spoke positively about the triage system in place. The comment cards received commented positively on the appointment system.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP

Are services responsive to people's needs?

(for example, to feedback?)

home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits. The practice offered a primary care practitioner, a qualified paramedic, three days per week to carry out home visits. The practitioner liaised with the GP during or after every visit.

Listening and learning from concerns and complaints

The practice had a system 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. In the event this person was not at the practice, there was a deputy designated.

- We saw that information was available to help patients understand the complaints system. There were signs in the waiting room advising patients of how to complain and information available on the website.

We looked at 26 complaints received in the last 12 months which were both verbal and written. These were recorded on the practice system; records included details of the complaint, the date it was responded to, any actions required and the date of completion. However, we found that learning outcomes were not always recorded. We found that written complaints went to the East Coast Community Healthcare (ECCH), who monitored the practice response and any trends. There was some evidence of lessons learned from individual concerns and complaints and action was taken to as a result to improve the quality of care. For example, after a patient complained about being unwell in the second floor reception area, a telephone was inserted to ensure patients could call down to reception. This area was also monitored by CCTV. Complaints were discussed at meetings every six weeks and this was evidenced by meeting minutes.

Are services well-led?

Requires improvement 

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

Our findings

Vision and strategy

East Coast Community Healthcare (ECCH) had been an established community interest social enterprise for five years. They formed a partnership with Bungay Medical Practice in August 2015 and assumed responsibility for the practice. The decision had been made by ECCH to work alongside the practice and evolve, rather than 'take over' and risk destabilisation of the service provided by the staff at Bungay Medical Practice.

ECCH's vision was 'We will be a ground-breaking, forward thinking community focused social enterprise with a reputation for excellence and quality in improving health and wellbeing.' In addition the practice vision was 'good clinical standards, underpinned by high quality standards', which is supported by ECCH. Most staff we spoke with were aware of the visions and values and their responsibility in relation to these at practice level, however some staff told us they were not aware of the ECCH vision and values. ECCH had a strategy and supporting business plan for the practice which reflected both visions and values and this was regularly monitored.

Governance arrangements

There was an organisational structure for Bungay Medical Practice, which detailed the reporting relationships from frontline staff to the ECCH executive team. ECCH had a governance framework for primary care which supported the delivery of the strategy and good quality care. However this needed to be improved at a local level as it did not always operate effectively:

- There was a staffing structure and most, but not all staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as safeguarding and infection prevention and control. However, not all staff spoken to were clear about whom the safeguarding leads were at local and provider levels and there were not clear lines of communication between the provider and the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. However, on the day of the inspection,

there was no evidence that audits specific to the dispensary were undertaken to help ensure dispensing processes were suitable and the quality of the service was maintained.

- There were some arrangements for identifying, recording and managing risks, issues and implementing mitigating actions but these needed to be improved. For example there was no system to ensure that regular checks were undertaken to ensure medicines available for use in GP bags were safe to use. Some of the standard operating procedures used in the dispensary had not been reviewed since 2013.
- We saw evidence from minutes of a meeting where significant events and complaints were discussed, however this did not always detail the lessons to be learned and shared following significant events and complaints. These were not always discussed in a timely manner. For example, a dispensary significant event from August 2016 was not discussed until May 2017.

The governance structure of ECCH was made up of eight committees including the policy group, strategic HR Education and training group, safeguarding committee, medicines management committee, health and safety committee, infection prevention and control committee, medical devices management group and primary care, which fed directly into the Integrated Governance Committee (IGC). The IGC was chaired by a non-executive director (NED) and was responsible for patient safety, risk management, patient involvement, complaints and human resources and workforce. The IGC met every two months and reported directly to the ECCH board. The remuneration committee, audit committee and shareholder council also reported directly to the ECCH board. Information regarding Bungay Medical Practice and collated information for ECCH GP practices was reported as appropriate to the IGC.

There was a governance process for policies to be ratified by the provider before implementation within the practice. Policies were implemented and were available to all staff.

Leadership and culture

There were mixed views in relation to the leadership and culture. Some staff told us they respected the leadership at the practice and felt supported by the local team. Some staff also reported that the expectation of improved leadership by joining ECCH had not been achieved and

Are services well-led?

Requires improvement 

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

staff satisfaction was mixed. There was also frustration expressed by some staff with the time it took to achieve local objectives since ECCH had become the provider, for example the handling of complaints.

The communication between ECCH and Bungay Medical Practice management teams was not always effective and staff were not always clear on their responsibilities or accountabilities. This had resulted in delays in information being shared and recommendations from complaints and significant events not being actioned.

ECCH had identified challenges to service provision at the practice, and given consideration to how they would be managed. For example, the difficulty in recruiting GPs and the need to offer alternative provision to meet health care need, had resulted in a primary care practitioner being appointed to undertake some urgent care work and appointments with a physiotherapist being available to patients directly through booking at the practice. ECCH had recently appointed a business lead for primary care with responsibility for implementing actions plans for all ECCH GP practices on new ways of working and models of care.

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). The practice had systems in place to ensure that when things went wrong with care and treatment, they gave affected people reasonable support, detailed information and a verbal and written apology.

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

ECCH encouraged and valued feedback from patients. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had an active patient participation group (PPG). The PPG met every month with the practice manager and practice manager assistant. The PPG had recently set up a social media page which gave patients information about the practice and information regarding various support groups. The PPG reported they were promoting mental health advice and support groups to reflect the practice population needs. However, the PPG reported they did not feel supported by ECCH. The practice engaged with the Friends and Family Test. The most recent data which was

published in December 2016, showed that from 132 responses, 87% of patients would recommend the practice. ECCH had developed a patient satisfaction questionnaire as part of the friends and family test, in order to obtain more detailed feedback from patients.

ECCH facilitated a 'patients as teachers' forum in May 2016. They invited patients to share their story and identified the main themes from these. Themes were identified such as engagement, environment and education. Patients were kept informed of the progress of the actions from the themes. For example a discussion was held regarding offering patients the chance to participate in research. The practice had two studies underway which had patients participating in which were regarding bowel symptoms and patients presenting with a cough.

Staff told us they would give feedback and discuss any concerns or issues with colleagues and management staff at the practice. Staff had given feedback directly to a human resource representative from ECCH. ECCH had also obtained feedback from staff through staff meetings, appraisals and discussion and were aware of some of the frustrations of staff, for example in relation to their employment. ECCH explained that these difficulties had arisen late in the merging process and had apologised to staff.

The practice had an established local leadership team which included a manager within each department. For example, the nursing team were led by a nurse manager and the reception team were led by a reception manager. Each department held monthly meetings to discuss any issues and staff reported this was an open forum and felt enabled to give feedback. Issues from these meetings were then discussed at practice meetings. Feedback from staff spoken with was positive regarding local leadership within the practice.

Continuous improvement

ECCH was forward thinking and took part in local pilot schemes to improve outcomes for patients in the area. For example 'releasing time to care' workshops had been arranged, with the overall aim of supporting practice teams to develop and learn, with local agreement on how time can be released in general practice. ECCH was working with the practice to identify how time can be released for the clinical staff by developing the skills of the administration team. Bungay Medical Practice is a training practice for GP

Are services well-led?

Requires improvement 

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

Registrars (qualified doctors who are undertaking training to become GPs) and nurse students. ECCH were planning to support the physiotherapist and primary care practitioner to gain their prescribing qualification and extend their scope of practice.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment <ul style="list-style-type: none">• In three GP bags, we found medicines and devices that were not within the expiry date.• We identified safety alerts that the practice had not actioned. The practice system and process did not ensure all safety alerts were received. There was no system to ensure that historical alerts were monitored.• The lead infection prevention and control had not received appropriate training to undertake this role. We found a sharps bin that had expired.
Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance <ul style="list-style-type: none">• We found there was not an effective system in place to monitor that actions plans were completed and that learning was recorded and shared appropriately from significant events in a timely way.• The practice had not ensured that all standard operating procedures had been reviewed in a timely manner. We found some standard operating procedures had not been reviewed since 2013.• We found that some staff had not completed training the provider deemed mandatory in all areas, including basic life support.• We found that there was a lack of oversight by the provider to ensure the governance systems of the practice were effective.