The Birches Medical Centre

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this practice on 04 March 2015 as part of our new comprehensive inspection programme.

The Birches Medical Centre is located in a purpose built building and serves a population of approximately 8100 patients.

The overall rating for this practice is good. We found the practice was good in the safe, caring and well led domains as well as in the effective and responsive domains. We found the practice provided good care to older patients, patients in vulnerable circumstances, families, children and young patients, working age patients, patients experiencing poor mental health and outstanding care to patients with long term conditions.

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice was aware of its patient population and tailored its services accordingly.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a vision and strategy for the delivery of high quality care and staff were working towards it.
- 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.

We saw three areas of outstanding practice:

Summary of findings

- The practice provided specialist nursing in MacMillan Cancer Survivorship care to patients suffering with cancer. This care focusses on patients living with or beyond cancer.
- The practice provided specialist diabetic nursing which allowed the practice to provide diabetic patients with a care provision normally encountered in secondary care. The practice had the ability to initiate insulin treatment and provide support through the initial process related to this intervention.
- The practice provided regular information evenings where different external speakers would educate patients on specialist health related topics.

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

Importantly the provider should:

- Undertake a fire safety risk assessment and ensure staff are trained in fire evacuation procedures.
- Identify those staff required to be vaccinated against Hepatitis B and risk assess the roles where it is not required.
- Ensure all staff receive performance appraisals.
- Review the appointment system in light of patient feedback so that it meets their needs

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Arrangements were in place to manage emergencies. Staff understood their responsibilities to raise any concerns about patients who may be at risk. Staffing levels were appropriately managed and maintained.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average in most cases for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. Staff members specialised in different clinical areas providing a variety of specialist care. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice well for several aspects of care. Patients we spoke with and those who had taken part in surveys said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information was available at the practice that helped patients understand their condition and the services that were available to them externally. Staff treated patients with kindness and compassion and treated information about them confidentially. Patients with caring responsibilities were supported.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They were aware of their practice population and tailored their services accordingly. Telephone consultations and home visits were available when necessary. The premises were suitable for patients who were disabled or with limited mobility. A prescription service was available for those patients unable to attend the practice. Feedback from patients indicated that they were able to obtain appointments and that they would be seen the same day for urgent healthcare needs, although it was difficult for patients to make

Summary of findings

advance appointments. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and strategy for the delivery of high quality care and staff were working towards it. There was a leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular team meetings. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions and attended staff meetings and events. An ethos of learning and improvement was present amongst all staff. Staff appraisals were not completed in all cases.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice mostly had good outcomes for conditions commonly found amongst older people. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example in diabetes care and MacMillan Cancer Survivorship. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, home visits were available. The practice offered nurse led clinic appointments or home visits for a number of long term conditions, including cancer and diabetes. All patients with long term conditions had structured reviews, to check their health and medication needs were being met. For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives. Immunisation rates were relatively high for all standard childhood immunisations. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

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

students, had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had experimented with different appointment systems to improve access. This was due to be further discussed at the partners meetings to see how the needs of this population could continue to be met effectively.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the clinical commissioning group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability. There was no formal process for following up patients who did not attend. The practice tended to see patients who were from the travelling community on an opportunistic basis, when they visited the practice. There were arrangements for supporting patients whose first language was not English.The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. Staff we spoke with were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in-and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). Nationally reported data showed the practice had below average outcomes for people with mental health needs, but performed above average for those with dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had in place advance care planning for patients with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and external organisations.

Summary of findings

What people who use the service say

We gathered the views of patients who used The Birches Medical Centre by looking at the 14 CQC comment cards that patients had completed and we spoke in person with six patients and family members. The responses from patients were mostly positive with patients reporting that staff at the practice were kind, caring and helpful. Patients told us they felt listened to and that they were happy with the care and treatment they received.

Feedback received from patients confirmed that they could see a doctor on the same day and were confident they would be seen if their needs were urgent.

However comments on four CQC comment cards received raised concerns regarding access to advanced appointments. This was reflected in our conversations with patients during the inspection. We discussed this with the GPs and management team and we found there was continued monitoring of the patients appointment system to ensure the system was accessible and responsive to patient needs.

We spoke with four members of the patient participation group (PPG) on the day of the inspection. PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They told us that the practice had listened to their feedback about the appointment system and made changes to improve it. This had improved access to the GPs and nurses at the practice and it was being continually reviewed.

We reviewed the results from the GP Patient Survey run by Ipsos MORI on behalf of NHS England for 2014. Over 70% of patients who completed the survey found the reception staff helpful, 91% reported they had confidence and trust in the last nurse they saw and 89% in the last GP they saw.

Areas for improvement

Action the service SHOULD take to improve

- Undertake a fire safety risk assessment and ensure staff are trained in fire evacuation procedures.
- Identify those staff required to be vaccinated against Hepatitis B and risk assess the roles where it is not required.
- Ensure all staff receive performance appraisals.
- Review the appointment system in light of patient feedback so that it meets their needs

Outstanding practice

- The practice provided specialist nursing in MacMillan Cancer Survivorship care to patients suffering with cancer. This care focusses on patients living with or beyond cancer.
- The practice provided specialist diabetic nursing which allowed the practice to provide diabetic patients with a care provision normally encountered in secondary care. The practice had the ability to initiate insulin treatment and provide support through the initial process related to this intervention.
- The practice, along with the PPG (PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care), provided regular information evenings where different external speakers would educate patients on specialist topics.

The Birches Medical Centre

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 advisor, a practice manager specialist advisor and a second CQC inspector.

Background to The Birches Medical Centre

The Birches Medical Centre, in the Ipswich and East Suffolk clinical commissioning group (CCG) area, provides a range of general medical services to approximately 8100 registered patients living in Kesgrave and the surrounding villages. According to Public Health England information, the patient population has a slightly higher than average number of patients under 18 compared to the practice average across England. It has a slightly higher proportion of patients aged over 65, 75 and 85 compared to the practice average across England. Income deprivation affecting children and older people is significantly lower than the practice average across England.

There are three male GP partners, who hold financial and managerial responsibility for the practice. The practice employs one salaried female GP. There are two practice nurses, two nurse practitioners and three practice technicians. There is also a team of administrative and reception staff. The practice is managed by a practice manager.

The practice provides a range of clinics and services and operates between the hours of 8am and 6.30pm on weekdays. The practice had opted out of providing out of hours services to their own patients which is now provided by another healthcare provider. The practice is a training practice for doctors who were training to be qualified as GPs.

We previously inspected this location on 5 February 2014, as a result of concerns being raised in relation to requirements relating to workers. We found that there were areas for improvement required. We completed a follow up inspection on 23 June 2014 and found that the required improvements had been made.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

- 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)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 04 March 2015. During our visit we spoke with a range of staff including GP's, practice nurses, reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The safety alerts were distributed amongst staff if relevant to their role, in either paper or electronic form. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records and incident reports and minutes of meetings where such issues were discussed for example, the management of a complaint. Complaints were managed effectively.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used accident forms which were available in the practice in paper format. Significant events and incidents were recorded by the clinicians and raised at the weekly clinical meeting where they were discussed. Staff we spoke with told us that the outcomes of these discussions were disseminated across the practice staff by the practice manager face to face or in a practice meeting.

There were records of significant events that had occurred during the last year and we were able to review these. We saw that for significant events that related to clinical care, there was evidence that the practice had learned from these and that the findings were shared with relevant staff.

We also reviewed the minutes of the weekly clinical meeting where significant events had been discussed. There was scope to both improve the process for reporting significant events, so that it was timely, and to improve the investigation and the learning from significant events.

National patient safety alerts were disseminated to practice staff, via a printed copy being kept in a staff folder. We saw that not all recent alerts were included but staff told us that these were disseminated to appropriate staff electronically and verbally as well. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at regular (quarterly) practice meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had a system in place to help ensure that patients were safeguarded against the risk of abuse. We reviewed their safeguarding adults and safeguarding children policies. Contact information for safeguarding professionals external to the practice was available. All the clinical staff had completed training for safeguarding adults and safeguarding children and most of the administrative staff had as well. Staff we spoke with had an understanding of the different types of abuse and how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible and were on display in each of the clinical and consultation rooms.

The practice had a named GP appointed as lead in safeguarding vulnerable adults and children who had been trained to the appropriate level to enable fulfilment of this role. All staff we spoke with were aware who the lead GP for safeguarding was and how to escalate concerns they might have about particular patients. Staff also told us that they could raise any concerns they had about vulnerable adults or children at the weekly clinical meeting, where this would be discussed. We were also provided with examples when clinicians had shared possible concerns directly with other health care professionals in order to agree the best coordinated approach at monthly multidisciplinary team (MDT) meetings. The staff informed us that external services did not always attend, making it difficult for the practice to liaise with these services at times.

A chaperone policy was in place and staff we spoke with confirmed that chaperones were used. (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). We saw that notices were displayed in the waiting room advising patients that this service was available. Staff told us that clinicians acted as chaperones, however one non-clinician told us that they had acted as a chaperone before when nursing staff were not available.

Good

Are services safe?

They had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We discussed this with the provider who advised that only clinical staff were used as chaperones unless unavoidable, this would always be discussed with the patient and the option to rebook an appointment would be given.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear process for ensuring that medicines were kept at the required temperatures and staff we spoke with were aware of this. We saw that the temperature checks recorded the minimum and maximum temperature ranges.

Staff told us processes were in place to check medicines were within their expiry date and suitable for use by means of daily checks. There was no record of these checks available and no register containing an index of all drugs was in use. All the medicines we checked were within their expiry dates.

Expired and unwanted medicines were not always disposed of in line with waste regulations in the past but this had been addressed and new procedures in line with regulations were implemented.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, a management plan was developed together with a local pharmacy on the prescribing of analgesia to a specific patient.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. All members of the nursing staff were qualified as independent prescribers and they received regular internal supervision and support in their roles as well as updates in the specific clinical areas of expertise for which they prescribed.

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, including the cleaning of children's toys in the waiting room. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice showed us evidence of an arrangement that the carpets throughout the premises were due to be cleaned. There was no evidence of previous cleaning records on the carpets or the material chairs in the waiting room but these appeared to be in clean and generally good condition.

All staff received induction training about infection control specific to their role. The practice had a lead nurse for infection control who told us they felt competent to undertake this role. The infection control lead told us that they had undertaken infection control audits and improvements had been made. We looked at the last infection control audit that had been completed in February 2015. We saw evidence that actions had been identified and completed.

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, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Staff informed us they disposed of materials appropriately and cleaned surfaces after clinical interventions.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Notices about hand hygiene techniques were displayed throughout the practice.

The practice had a policy for the management, testing and investigation of legionella (a term for particular bacteria which can contaminate water systems in buildings). There were records that confirmed the practice had sought advice from an external company. Checks were documented and being undertaken to reduce the risk of infection to staff and patients.

During the inspection we found records of staff immunisation against Hepatitis B. We found that this was not being monitored to ensure staff were protected. status had not been kept up to date. There were no risk assessments for practice staff that had not received a Hepatitis B vaccination. We informed the practice of this

who told us that despite staff having received the vaccination in the past the records had not been kept up to date. The practice advised us this would be addressed in the near future.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items required for a variety of clinics, such as the respiratory and diabetes clinic.

Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body.

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

Monitoring safety and responding to risk

The practice did not have effective systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. There was a health and safety risk assessment put in place shortly after our visit but the practice we unable to evidence regular checks of the building and there was no fire risk assessment in place. Health and safety information was displayed for staff to see.

Staff we spoke with were able to identify how they would respond to patients with deteriorating health or medical emergencies. An alarm was also available in the disabled toilet for patients to summon help.

We received feedback from patients who needed to be seen urgently that they were always given an urgent, on the day appointment.

Population group evidence

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example:

- There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.
- There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made. PPG comments supported this.
- Staff gave examples of how they responded to patients experiencing an emergency medical situation, including supporting them to access emergency care and treatment.
- The practice monitored repeat prescribing for people receiving medication for mental ill-health.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we viewed showed that all staff had received up to date training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Staff informed us processes were in place to check whether emergency medicines were within their expiry date. We found that this was being checked on a daily basis and records were being maintained..

All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. Risks identified included, amongst others: loss of computer system, power failure, staff incapacity and loss of utilities. The document also contained relevant contact details for staff to refer to and these were in the process of being updated. We noted that a copy was available off site as per business continuity protocol.

The practice had not carried out a fire risk assessment and there was no evidence of the actions that needed to be taken to maintain fire safety. Records showed that all staff were up to date with fire training. We were told that the practice regularly test the fire alarm although we did not see written evidence of this. We were told that the practice had not undertaken a practice fire evacuation recently.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. 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. A system was in place to disseminate new guidelines to staff . We saw minutes of practice meetings where new guidelines were discussed, the implications for the practice's performance and patients were considered and required actions agreed. 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 in response to any risks identified, and these were reviewed when appropriate.

We were told that patients who had a long term condition had been assessed, their future care had been discussed and a personal care plan had been agreed. Patients who had a long term condition and who had been admitted to hospital were reviewed and plans made to avoid future admission, if this was appropriate.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included scheduling clinical reviews and medicine reviews, recall of patients with long term conditions and those who had been identified by the records as needing to be reviewed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice had a system in place for completing clinical audit cycles. Examples from three clinical audits undertaken included medicines being taken by patients with heart conditions,) and those taking medicines that thinned the blood (aspirin and warfarin). All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example a patients' aspirin prescription was stopped.

The practice also used the information collected for the QOF (a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually) and performance against national screening programmes to monitor outcomes for patients. For example, 89% of patients with diabetes in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80mmHg or less, and the practice exceeded all the minimum standards for QOF in epilepsy/diabetes/asthma/dementia/chronic obstructive pulmonary disease (lung disease) amongst others.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

Good

Are services effective?

(for example, treatment is effective)

The practice provided specialist nursing in "NHS England/ MacMillan National Cancer Survivorship Initiative" care to patients suffering with cancer. This care is in place to ensure that those living with and beyond cancer get the care and support they need to lead as healthy and active a life as possible, for as long as possible. The Initiative's aim is to ensure cancer patients have access to holistic needs assessments, treatment summaries, cancer care reviews and patient education and support events (the 'Recovery Package')

The specialist nurse provided structured home visits to cancer patients and aim to promote physical health and wellbeing.

The practice provided specialist diabetic nursing which allowed the practice to provide diabetic patients with a care provision normally encountered in secondary care. For example, the practice had the ability to initiate insulin treatment and provide support through the initial process related to this intervention. The local hospital diabetes service supported this practice. As there was no second tier service available in the area patients at the practice benefitted from having this service in place.

Effective staffing

We were told that all new staff underwent a period of induction at the practice. We saw the newly developed induction checklist, which covered a range of areas including for example, training, emergency procedures and health and safety.

The practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending training courses such as infection control, fire safety and health and safety. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Practice nurses were all prescribing nurses and had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. This included administration of vaccines. Those with extended roles, which included seeing patients with long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease, were also able to demonstrate they had appropriate training to fulfil these roles. One nurse provided specialist care for cancer patients; maintaining a register and ensuring appropriate care was provided to them at the surgery.

The practice was in the process of developing their appraisal policy and process. Only some of the staff we spoke with had received an appraisal in the preceding 12 months and the records we viewed confirmed this. Most of the staff did have one-to-one meetings over the preceding 12 months. The practice manager was able to evidence progress on holding appraisals, and the scheduling of these, since his commencement at the practice and confirmed all appraisals will be up to date in the coming year.

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

Working with colleagues and other services

The practice had weekly and monthly team meetings, where patients on the palliative care register were discussed and reviewed so all team members of aware of the current care and treatment plan. During this meeting, all patients who had been admitted to hospital over the previous week were reviewed. This included discussion regarding the appropriateness of the admission and how future admissions could be avoided. We were told that patients who may be vulnerable to hospital admission, for example those diagnosed with cancer, were regularly reviewed.

The practice had a palliative care register and had monthly clinical governance meetings to discuss the care and support needs of patients with palliative care needs and their families. Other members of the multi-disciplinary team attended on a less regular basis.

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, x-ray results and letters from the local hospital including discharge summaries, out of hour's providers and the 111 service were received both electronically and by post. The practice had a process in place to ensure these were seen daily and appropriate actions were taken by the GPs. All

Good

Are services effective?

(for example, treatment is effective)

staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries not being followed up appropriately.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice used 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.

We found that information was being shared appropriately between other healthcare providers and the practice in relation to their patients. Hospital discharge letters were brought to the attention of one of the GPs for review, action taken if necessary and the patient's record updated in a timely manner.

Information from Accident and Emergency attendance by patients and 'out of hours' consultations, were sent to the practice and acted upon. This was then reviewed, follow-up action taken if necessary and the details added to the patient record.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (SystmOne) and a risk profiling system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference and to be considered in the patient care process.

Consent to care and treatment

We saw that the practice had a consent policy and consent forms. The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. A nurse practitioner confirmed consent was always obtained from parents prior to treatment being given. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies (these are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The Mental Capacity Act is designed to protect people who cannot make decisions for themselves or lack the mental capacity to do so. The clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All staff were aware of patients who needed support from nominated carers, and clinicians ensured that carers' views were listened to as appropriate.

Patients suffering from poor mental health and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and patients were consulted about their preferences for treatment and decisions and their consent obtained.

Health promotion and prevention

We saw that new patients were invited into the surgery when they registered to find out details of their past medical and family health histories. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner.

The practice offered NHS Health Checks to all its patients aged 40-75 and these were undertaken by a practice nurse. We were told that GPs followed up patients if they had risk factors for disease identified at the health check and that further investigations were scheduled if appropriate.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Clinical staff we spoke with told us about the arrangement in place for following up patients who did not attend for their immunisations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients suffering with cancer and diabetes.

The practice also offered nurse-led smoking cessation clinics to the patients.

Data available to us from NHS England for the year 2013/14 showed that the practice performed above average in its smoking cessation services.

Similar mechanisms of identifying 'at risk' groups were used for patients who were receiving end of life care. This groups was offered further support in line with their needs and received regular home visits and personal consultations from a dedicated clinical member of staff.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We gathered the views of patients who used The Birches Medical Centre by looking at the 14 CQC comment cards that patients had completed and we spoke in person with six patients and family members. The responses from patients were mostly positive with patients reporting that staff at the practice were kind, caring and helpful. Patients told us they felt listened to and that they were happy with the care and treatment they received. However five comments were less positive with concerns raised regarding difficulties in obtaining advanced appointments.

We reviewed the results from the GP Patient Survey run by Ipsos MORI on behalf of NHS England for 2014. Over 70% of patients who completed the survey found the reception staff helpful, 91% reported they had confidence and trust in the last nurse they saw and 89% in the last GP they saw.

We saw that consultation and treatment rooms were closed during consultations and that conversations taking place in these rooms could not be overheard. The practice switchboard was located away from the reception desk which helped to keep patient information private. Phone conversations at the switch board could at times be overheard at the front desk. Staff at the front desk did not discuss any confidential information that could be overheard. Staff were aware of the practices' policies for respecting patients' confidentiality, privacy and dignity. Staff told us that patients who wished to speak privately to a receptionist or if they wished to wait to be seen in a quiet area, they were offered the opportunity to do so.

Care planning and involvement in decisions about care and treatment

There were policies and procedures in place for obtaining patient's consent to care and treatment where patients were able to give this and involving patients in making decisions about their care and treatment. The procedures included information about patients' right to withdraw consent. Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decisions, they were listened to and supported by staff and had sufficient time during consultations to make informed decisions about the choice of treatment they wished to receive.

The practice participated in the admissions avoidance direct enhanced service. Participating practices reviewed the emergency admissions and A&E attendance of patients on their register to understand why these admissions occurred and whether they could have been avoided. The practice had a register of over 300 patients on the admissions avoidance register, each of these patients had a personalised care plan which had been developed collaboratively between the patient and either the practice nurse, when visiting cancer patients, or by the patients named GP. The plans detailed how the patient's on-going health and care needs would be addressed to reduce their risk of avoidable admission to hospital.

GPs and nurses we spoke with had a clear understanding of Gillick competence in relation to the

involvement of children and young people in their care and their capacity to give their own informed consent to treatment. They were knowledgeable about the Mental Capacity Act and the need to consider best interests decisions when a patient lacked the capacity to understand and make decisions about their care. Clinical staff showed us the systems in place for obtaining patients' wishes in respect of their care and treatments such as advanced directives, which outline patients' wishes for their care if approaching the end of their life.

Patient/carer support to cope emotionally with care and treatment

Staff at the practice were pro-active in identifying people with caring responsibilities. Once identified they were offered appropriate support and signposted to external agencies that could help them. Notices in the patient waiting room told carers how they could access a number of different organisations, how to access financial advice and information as to where they could obtain additional equipment and mobility aids if required. A local carers group was also available for them to access.

A system was in place to identify patients who had recently suffered bereavement. They were offered support by the practice staff and referred to external agencies if required. Literature was available to them in the reception area to identify services that were available to them. The practice nurse took steps to identify those patients that may be vulnerable following bereavement or following cancer treatment and arranged to visit the patient and/or family to

Good

Are services caring?

assess their needs and offer advice and support. There were also systems in place to provide home health care reviews for those patients suffering from and surviving cancer treatment.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including vulnerable and homeless people and those with dementia, mental health conditions, learning disabilities or life limiting conditions who were receiving palliative care and treatment. These registers were used to monitor and respond to the changing needs of patients.

Patients could request to see a GP of their choice and this was accommodated on most occasions. Home visits were available for older people, those with long term conditions and those with limited mobility. Telephone consultations took place when appropriate and time was allocated to these each day so all patients received a call back. Although patient appointments were generally of fifteen minutes duration, the practice recognised when these needed to be extended for patients with complex needs. This included making a double appointment available for people with learning disabilities who required a health check or when dealing with multiple issues. Patients we spoke with told us they did not feel rushed during their appointment, that the GPs listened and understood their concerns, explained things to them and gave them the time they needed. Patients over 75 years of age had a named GP to ensure continuity of care for the elderly.

Patients were able to request repeat prescriptions on-line or to attend the practice personally. The practice had a palliative care register and a cancer survivor register for patients who had completed their cancer treatment and had been discharged from their treatment. There were regular internal as well as multidisciplinary meetings to discuss patients, their families and their care and support needs.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The system for recording information received from the out of hours provider and secondary care providers such as the local hospital was managed effectively by the administration team. They ensured that GPs were informed of outcomes for patients accessing those services by the use of task notes and flags on the practice's computerised records system.

Tackling inequity and promoting equality

The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. There were arrangements to enable patients with diverse needs to access the service. Patients who were hard of hearing were able to access the service using a hearing loop. Staff told us that they had access to a specialist language translation service for patients who did not speak English as their first language. Staff were able to give examples of how translation services had been accessed to assist patients..

Access to the service

The practice opened every week day and offered extended appointment times until 8.30pm on Tuesday evenings. Patients could book advance appointments or phone for 'on the day' appointments. The practice monitored patients who repeatedly failed to attend for appointments. Information about the impact this had on other patients was published in the practice quarterly newsletter in order to improve the service to patients.

Information on the appointment times and system was available on the website and on an information board in the waiting room area of the practice. In addition information and advice for patients on how to make the best use of the appointment system was detailed on a patient advice board, in the newsletter and on the website. This included how to arrange appointments and home visits and how to get urgent medical assistance when the practice was closed.

The practice benefited from three advanced nurse practitioners (ANPs) who were qualified and experienced in dealing with a variety of health care needs including minor illness; each ANP was qualified to prescribe medication. The ANPs dealt with daily urgent appointments, but were able to refer patients with more complex needs to the GPs on the day. This ensured GPs were able to prioritise appointments for patients with more complex health needs.

Feedback received from patients confirmed that they could see a doctor on the same day and were confident they

Good

Are services responsive to people's needs?

(for example, to feedback?)

would be seen if their needs were urgent. However comments on four CQC comment cards received, reflected that patients had difficulty in booking appointments in advance. This was reflected in our conversations with patients during the inspection. One patient we spoke with told us they had to wait over two weeks to get a routine appointment. Routine appointments were not always available with GP of choice. We discussed this with the GPs and management team who were aware of the issue. We found there was continued monitoring of the patients appointment system to ensure the system was accessible and responsive to patient needs. For example we spoke with four members of the patient participation group (PPG). PPGs are an effective way for patients and GP surgeries to work together to improve the service and to promote and improve the quality of the care. They described the recent changes made to the embargoed five day advanced appointments in response to patients' comments and concerns. The practice continued to monitor the impact these changes have had on availability. Staff told us everyone who wants to be seen on the day will be seen.

GP appointment times were 15 minutes and staff told us that GPs did not offer longer appointments but that the GP would not rush patients who needed additional time. The receptionist informed us that sometimes patients who required extra time for appointments for individual reasons would, where possible, receive appointments at the end of surgery where there would be more time available

We asked the practice about patient access to medical services when the surgery was shut. We were told that the practice had subscribed to a local out of hours service to answer calls and refer patients. This was also advertised on the practice website.

Listening and learning from concerns and complaints

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

We saw that detailed information was available on the practice website to help patients understand the complaints system. Brief information on making a complaint was also included in the practice leaflet.

All staff were aware of the complaints procedure and were provided with a protocol that helped them support patients and advise them of the procedures to follow.

The policy explained how patients could make a complaint and included the timescales for acknowledgement and completion. The process included an apology when appropriate and whether learning opportunities had been identified. The system included cascading the learning to staff at practice meetings. If a satisfactory outcome could not be achieved, information was provided to patients about other external organisations that could be contacted to escalate any issues.

We saw that complaints recorded in the last 12 months had been dealt with in a timely manner. Minutes of team meetings showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to be recognised as a high performing practice with matching levels of patient satisfaction. The practice vision and values included continually questioning the way in which services were provided to ensure continued improvement of patient care, and to offer best care and personal service along with a range of modern services.

They had an up to date statement of purpose that clearly described their objectives, vision and strategy. Staff spoken with were aware of the direction of the practice and were working towards it.

A statement of the vision was displayed in the entrance to the practice, clearly visible to patients.

Staff job descriptions and appraisals supported the direction in which the practice wished to head and these were clearly linked to the vision and objectives. Staff we spoke with told us they felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were readily available for staff to read. We viewed several of these policies and found that they had been reviewed and read by staff. Policies included information governance, infection control, chaperones and safeguarding.

There was a clear leadership structure within the partners, the practice manager and team leaders such as nursing, reception and office managers. Designated leads included infection control, chronic disease management such as diabetes, cancer, safeguarding and complaint handling. Staff we spoke with were aware of the various leads and knew who to discuss issues with if the need arose.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. This is an annual incentive programme designed to reward good practice. The 2013/14 QOF data for this practice showed it was performing above local and national standards. We saw that QOF data was reviewed each month to ensure that health targets were being achieved. This was discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice held a range of regular meetings including governance meetings. We saw that items for discussion included significant events, complaints and compliments, health and safety and training for example.

Audits, the results of a patient survey and the analysis of significant events were used to improve the quality of services. However the practice did not have a robust programme of audits for monitoring quality and systems to identify where action should be taken. We saw that some risks had been identified, however there were no systematic processes in place for identifying, recording and managing risks, for example around health and safety so that they could be appropriately mitigated against. We discussed this with the GPs and practice manager who confirmed that appropriate systems to monitor health and safety risks would be put in place; we saw evidence immediately following our inspection that these had been implemented.

Leadership, openness and transparency

There was a clear leadership at the practice. One GP told us the new practice manager was working towards a new strategic direction with the partners to ensure staff with the right skill mix and strengths were supported in their role. We found that the practice manager led by example and demonstrated to us that they were aware of all policies and procedures and was driving improvement.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies in place that included the induction policy and job descriptions which were in place to support staff. A staff handbook was available to all staff, which included useful sections to support staff in understanding the procedures to follow and the standards expected of them. However not all staff we spoke with were aware of how to access this.

Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was low turnover of staff.

Are services well-led?

Good

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

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

The practice had a patient participation group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients.

Members of the patient group told us they were able to help inform and shape the management of the practice in relation to patient priorities, any planned practice changes and the outcomes from local and national GP surveys. The practice worked closely with the PPG to provide 'Patient Support and Information Events'. These were open evenings held at the local community centre which provided patients with health education and advice from the practice clinical team and other support organisations. We were told the previous event which focused on dementia had been well attended with opportunity for patients to have informal discussions with the GPs, nurses and other practice staff.

The practice was planning the next event on 'Mental Health and Wellbeing' to coincide with 'Mental Health Awareness' week in May. The practice anticipated participation from a number of support organisations such as Suffolk Carers, Suffolk Wellbeing, Voicability and Children and Family Pathways.

Information about these events were available in the waiting room on a special notice board and were also advertised through various means by the PPG.

The practice gathered feedback from staff through team meetings and the appraisal process. Staff we spoke with told us that they were encouraged to provide feedback and to contribute ideas for improvement. For example the practice held quarterly Saturday morning breakfast meetings for all staff to attend, where breakfast was provided for all the team and staff were invited and encouraged to add items to the agenda for discussion. Staff were able to describe examples of suggestions made that had been put in place by the practice, such as the staff apprentice scheme. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

We found the practice listened and responded in a timely way to formal and informal feedback from patients. They practice were continually looking at means of formally seeking and obtaining patients views

The staff we spoke with described the working environment as caring, supportive and they enjoyed

attending and felt staff were valued. We were told they felt that any suggestions they had for improving the service would be taken seriously and would be listened to. The practice provided both patients and staff with quarterly newsletters which detailed forthcoming changes and suggestions for health care support, for example the latest patient newsletter detailed the monthly Age UK clinics recently available at the practice. The practice had also launched a new website where patients were updated on any changes, for example staff changes. Were updated on practice news and information and were able to request repeat prescriptions, make appointments as well as access questionnaires and information on wider health topics.

Management lead through learning and improvement

We viewed records evidencing that only some of the staff had appraisal processes in place. The practice informed us that a new system of appraisals was being embedded and this was overdue for some staff. The practice told us that this was being addressed. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was generally supportive of training and that they had staff training sessions where guest speakers and trainers attended. Staff files reflected that training had been identified and provided to staff to enable them to meet the needs of the patients.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings and away days to ensure the practice improved outcomes for patients The results of patient surveys and the analysis of significant events were used to improve the quality of services. Where audits had taken place these were part of a cycle of re-audit to ensure that any improvements identified had been maintained.