Dr Emerson and Partners

Quality Report

Bungay Medical Practice,
28 St John's Road,
Bungay,
Suffolk, NR35 1LP
Tel: 01986 892055
Website: www.bungaymedical.co.uk

Date of inspection visit: 14 October 2014
Date of publication: 30/04/2015

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Emerson and Partners (known as Bungay Medical Practice) on 14 October 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for all of the population groups it serves. The practice required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to medicines management where some improvements are required.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received appropriate training and received support to further their individual training needs.
- 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.
- Patients told us they did not always find it easy to make an appointment with a named GP although urgent appointments were usually available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs. They had their own small charitable funds to help support the practice facilities and provide some enhanced resources for patients that were not covered by the NHS.

Summary of findings

- 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.

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

Importantly the provider must:

- Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the safe supply of medicines as prescriptions were not always signed by a GP before the dispensed medicines were handed to patients
- Controlled drugs kept in doctor's bags are required by law to be recorded in a special register. In addition, the practice must conduct comprehensive checks of all controlled drugs on a regular basis to ensure that all drugs can be accounted for and prompt action taken if any items are missing.

In addition, the provider should:

- The practice should review access and security of the keys to the dispensary and review the systems in place to track prescription pads.
- Ensure that all relevant staff are reminded of the vaccine administration and cold chain Policy.
- The practice should ensure that all relevant infection control policies contain information that is in line with the practice's current procedures.
- The practice should strengthen their clinical audit plans so that the audit cycle is fully completed. This will maximise learning and improvement in 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?

Requires improvement

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not always well implemented to ensure patients were kept safe in relation to medicines management. This related to the safe issue of repeat prescriptions and the management of controlled drugs. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff were able to demonstrate that they regularly referred to best practice guidelines such as from National Institute for Health and Care Excellence. Staff received appropriate mandatory training and were supported to develop their role and skills through additional training opportunities identified as part of their appraisal. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health in partnership with the patients and other members of the wider multidisciplinary team.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they did not always find it easy to get an appointment with a named GP although urgent appointments were usually available. The practice had good facilities and was well equipped to

Summary of findings

treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy in place that was being reviewed with staff. Staff were clear about their responsibilities within the team and how this impacted upon the service. They also had an understanding of issues that required improvement and were committed to making improvement plans. 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 were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

Approximately 25% of the patient population at the practice are aged over 65 years. In response to this the practice, with support from the local CCG, have placed a community matron based at the practice to help support this patient group. The practice had a register of over 200 patients who were at risk of unplanned admissions, all of whom had a care plan in place to help limit the need for hospital admission. These had been produced in partnership with the patients, their carers and other health and care professionals. Monthly multi-disciplinary meetings bring together community staff including ambulance and social care staff to review patients with the most current complex needs. Elderly patients are encouraged to visit the surgery if they are able to do so. There were a high number of home visits each day due the number of frail elderly patients living in rural locations. This included visits to patients living in nursing and care homes supported by the practice. Regular weekly rounds were in place for each home with a named GP to help promote continuity of care and to work in a more pro-active way to improve and manage patient's health needs.

People with long term conditions

Good

The practice had a long term conditions service led by the practice nurses. They followed up to date clinical protocols and were appropriately trained. There was a system in place to conduct reviews for patients at regular intervals and those with several conditions could be seen in one long appointment if this was more convenient. A system was in place to ensure that blood tests were taken two weeks prior to their review.

Other diagnostic tests could be provided such as diabetes, spirometry, urine tests and ECGs. Patients can be provided with a range of written information and where appropriate, shared care plans are agreed i.e. asthma, diabetes.

A diabetes nurse specialist runs weekly clinics at the practice and nurses can offer home visits for patients who are housebound. Patients are also monitored for signs of depression, dementia and carer fatigue.

Families, children and young people

Good

Midwives from both the Norfolk and Suffolk teams run weekly clinics in the practice and pregnant women can choose their preferred hospital to have their baby. GPs usually see pregnant women on presentation and around the 26th week of pregnancy.

Summary of findings

All new mothers are contacted by reception on receipt of their discharge summary to ask if they need a review and are booked in for their 6 week check with the GP.

The Health Visiting Team is based on site which greatly enhances the care of children aged under five years. In addition, vulnerable children are discussed at a regular meeting between safeguarding leads at the practice and the health visitors.

The nurse-led "Same Day Clinic" is used mostly by families of young children and includes assessment of minor injuries. All pregnant women and babies under one year are booked in an urgent slot with a GP the same day. Parents anxious about a sick child will be triaged straight away and can be seen urgently if required. The practice has adopted the traffic light system for assessing ill children and also the open access form for paediatric review within 24 hours run by James Paget Hospital.

Young people can access the Same Day Clinic for any health concerns including advice about their sexual health. Pregnancy tests, test for sexually transmitted infections and emergency contraception is also available. Requests for contraception are passed onto the GP and patients can be referred on to family planning clinics in Norwich or Great Yarmouth if they prefer.

The practice offer contraceptive implants and refer patients for a vasectomy to a local service.

Working age people (including those recently retired and students)

Requires improvement

The practice offered later evening appointments on a Thursday and some early Monday morning appointments from 07.00. Patients could book appointments on-line and email requests were also accepted. However, the wait for a routine appointment with a patient's own GP could be from 2 to 4 weeks. Patients can usually access another GP in a more timely way although this may be a junior doctor supervised by an experienced GP.

The practice were concerned about access to the practice for this patient group. Urgent problems could be managed by the Same Day Clinic and if this became full the GPs worked into the evening until all urgent patients had been seen. This was not a long term solution and the practice had already discussed this with the Patient Participation Group. They had also had an assessment by the Doctor First team to consider changing the appointment system and were waiting for the results to see whether this would benefit the service.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice has a small local traveller population that use a local address as a base. They use the Same Day Clinic quite often. Nurses running the clinic have access to a named GP for advice and review of unwell patients or those who might move on.

The practice holds a register of patients with a learning disability. They are offered annual health checks. Records are flagged so these patients have double appointment slots to allow them ample time. In addition the practice plan to introduce a system whereby a member of the nursing administration team will liaise closely with patients with learning disabilities and their families to improve their continuity of care and attendance.

Patients with sensory impairment who might not respond to waiting room calls are collected from the waiting room. Waiting rooms are always checked before assuming non-attendance.

There is a small number of registered patients from Eastern European backgrounds. The practice told us that most have good language skills although translation services can be accessed if required to avoid reliance on family members.

People experiencing poor mental health (including people with dementia)

Good

The practice had 224 patients on the mental ill health register at the time of the inspection. These patients were offered an annual medical review and non attendance was followed up. For patients who did not have a care plan agreed with the community mental health team, the practice developed a care plan with the patient's agreement. Patients on long term medication were provided with appropriate monitoring and medication reviews.

The practice also treated a large number of patients with anxiety and depression. This included an assessment of their psychological, medical and social needs. Further referral to the Wellbeing Service, in-house counsellors or self-help resources could be given if appropriate.

Children with mental health and behavioural problems could be referred to the Child and Adolescent Mental Health Service, health visitors, school nurse service or social services. The practice also had a role in supporting physical health checks for children on long term medication e.g. methylphenidate.

Patients with long term conditions are screened for depression and patients are offered a Mini Mental State Examination MMSE if they or their family are concerned about dementia. Patients with dementia are referred to a local memory service and carer support is offered to them through social services. The Community Matron is often

Summary of findings

involved with these patients to provide support and on-going advice. In addition the practice can access the local Dementia Intensive Support Team (DIST) for those with high level needs in order to continue to support them in their own homes for as long as possible.	

Summary of findings

What people who use the service say

We spoke with seven patients as part of the inspection process and we received 24 CQC comments cards. Patients told us the practice offered an excellent service, staff were efficient, helpful and caring. They said staff treated them with dignity and respect and always gave time to listen and explain information to them clearly. We also received six comments that were less positive. Four of these related to the lengthy waiting times to see their preferred GP.

Areas for improvement

Action the service MUST take to improve

Improve arrangements for the safe management of medicines. The provider did not have appropriate arrangements in place for the safe supply of medicines as prescriptions were not always signed by a GP before the dispensed medicines were handed to patients

Controlled drugs kept in doctor's bags are required by law to be recorded in a special register. In addition, the practice must conduct comprehensive checks of all controlled drugs on a regular basis to ensure that all drugs can be accounted for and prompt action taken if any items are missing.

Action the service SHOULD take to improve

The practice should review access and security of the keys to the dispensary and review the systems in place to track prescription pads.

In order to support staff in maintaining storage of vaccine at the correct temperature, the practice should ensure that all staff are reminded of the Vaccine Administration and Cold Chain Policy.

The practice should ensure that all relevant infection control policies contain accurate information about the management of reusable surgical instruments.

The practice should strengthen their clinical audit plans so that the audit cycle is fully completed. This will maximise learning and improvement in practice.

Dr Emerson and Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, CQC medicines inspector and practice management advisor.

Background to Dr Emerson and Partners

Bungay Medical Practice serves the town of Bungay and its surrounding villages within a five mile radius. There are approximately 11,100 registered patients of which 25% are aged 65 and older. There are five GP partners and three salaried GPs (one on maternity leave) and a GP vacancy. Two GPs are male and six are female. Recruitment of GPs in the area is particularly difficult and the practice are hoping to recruit in the near future.

The nursing team consists of two nurse practitioners, a community matron, four practice nurses and three health care assistants. Clinical staff are supported by a team of approximately 31 other staff and this includes managerial roles, administrators, secretaries, reception and dispensary staff, The practice is a training practice and holds a GMS contract.

This was the first inspection visit to this practice and was completed as part of our routine inspection programme.

The CQC intelligent monitoring placed the practice in band 6. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice have opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24 Limited.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

Detailed findings

- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 October 2014. During our visit we spoke with a range of staff including GPs, nurses, managers, reception and dispensary staff. We also spoke with patients who used the service with their carers or family members if they were present. We observed how people were being cared for and greeted by staff and reviewed some personal care or treatment records of patients. We reviewed 24 comment cards where patients and members of the public shared their views and experiences of the service and spoke with three representatives of the patient participation group.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice were able to evidence a clear track record on safety and monitoring performance. This was evidenced through the reporting and review process for significant events, comments and complaints received from patients. Electronic and paper records that we reviewed showed the practice had an established culture for monitoring safety and raising issues for discussion at team meetings.

When we spoke with staff we found they were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a scanning error meant that electronic records were not accurate. This was detected and discussed at the administration meeting so that learning could be shared to prevent further errors.

Learning and improvement from safety incidents

The Practice had a system in place for reporting, recording and monitoring significant events.

Staff reported issues using a form on the practice intranet and sent completed forms to a designated member of staff for monitoring and management of the issues. Each incident was raised at the relevant staff meeting for discussion and shared more widely if learning was relevant to the wider team. Staff also told us that relevant issues were escalated to the appropriate levels for example to the CCG (Clinical Commissioning Group).

We tracked two incidents and saw records were completed in a comprehensive and timely manner. There was evidence of action taken as a result of learning from the incidents for example, following an incident involving the management of a long term medicine for a patient, checks were put in place for all patients who received the same medicine. Where patients had been affected by something that had gone wrong, they received an apology and were informed of the actions taken by the practice.

National patient safety alerts were received by a designated team member and disseminated by email to practice staff. Staff we spoke with told us that alerts were discussed at practice meetings when they were of particular significance to their work.

Reliable safety systems and processes including safeguarding

There was a GP who led and advised staff on issues or concerns that related to safeguarding children and vulnerable adults. The community matron was involved with most issues that related to vulnerable adults. Clear policies were in place to guide staff in taking appropriate action if concerns were suspected for children or vulnerable adults. These referred to local authority contacts so that issues could be raised in a timely way.

GPs had completed level three of safeguarding training. Records showed that all staff had access to safeguarding training for both children and vulnerable adults and the majority of staff had completed this within the last year. When we spoke with staff they were able to give us examples of abuse and how they might identify any potential issues of abuse experienced by patients at the practice.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended for appointments for example, family members who were able to give consent to treatment on behalf of a person who was unable to make those decisions without support.

The health visitors and district nurses were both based at the practice. This meant it was easy to discuss any safeguarding concerns with the relevant team and ensure that patients were protected and supported following local guidelines.

A clear chaperone policy was in place and there were notices in the waiting room and consultation rooms alerting patients to this support if they wanted it. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. The reception manager had also received training and would act as a chaperone if nursing staff were not available. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

The practice must make some improvements to the way they manage medicines.

Requires improvement

Are services safe?

We looked at areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary was well organised and operated with adequate staffing levels.

Feedback we received indicated patients were happy with the supply of their repeat prescriptions and reported no delays in obtaining their medicines. The dispensary offered a medicine delivery service to its housebound patients. There was clear information posted outside the dispensary about its opening times and where to find additional medicine supply services outside of hours.

We observed that members of staff gave helpful advice to patients when dispensing and handing them their medicines. However, we found that repeat medicines supplied at the dispensary were handed to patients before prescriptions were signed and authorised by the GPs. Therefore we could not be assured that safe procedures for medicine supply were always being followed.

We asked about the arrangements in place for the security of medicines. Whilst we noted that medicines, including injectable medicines, were kept securely in clinical areas of the surgery, we noted that arrangements for the security of keys to the dispensary were not sufficiently robust and at times the dispensary was accessed by unaccompanied members of staff who were neither doctors nor members of dispensary staff. In addition, we found whilst there was secure storage for prescription pads, record-keeping practices did not allow them to be fully accounted for so we could not be assured that if blank prescriptions were lost or stolen this could be promptly identified and investigated.

We looked at records of temperatures for medicines requiring refrigeration which showed temperatures had been maintained within the accepted range. A practice nurse on duty described the arrangements for maintaining the cold-chain for vaccines following their delivery, however, when we asked, they were unable to locate a written procedure about this. We saw that the surgery had medicines for use in an emergency in clinical areas and in doctors' bags which were checked regularly for their availability and to ensure they were fit for use.

Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. We checked a sample of controlled drugs and found we could account for them in line with registered records. However, controlled drugs kept in doctors' bags were not separately registered. In addition, we noted that the practice was not conducting its own comprehensive checks of all controlled drugs on a regular basis so we could not be assured that if some controlled drugs were lost or stolen this could be promptly identified and investigated.

The practice noted records of discussions about medication errors at dispensary meetings which led to actions and learning, however we noted meetings did not always take place monthly as scheduled. The dispensary had undertaken its own internal surveys to assess quality and performance. We noted that a patient questionnaire resulted overall in a high return of patient satisfaction, however, there were some comments about incomplete prescriptions where patients had to return to the practice to collect outstanding medicine supplies. The practice conducted a survey of acute 'owing' prescriptions (medicines that were not on a repeat prescription basis) and also found a high rate of owed medicines where patients often had to return to the practice to collect commonly prescribed medicines.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. Procedures were updated regularly and staff confirmed they had read and understood revised practices. Records showed that the competence of dispensing staff in relation to their role was assessed annually.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who ensured that staff received mandatory infection control training. The staff member had not had any additional training to undertake this role which should be given further consideration.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, a policy for handling specimens guided staff in how to safely receive specimens from patients at the reception desk. We noted the decontamination of reusable medical

instruments contained guidance on rinsing items in a dedicated sink. We discussed this with the infection control lead who assured us this was not practice as instruments were decontaminated by an external service and a contract was in place. The policy did not reflect the safe practices being followed by staff and required updating.

The infection control lead had conducted clinical waste and hand hygiene audits during the previous year. Findings were fed back to individuals but the overall results were not reported to any quality monitoring meetings. A wider audit of general infection control practice had been commenced but not completed in full and there were no actions documented.

Minor surgical procedures are conducted in a dedicated treatment room. The practice had a minor operations policy that detailed the safe management of the environment and procedures to prevent any cross infection. We noted the room had only one sink dedicated to hand washing and no sink for disposing of dirty waste. When we checked this with staff, the risks had been considered and adequately managed.

Relevant checks had been completed for staff to demonstrate they had immunity against Hepatitis B.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. There were pictorial guidelines reminding staff of the correct hand washing procedure.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that all equipment was tested and maintained regularly and records we saw confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A health care assistant was responsible for arranging this on a regular basis. The practice also had a system in place to ensure that equipment was regularly serviced. We saw evidence of calibration of relevant equipment; for example weighing scales and nebulisers.

Staffing and recruitment

We reviewed six sets of staff records and saw evidence that appropriate recruitment checks had been undertaken prior to employment. For example, employment history, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). All but one file contained documents to confirm the staff member's identity. These items had not been retained on the file. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager had daily contact with all departments to monitor management of the workload so that any limitations could be considered and action taken as appropriate. For example the administration team were under pressure to address the summarising of patient records due to the increase in registered patients. Staff skills were being utilised when possible and options to address the situation were being considered.

At the time of the inspection the practice had one GP vacancy that they had been unable to recruit to and another GP on planned leave. These vacancies were covered by some existing GPs who worked part time hours or by other local GPs who had recently retired or worked at nearby practices. This meant the GPs were more familiar with the patients and local resources in the area.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors

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

Identified risks were recorded, assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at management meetings and within team meetings. However we found that risks identified through infection control audits were not routinely shared in these forums.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment such as oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency) were accessible and staff were aware of the location of this equipment. There were records to demonstrate this equipment was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. The medicines were checked regularly to ensure they were fit for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Key risks were considered within the plan and staff were guided on initial responses as well as actions to be taken to minimise disruption to services where possible. Risks identified included power failure, adverse weather, unplanned sickness and local epidemics. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they had practised fire drills. Three staff were trained as fire marshals.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with were able to describe their rationale for the care and treatment approaches used on a daily basis. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Records of practice meetings included discussions of new guidelines, the implications for patients as well as the practice's performance. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs at the practice shared responsibility for leading in specialist clinical areas such as diabetes, family planning and minor surgery and the practice nurses supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of specific conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice had a process in place to follow up all patients recently discharged from hospital with a contact call and if needed they received a follow up appointment with their GP.

Clinical meetings were used to review patient referral rates for elective and urgent specialist treatment. Opportunities were used to share best practice guidelines.

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

Management, monitoring and improving outcomes for people

We reviewed the clinical audits that had been undertaken by the practice. One clinical audit commenced in March 2014 compared the management of patients with COPD (chronic obstructive pulmonary disease) to national best practice guidelines. However the audit cycle had not been completed as the review, planned for September had not been completed. Another audit looking at screening patients for coeliac disease was in progress. Other evidence we were shown were activity reviews and did not demonstrate that the full clinical audit cycle was being used to its full extent. This was a missed opportunity to review clinical practice and demonstrate changes to support professional and best practice guidance.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Data we reviewed showed the practice mostly achieved outcomes for patients that compared with national average scores. They scored higher than the national average in managing their register for patients with a learning disability, the palliative care register and multidisciplinary team reviews.

The team made use of supervision opportunities and meetings to assess the on-going performance of clinical and non- clinical staff. The staff we spoke with told us they focused on care needs, outcomes being achieved for patients and the overall patient experience. Staff spoke positively about the culture in the practice around learning and improvement and told us they were comfortable in raising questions.

Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice followed the gold standards framework for end of life care. It had a palliative care register and held monthly multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support, equality and diversity and information governance. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice had an established system for appraising staff performance in each department. All staff received annual appraisals that identified their individual learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training or funding for relevant courses, for example management skills such as conducting performance reviews.

A member of the nursing team told us they had received a review following their three month probationary period. It involved feedback from other members of staff and had been very useful.

The practice had good training facilities to provide in-house mandatory training. They were also a training practice for doctors who were training to be qualified as GPs. Two GP partners supported this work at the practice.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties such as the administration of vaccines. The practice nurses were responsible for managing the long term conditions service and followed best practice protocols to advise and treat patients. Long-term conditions include for example asthma, COPD, diabetes and coronary heart disease. The nurses had received appropriate training to fulfil these roles.

The practice manager had a policy for managing poor performance with the support of the GP partners. We did not see evidence of its use but the practice manager spoke about the process with us. It involved a constructive and supportive process for the member of staff concerned with opportunities for them to demonstrate improvements. Further appropriate action could be taken if the member of staff did not improve.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. This included managing communication with specialist hospital services, out-of-hours GP services and the 111 service to ensure that patient's needs were met in a timely way. For example by requesting tests and investigations or managing test results and actions required following the assessment of the patient's needs.

It was practice policy to read and act on any issues arising from communications with other care providers on the day they were received. The GP reviewed all the correspondence received from the out of hours GP service and received electronic test results they had requested for their patients. Arrangements were in place for a GP to cover when colleagues were unavailable so that delays in acting upon results did not occur. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The local district nursing and health visiting teams were based within the same building and this meant there was a good opportunity for face to face discussions about complex case needs which promoted better communication and positive relationships. The practice held weekly team meetings one day a week and these community based staff were invited to attend if there was a specific patient issue to share and discuss such as concerns about a child.

The practice employed a community matron and had developed a register of patients who were at risk of unplanned admissions. There were over 200 patients on this list and the practice had developed a care plan for each patient with the support of community health and care staff to ensure that effective person centred support could be provided.

The practice held monthly multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or the frail elderly. These meetings were attended by district nurses,

Good

Are services effective?

(for example, treatment is effective)

social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and was a useful way to share important information.

All emergency admissions and A&E attendances were reviewed at practice meetings to prevent further episodes if possible.

Information sharing

The practice had recently changed their clinical computer system to SystmOne. They told us this had (with the consent of patients) helped to improve information sharing between agencies such as the local GP out of hours provider and the district nursing team.

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

Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. Staff had also received mandatory training in the safe management of information.

Consent to care and treatment

We found that staff had received training in the Mental Capacity Act 2005 and were aware of their duties in fulfilling it. Staff we spoke with understood the key parts of the legislation and were able to describe how this should be implemented in their practice. Staff were aware that patients should be supported to make their own decisions and this should be documented in the medical notes. Staff gave examples of how a patient's best interests were taken into account when a patient's capacity to make a decision was impaired. (For example for some patients with a learning disability or dementia)

Staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was obtained and scanned into the electronic patient record along with the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way.

Clinical staff used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers and monitoring patients for signs of depression, dementia or carers fatigue. The practice also managed their registers of patients with a learning disability and with palliative care needs very well. This enabled them to build a relationship with the patient and families so that appropriate support and lifestyle advice could also be provided to them.

We noted the practice followed up patients with conditions such as Coeliac disease, gestational diabetes (occurs during pregnancy) or pre- diabetes symptoms although they received no funding to do so.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice's performance for cervical smear uptake was better than others in the CCG area.

The practice offered a full range of immunisations for children and travel vaccines in line with current national guidance. Last year's performance for immunisations was mostly comparable to overall performance for the CCG. The practice had completed a recent flu vaccination campaign achieving 600 vaccinations during a dedicated clinic.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice that contained feedback from patients at the practice. This included six comments from the NHS Choices website between February and October 2014. There were mixed comments about patient's experience and no clear themes or issues were identified. Other information included data from the national patient survey 2013. The evidence from this source showed that patients were satisfied they were treated with compassion, dignity and respect. The practice were rated comparably to national average scores.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and the majority contained positive comments about the service. Patients said they felt the practice offered an excellent service, staff were efficient, helpful and caring. They said staff treated them with dignity and respect and always gave time to listen and explain information clearly. Six comments were less positive. Four of these related to the lengthy waiting times to see their preferred GP. We also spoke with 5 patients on the day of our inspection and two patients by telephone after the visit. They were all very happy with the care and treatment they received from the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors remained closed during consultations so that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when holding conversations about patients' treatments so that confidential information could not be overheard. Other precautions such as the location of the switchboard, management of personal data and the layout at the reception desk helped to minimise conversations being overheard by others.

The entrance to the surgery had automatic doors and there was a low level section on the reception desk. These measures ensured people with a disability could access the service with greater independence.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas

Data from the national patient survey showed that patients were satisfied with the way staff listened to their needs, gave them time and involved them in decisions. The practice were rated comparably to national average scores for GP practices across England. The results from the practice's own satisfaction survey in December 2013 showed patients felt their individual needs were considered and they received sufficient explanations about their care and treatment to enable them to be involved in decisions or to provide self-care with confidence.

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

Staff told us that translation services were available for patients who did not have English as a first language although there were low numbers of patients who required this level of support.

Patient/carer support to cope emotionally with care and treatment

The survey undertaken by the practice in December 2013 indicated that patients were positive about the emotional support provided by the practice. Patients rated staff highly for the level of reassurance, consideration and concern they demonstrated towards each patients. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information.

Good

Are services caring?

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We spoke with the community matron who was particularly involved in supporting carers and had an interest in a national carers project. She viewed support to carer's as an integral part of her role in supporting patients and families at the practice. She confirmed that the staff were able to signpost carers to relevant local support groups or facilitate referrals to social service teams so that they were aware of the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, the GP involved in the care and support to the family made contact with them to assess any requirement for on-going support. The matron also saw some families following bereavement when she had been closely involved. Reception kept a record of any recent bereavements so that staff were kept up to date of those patients with bereavement support needs so that calls or contact with them could be handled sensitively. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had a clear understanding of the practice population. They also made efforts to shape services around these needs and considered the best use of their resources to achieve this.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We also heard that the practice worked with a neighbouring practice to share skills, support ideas and consider future service developments to meet local needs. For example consideration of extended hours surgeries to suit the needs of the working population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had an established relationship with the group and were able to demonstrate ways they had worked in partnership to improve the service and communicate with registered patients. For example making contributions to the quarterly practice newsletter, recommending and supporting the installation programme of a cooling system in the waiting area, recommending the appointment of a receptionist to ensure that cover was always available at peak times.

The premises of the practice are owned by Bungay Medical Centre Charitable Trust whose remit is to invest profits into the maintenance of the building so that a high standard of facilities are provided for their patients. Funds and donations are also used to help patients in ways that the NHS cannot. For example provision of specialist equipment or individual transport for patients with serious health issues. The board consists of two GPs and other trustees who are registered patients.

Tackling inequity and promoting equality

The practice had provided equality and diversity training to most of it's staff in 2012. Staff we spoke with confirmed that they had completed this training and had an awareness of equality and diversity issues to ensure fair and equal access to health services.

The premises and services had been adapted to meet the needs of patient with disabilities. For example the reception entrance had automatic doors and the reception desk had been lowered to ensure it was suitable for patients who used a wheelchair. The consultation rooms were situated on the ground and first floor of the building with most services for patients on the ground floor. There was lift access to the first floor if required and sufficient space for turning wheelchairs and scooters in most areas to help maintain patients' independence. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had access to online and telephone translation services if these were required although they had a very small number of patients who had limited English language skills.

There was a small travelling community who used a local address as a base and accessed the same day clinic quite often. Staff provided appointments they required and the clinic nurses had access to a GP if they required advice or a review of patients who were particularly unwell.

Access to the service

The practice is open from 8.00 am until 6.30 pm each day. It also has extended opening hours on Monday mornings from 7.00 am and Thursday evenings until 8.20 pm to accommodate patients who are working. Routine appointments could be booked one working day in advance or up to six weeks ahead. Telephone consultations were also available along with urgent on the day appointments. Patients could choose to book their appointment by phone or through the practice website if they had registered to do so. There was also a same day clinic run by the nurse practitioner.

There were details on the practice website on how to register for online appointment requests and how to access appointments. There were also details on the out of hours arrangements provided by Integrated Care 24 Limited including the contact number. Further advice was given about access to emergency care and advice which included local walk in centres and the NHS 111 service.

Generally appointment times were for 10 minutes although longer appointments were such as those with specific communication difficulties or patients with complex needs. The practice provided a high number of home visits on a daily basis which was due to the rural setting as well

Are services responsive to people's needs?

(for example, to feedback?)

as the high number of elderly patients. They told us they were reviewing their criteria for providing this due to the resource implications this had on GP time. The practice also provided support to local care homes on a specific day each week, by a named GP and to those patients who needed one.

The management team at the practice were very aware of the difficulties that patients experienced in accessing their service and were considering options to make improvements. This included working more closely with a neighbouring practice to offer extended hours and consideration of changing the appointments system to the "doctor first" scheme although this could only be done if the capacity for GP cover was increased through additional recruitment.

We found that patients had mixed views about the appointments system. Patients we spoke with or who completed CQC comments cards said they needed to call early in the morning if they required a same day appointment. Comments received from patients showed that those in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us. We received several comments from patients who said they had to wait some time to see their preferred GP. The waiting time ranged between two and six weeks.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager had designated responsibility for handling complaints in the practice.

We saw that information was available to help patients understand the complaints system. This included information in the practice leaflet, on the website and within a specific leaflet about the complaints process which contained clear information in line with the NHS complaints policy.

When we spoke with patients they were aware of how to raise a complaint. None of the patients we spoke with on the day of the inspection had ever needed to make a complaint about the practice.

We looked at the complaints records and found that 16 had been received since January 2014. In the previous year 37 written or verbal complaints had been received. Records demonstrated that the practice had a framework in place to ensure that issues raised were investigated and any learning points were actioned in a timely way. For example a patients prescription had been faxed through to their chosen dispensary but upon collection, the prescription was not available. As a result, the practice began to keep proof of prescription requests so that errors could be more easily tracked.

Staff also told us about a complaint that also became a significant event when a patient was seen for a minor injury and did not receive the correct treatment. This resulted in the introduction of enhanced guidelines about the clinical assessment of minor injuries.

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 business and succession plan in place that focused on ensuring the delivery of high quality care and promoting good outcomes for patients. We found the practice were refining their vision for the service in discussion with all staff groups. This was to ensure they could continue to provide a service that used resources wisely and responded to the needs of the local population.

We spoke with twelve members of staff who knew what their responsibilities were in relation to supporting practice values and were aware of the challenges faced by the practice in terms of delivering a responsive service.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. The policies and procedures had been reviewed regularly and were up to date. Staff we spoke with told us they referred to their protocols in everyday practice and they were particularly helpful to support new staff who were learning their role.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a reception team manager, a lead nurse for infection control and a GP lead for safeguarding. We spoke with twelve members of staff and they were all clear about their own roles and responsibilities. They could name their line manager, told us they felt valued and supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards with some areas scoring above average (learning disabilities register and management of palliative care patients). The QOF performance data was discussed at team meetings with staff so that improvements could be made or maintained where possible.

The practice had conducted several reviews of activities or services they provided such as the insertion of intra-uterine devices (IUD Contraception) and the management of patients with atrial fibrillation (rapid, irregular heart rhythm). These required further development to become an on-going programme of clinical audits which could be used to monitor quality and identify actions to further improve outcomes for patients.

One clinical audit had been completed in March 2014. This measured the management of patients with Chronic Obstructive Pulmonary Disease against best practice standards. However, it had not been reviewed to complete the audit cycle and maximise opportunities for shared learning.

The practice had arrangements for identifying, recording and managing risks and were able to show us examples of risk management they had in place. Examples included managing the environmental risks associated with providing minor surgical procedures. We saw that risks were discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

We saw from minutes that team meetings were held weekly and departmental meetings were held on a monthly basis. For example, reception team and the nursing team. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to ask questions or raise issues.

We also noted that management meetings were held regularly. These consisted of quarterly meetings for heads of department, weekly meetings for the executive management team (where quality/governance issues were raised) There were also monthly board meetings.

The practice manager was responsible for human resource policies and procedures. The policies we reviewed demonstrated these were fit for purpose and readily available for staff when required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey and a comments box located in the waiting area. We looked at the results of the last annual patient survey in December 2013. An action plan was agreed following discussion with the patient participation group and this was included in the practice newsletter in Spring 2014. One of the issues raised was difficulties patients experienced in getting an appointment of their choice. The practice responded by detailing the actions

Are services well-led?

Good

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

that had been taken in the previous year and the possible actions they could take during the next year. This included regular reporting back to the PPG on progress. Other actions taken included training for staff in conflict management, obtaining reading material and inviting children to bring toys to occupy them while in the waiting room.

The practice had an active patient participation group (PPG) that had been established for ten years. We spoke with three of their representatives. We found they had a positive relationship with the practice team and felt able to challenge and support improvements to the service. Examples of actions taken as a result of feedback from the group included the extension to opening hours and discussions with the practice about the appointments system has resulted in closer monitoring of the appointments system and consideration of solutions to make viable improvements.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Conversations with staff showed they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they also had staff meetings where guest speakers attended. We saw evidence that induction programmes were in place for clinical and non-clinical staff.

The practice was a GP training practice and took up to two GP trainees at a time as well as a doctor in the foundation year programme. Medical students also attended the practice to receive sessions from the GP partners in the training area of the practice.

The practice completed reviews of significant events and complaints and shared these with staff at meetings to ensure the practice improved outcomes for patients. This also included celebrating successful management of incidents for example when a patient collapsed in the practice and the staff managed the incident with a positive outcome.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not always protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the safe keeping and dispensing of medicines.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.