

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	Not sufficient evidence to rate	
Are services safe?	Good	
Are services effective?	Not sufficient evidence to rate	
Are services caring?	Not sufficient evidence to rate	
Are services responsive to people's needs?	Not sufficient evidence to rate	
Are services well-led?	Good	

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Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bungay Medical Practice on 12 February 2018. The surgery was inspected under the previous provider, East Coast Community Healthcare Community Interest Company (ECCH) on 9 May 2017 and rated as requires improvement overall; inadequate for providing safe services, requires improvement for providing well led services and good for providing effective, caring and responsive services. The practice was given requirement notices for regulation 12 (safe care and treatment) and regulation 17 (good governance). This inspection was to inspect whether sufficient changes had been made in response to those regulations. The current provider, Dr Castle and Partners, became the provider with the support of the Clinical Commissioning Group on 1 January 2018.

We have inspected, but not rated some key questions. This is because the service had recently been configured and data available related to the previous provider.

The key questions are rated as:

Are services safe? – good

Are services effective? – not sufficient evidence to rate.

Are services caring? – not sufficient evidence to rate.

Are services responsive? – not sufficient evidence to rate.

Are services well-led? - good

As part of our inspection process, we also look at the quality of care for specific population groups. We have

inspected, but not rated population groups, because we did not have sufficient evidence to rate. This was because the service had recently been reconfigured and the historical data related to the previous provider.

Older People – not sufficient evidence to rate.

People with long-term conditions – not sufficient evidence to rate.

Families, children and young people – not sufficient evidence to rate.

Working age people (including those recently retired and students – not sufficient evidence to rate.

People whose circumstances may make them vulnerable – not sufficient evidence to rate.

People experiencing poor mental health (including people with dementia) - not sufficient evidence to rate.

At this inspection we found:

- The practice had some systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes. However, not all near misses in the dispensary had been recorded. There was an effective and safe system for the management of safety alerts.
- Overall, arrangements for dispensing medicines at the practice kept patients safe. However checks the

Summary of findings

gap between the most recent controlled drugs check and the previous one was four months. The practice had considered some, but not all, risks related to ordering repeat prescriptions over the phone.

- Arrangements were in place to ensure the dispensary was only accessible to authorised staff, however, the arrangements for access were not always reviewed when members of staff left employment at the practice.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines. The new provider was in the process of reviewing these systems and processes to ensure patient outcomes were positive.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- The new provider was aware of the low results for the GP Patient Survey and they had already changed the appointments system to improve access and planned to monitor the outcome of this.
- The new provider had completed an assessment of the risks within the practice. Staff reported that they

felt confident about the changes made and were positive about the future of the practice. The new provider was in the process of updating and changing policies to be specific to them.

- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **should** make improvements are:

- Improve the system for recording controlled drugs checks.
- Improve the system for recording and learning from near misses in the dispensary.
- Fully risk assess ordering repeat prescriptions over the phone.
- Improve the system for the access to the dispensary to ensure it is safe.
- Continue to review and update policies to be specific to the new provider.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

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 practice manager specialist advisor and a second CQC inspector.

Background to Bungay Medical Practice

Bungay Medical Practice provides services to approximately 11,000 patients in a semi-rural area in Suffolk. In January 2018, Dr Castle and Partners, Sole Bay Health Centre became the provider of services for Bungay Medical Practice. Dr Castle and Partners, Sole Bay Health Centre is the provider for two GP practices, including Bungay Medical Practice and employs all staff at the practice.

The practice has seven female GPs. The plan is for one of the partners from Dr Castle and Partners to provide sessions at the practice to support the GPs, but also to improve access for patients to enable them to see a male GP, if required. There is practice manager support from the provider and an assistant practice manager on site. The practice employs two practice nurses, three trainee advanced nurse practitioners and a nurse manager. The practice also employs three health care assistants and a community matron. Other staff includes eight receptionists, four administration staff and four dispensers.

The practice holds a General Medical Services 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 trainees (qualified doctors who are undertaking training to become GPs) and nurse students.

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 hours 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 hours 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.

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which staff were following. The new provider was in the process of reviewing and updating these as they changed processes. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff but required updating to reflect the new provider. However, staff were able to identify who to go to for further guidance and external safeguarding bodies' information was available in all clinical rooms.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. Nurses and GPs were trained to safeguarding level three. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The practice carried out an annual audit and completed highlighted actions. The practice also completed hand hygiene and uniform

audits every three months and had cleaning schedules for the rooms. Sharps bins and curtains were in date and changed regularly. There were systems for safely managing healthcare waste.

- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. This included completing electrical and calibration testing.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. This included integrating teams across the provider's two locations.
- There was an effective induction system for temporary staff tailored to their role. The practice ensured, where possible, that they used GP locums who had worked in the practice previously to improve continuity of care.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety. For example, the new provider had completed a risk assessment when they came in to post and had highlighted risks that required immediate attention. These had been completed.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters we viewed included all of the necessary information.

Are services safe?

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines. Patients spoken to also reflected this.
- Patients on high risk medicines, such as methotrexate and warfarin, were closely monitored by the clinicians. We saw a log of all patients on these medicines and the date of the most recent blood tests. Where blood tests were required, the practice would phone the patient and arrange this.
- Overall, arrangements for dispensing medicines at the practice kept patients safe. Prescriptions were signed prior to dispensing by a GP and high risk medicines were only dispensed following clinical checks. All dispensed medicines were second checked prior to being dispensed. The dispensary held a range of standard operating procedures which had been recently reviewed and updated.
- Regular stock checks were undertaken and the fridge temperatures were monitored daily, however the gap between the most recent controlled drugs check and the previous one was four months. Controlled drugs we checked were in date and the correct quantity was present according to the log book.
- Patients had a variety of ways by which they could order repeat prescriptions and this included allowing telephone orders for some patients. The practice had

considered some risks related to this, for example, they had changed the time they responded to these so it was at a quiet time but the system had not been fully risk assessed.

- The practice had raised medicine errors as significant events and took action where appropriate, however, not all near-miss dispensing errors were being recorded to enable the practice to monitor and take further action to prevent errors.
- Arrangements were in place to ensure the dispensary was only accessible by authorised staff, however, the arrangements for access were not always reviewed when members of staff left employment at the practice.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues. This included risk assessments for fire safety, legionella and health and safety. Action plans for these risk assessments had been completed.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.
- The new provider was also aware of risks within the practice and had addressed immediate risks. This included risks identified at the previous inspection and responding to correspondence and medical tests.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. This process had been changed by the new provider. Staff understood their duty to raise concerns and report incidents and near misses and felt confident with the new system. Leaders and managers supported them when they raised concerns.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. The new provider had reviewed all significant events in the past

Are services safe?

year and ensured that appropriate action was implemented and embedded in to practice. For example, alerts were now placed on patients on methotrexate following an event.

- There was a system for receiving and acting on safety alerts. All alerts went to the practice manager and a data clerk. Searches were carried out and tasks were sent to

the GP to action these. There was also a computer system where all searches were run weekly to safety net any patients affected. A log had been set up which identified all alerts and the actions undertaken so that these could be closely monitored. The practice learned from external safety events as well as patient and medicine safety alerts.

Are services effective?

(for example, treatment is effective)

Our findings

We have inspected, but not rated whether services were effective. This is because the service had recently been configured and data available related to the previous provider. This includes data detailed below within this key question.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. Current best guidance was discussed regularly during meetings and supervision sessions.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice prescribed hypnotics in line with local and national averages.
- The practice prescribed antibiotic items, including Cephalosporins, Co-Amoxiclav and Quinolones, above local and national averages. However, the new provider was aware of this and had put plans in place to address this. This included regular meetings, an audit of prescribing antibiotics, discussion of current guidance and education. The management team planned to continually review this as part of the ongoing improvement plan for the practice. The practice were also aware that they had a higher than average elderly patient demographic, and a higher than average number of patients in care homes, but wanted to ensure prescribing for antibiotics was appropriate.
- We saw no evidence of discrimination when making care and treatment decisions in the records we viewed.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication. The practice had 27% of patients aged over 65, which was higher than the national average of 17%.

- The practice employed a community matron to enhance the care for this population group. This role included assessing and visiting patients for acute home visits, dementia reviews, a review of patients that had fallen and patients discharged from accident and emergency.
- The practice followed up on older patients discharged from hospital. The reception team rang each patient discharged to offer a home visit. The GP and community matron reviewed all hospital discharges to ensure that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training in areas such as diabetes and respiratory issues.
- 97% of patients deemed to be 'at risk' with a long term conditions had received the flu vaccine since April 2017.
- The practice was not an outlier for nationally reported data relating to long-term conditions including diabetes, asthma, COPD, hypertension and atrial fibrillation data.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- The practice had systems in place to monitor patients after they had given birth for diabetes if they had gestational diabetes.
- The nurses were trained in sexual health and there was a system to offer on the day appointments for emergency contraception.

Are services effective?

(for example, treatment is effective)

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

- The practice's uptake for cervical screening was 90%, which was above the 80% coverage target for the national screening programme.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- 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 had 58 patients registered with a learning disability. 43 of these patients had been offered an annual review. Since April 2017, 20 patients had received a review. The new provider was aware of this and had an action plan to improve it.
- All nurses had been trained in learning disabilities.
- Since September 2017, 55% of patients at the end of life had passed away in their preferred place of care, which is above the national average of 39%. The practice had achieved this through regular MDT meetings, advanced care planning and prescribing of anticipatory medicines that may be required at the end of life.

People experiencing poor mental health (including people with dementia):

- 87% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the CCG average of 80% and above the national average of 83%.
- 64% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the CCG average of 89% and below the national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of

patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 76%, compared to the CCG average of 87% and national average of 90%.

- The new provider was aware of this data and had a plan to improve it.

Monitoring care and treatment

The most recent published Quality Outcome Framework (QOF) results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 81% and national average of 96%. The overall exception reporting rate was 9% compared with the CCG average of 13% and the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.) This data was from 2016/17 and related to the previous provider. The new provider was aware of the results and had an action plan to improve them.

- Performance for diabetes related indicators was 91%; this was above the CCG average of 77% and comparable to the national average of 90%. Unverified data from 2017/18 showed exception reporting was 10% compared to the CCG average of 14% and national average of 11%. The prevalence of diabetes was 8% which was above the CCG and national average of 7%.
- Performance for mental health related indicators was 82%. This was above the CCG average of 76% and below the national average of 94%. Unverified data from 2017/18 showed exception reporting was 13%, which was comparable to the CCG average of 14% and the national average of 11%. The prevalence of patients with recorded mental health conditions in the practice was 1%, which was equal to the CCG and national averages.
- Performance for dementia related indicators was 100%, which was above the CCG average of 82% and above the national average of 97%. Unverified data from 2017/18 showed exception reporting was 10%, which was lower than the CCG average of 12% and equal to the national average of 10%. The prevalence of dementia was 2% which was above the CCG and national averages of 1%.

Are services effective?

(for example, treatment is effective)

- The performance for depression was 100%. This was above the CCG average of 76% and above the national average of 93%. The prevalence of patients recorded as having depression was 9%, which was the same as the CCG and national averages. Unverified data from 2017/18 showed exception reporting rate was 0.1%, which was lower than the CCG average of 26% and the national average of 23%.

The practice used information about care and treatment to make improvements. The practice was actively involved in quality improvement activity and had completed 20 audits during the period between 2015/17. 15 of these were two cycle audits, where improvements made had been monitored.

- For example, the practice had completed a two cycle audit on patients on aspirin for Stroke prevention. The focus of this audit was to ensure that the practice were following current best guidance that states aspirin is no longer an effective preventative medicine. The original audit showed 22 patients were on this medicine. On re-audit, this had reduced to three patients, all of whom were due for review by a GP.
- The new provider was currently reviewing the audit cycles. They were running an audit on antibiotic prescribing, with the overall aim to reduce this. The plan was also to run audits on accident and emergency attendances and referral rates.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, the new provider was supporting two practice nurses to become nurse practitioners.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation. The induction process for

healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.

- The nursing team had a lead GP for support and were given an hour of clinical supervision per week. Staff spoken to reported this was worthwhile and helpful. The team had also been encouraged by the new provider to attend morning coffee breaks. This was built in to the rota and designed to boost staff morale and to discuss patients, guidance and any other issues within the practice. Staff we spoke to were very positive about this addition.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment. This included the local dementia intensive support team, district nurses, health visitors and midwives.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice ensured that all patients discharged from hospital were phoned and offered support. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- 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. The practice worked closely with the local nursing and residential homes to ensure advanced care planning was documented. Since September 2017, 55% of patients at the end of life had passed away in their preferred place of care.

Are services effective?

(for example, treatment is effective)

- The practice held regular multi-disciplinary case review meetings where patients on the palliative care register were discussed.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- The practice had achieved 96% for patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. This was comparable to the CCG and national averages of 94%. The exception reporting rate was 42%, which was above the CCG average of 29% and above the national average of 25%. Unverified data from 2017/18 showed this had reduced to 0% on the day of inspection.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.

- Staff discussed changes to care or treatment with patients and their carers as necessary. The practice also completed carers fatigue assessments and referred carers, with consent, to social services for a carer assessment.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Are services caring?

Our findings

We have inspected, but not rated whether services were caring. This is because the service had recently been configured and data available related to the previous provider. This includes data detailed below within this key question.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- 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.
- The two patient Care Quality Commission comment cards we received were positive about the service experienced.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 215 surveys were sent out and 126 were returned. This represented a 59% completion rate. The practice was generally in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. This survey was carried out prior to the new provider taking over the practice. For example:

- 91% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 89% of patients who responded said the GP gave them enough time compared with the CCG average of 88% and the national average of 86%.
- 98% of patients who responded said they had confidence and trust in the last GP they saw compared with the CCG average of 96% and national average of 95%.

- 89% of patients who responded said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 87% and the national average of 86%.
- 93% of patients who responded said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 95% of patients who responded said the nurse gave them enough time compared with the CCG average of 94% and the national average of 91%.
- 100% of patients who responded 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%.
- 91% of patients who responded said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 92% and the national average of 91%.
- 76% of patients who responded said they found the receptionists at the practice helpful compared with the CCG average of 88% and national average of 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice pro-actively offered transport services for vulnerable patients and those receiving chemotherapy

Are services caring?

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 proactively identified patients who were carers. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 212 patients as carers (approximately 2% of the practice list).

- The practice had worked hard to increase the number of identified carers in order to offer support. The practice offered a carers leaflet, referral to appropriate services, a 'carers fatigue' assessment and a carer health check. Since April 2017, the practice had offered 209 health checks. 89 had not replied, 8 had declined and 48 health checks had been carried out.
- Staff told us that if families had experienced bereavement, their usual GP contacted them. 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.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages:

- 90% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 89% and the national average of 86%.
- 80% of patients who responded said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 85% and the national average of 82%.
- 94% of patients who responded said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 90% of patients who responded said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Patients could be seen by clinicians of the same sex, where required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We have inspected, but not rated whether services were responsive. This is because the service had recently been configured and data available related to the previous provider. This includes data detailed below within this key question.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example, extended hours appointments were available between 7am and 8am on Mondays and between 6.50pm and 8.20pm on Thursdays.
- The practice improved services where possible in response to unmet needs. For example, the new provider was in the process of assessing the processes and systems within the practice to improve and enhance them. There was a plan in place to address any weaknesses identified.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, the new appointments system allowed for a greater number of appointments and improved use of the skill set within the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services, including district nurses and the palliative care team.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme. The practice also employed a community matron to support this patient group.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.
- The practice carried out weekly rounds at local care homes and daily rounds at the local rehabilitation unit, with weekly multidisciplinary team meetings.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. Administration staff would ensure that appropriate blood tests were carried out prior to these appointments to ensure information was available for the nurse on the day.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice also enabled the local specialist diabetes nurse to visit the practice once per week to enhance the care of patients with complex diabetes.

Families, children and young people:

- We found 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. Records we looked at confirmed this. The practice phoned the parents or guardians of any child that had not attended a hospital or practice appointment.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- All new mothers were phoned six weeks after giving birth to offer support, appointments and to book a post-natal check and baby immunisations.
- The practice held regular meetings with the midwives and had contact with the health visitors.

Are services responsive to people's needs?

(for example, to feedback?)

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

- 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 Monday mornings and Thursday evenings.
- The practice had reviewed access and added telephone consultations which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had worked with the local traveller population and the patients used the practice has an address base.
- The practice offered double length appointments for patients with a learning disability.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. The practice had good liaison with the local dementia intensive support team and regularly referred patients to them for enhanced support.
- The practice completed regular dementia screening and depression screening for patients with long term conditions.
- Patients with poor mental health that failed to attend annual reviews were phoned by the practice to discuss why they did not attend.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment. The new provider had reviewed the system for responding to test results and correspondence and had changed this to ensure they were viewed within 24 hours of receipt.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system had been changed to include telephone appointments and an 'on the day' team which increased the number of appointments available.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to or below local and national averages. 215 surveys were sent out and 126 were returned. This represented a 59% completion rate. This survey was carried out prior to the new provider taking over the practice and patients told us that access was improving.

- 81% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 73% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 77% and the national average of 71%.
- 81% of patients who responded 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 88% and the national average of 84%.
- 78% of patients who responded said their last appointment was convenient compared with the CCG average of 84% and the national average of 81%.
- 66% of patients who responded described their experience of making an appointment as good compared with the CCG average of 75% and the national average of 73%.
- 49% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 58% and the national average of 58%.

Are services responsive to people's needs?

(for example, to feedback?)

- 28% of patients who responded said they usually got to see or speak to their preferred GP compared with the CCG average of 66% and the national average of 56%.
- 79% of patients who responded said they would recommend the surgery to someone new to the area compared with the CCG average of 82% and the national average of 77%.

Since the new provider came in to place on 1 January 2018, the appointments system had been changed. This allowed for telephone appointments and there was implementation of an 'on the day team' which was triaged by the nurses and a duty GP. This increased the number of appointments available. Patients spoken to were pleased with the change to the system. The provider planned to conduct their own survey to assess the impact of these changes.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 30 complaints were received in the last year. Five had been received since the new provider took over on 1 January 2018. We reviewed all five complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a staff member had completed a customer care course to enhance their skills after a complaint had been made regarding staff attitude.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Dr Castle and Partners had made progress in improving services to patients in the short period of time since they became the provider on 1 January 2018. They were aware of the risks to patients and had prioritised and addressed some of these already. Practice staff we spoke with told us that improvements had been made and they felt positive about the future of the practice since Dr Castle and Partners had become the provider.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Staff told us that the leadership at the practice had improved and felt it would continue to improve. Leadership and clinical support was in place from Dr Castle and Partners to develop the practice. Dr Castle and Partners were keen to integrate staff from both practices they were the provider for so that improvements could be made to team working.
- There was a practice plan which identified the risk areas, issues and actions to address these. Outcomes were identified and actions and progress was monitored.
- The strategy was in line with health and social priorities across the region.

Vision and strategy

Dr Castle and Partners had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. They were establishing new, and improving existing systems in place at Bungay Medical Practice to enable this for the patients registered at the practice.

- The practice values were shared at meetings held with the new staff team before they became the provider. Staff we spoke with had awareness of the values.

- The vision included; providing a modern, accessible, caring and flexible service, providing individualised evidence based care, providing a multi-skilled approach and ensuring a culture of happy healthy staff.
- There was a practice action plan which identified the risk areas, issues and actions to address these. Outcomes were identified and actions and progress was monitored.
- The new provider's strategy was in line with health and social priorities across the region.

Culture

There was willingness for staff to improve the services provided at the practice. Staff we spoke with were positive about the changes that had occurred and those that were planned.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice and reported the new provider had been supportive and engaging with the process of change.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- Dr Castle and Partners was in the process of establishing systems to identify and monitor that staff had received training and support appropriate to their role. Staff had received support and felt involved in the new processes.
- All staff were considered valued members of the practice team. Clinical staff were given protected time for professional development and evaluation of their clinical work.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and

Are services well-led?

Good 

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

management. However, the new provider had not implemented policies specific to them. They were in the process of reviewing systems and processes and planned to update them as they were reviewed.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The practice followed current policies which supported good processes. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control. Staff were able to clearly identify the leads in these roles.
- Dr Castle and Partners were aware of high antibiotic prescribing and outliers for the Quality and Outcomes Framework for mental health indicators. There were plans in place to address these. Some systems within the dispensary required further review. For example, patients ordering repeat prescriptions over the phone was not fully risk assessed, and the checking of controlled drugs stock was not undertaken frequently, although all controlled drugs were accounted for when we checked.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective process to identify, understand, monitor and address current and future risks including risks to patient safety. A number of risks had been identified and rectified by the new provider. This included the process for the management of correspondence and test results.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of safety alerts, incidents, and complaints.
- A number of clinical audits had been completed and others had been identified. The new provider was

currently reviewing the audit cycles. They were running an audit on antibiotic prescribing, with the overall aim to reduce this. The plan was also to run audits on accident and emergency attendances and referral rates.

- The practice had plans in place and had trained staff for major incidents.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. However, the practice performance for mental health indicators was below local and national averages.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were effective arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture through the process of Dr Castle and Partners becoming the new provider for the practice.
- There was an active patient participation group. The group had met with the registered manager for Dr Castle and Partners twice. We spoke with a member of this group who reported the new provider had been open

Are services well-led?

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about the changes and had encouraged regular meetings. The provider planned to work closely with this group to implement changes to practice that had been identified in the group. In the short time since taking over, the provider had a plan to change the practice website, which had been suggested by the group.

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. The new provider was keen to upskill staff within the practice and was undertaking a review of all the roles within the practice before deciding jointly with staff what training was required.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.