The Three Spires Medical Practice

Quality Report

Three Spires Medical Practice
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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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Three Spires Medical Practice was inspected on Wednesday 18 March 2015. This was a comprehensive inspection.

Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led care. It was also good for providing services for the six population groups.

Our key findings were as follows:

There was a track record and a culture of promptly responding to incidents, near misses and complaints and using these events to learn and change systems so that patient care could be improved.

Staff were aware of their responsibilities in regard to consent, safeguarding and the Mental Capacity Act 2005 (MCA).

The practice was clean and tidy and there were effective infection control procedures in place.

Medicines were managed well at the practice and there were effective systems in place to deal with emergencies.

The GPs and other clinical staff were knowledgeable about how the decisions they made improved clinical outcomes for patients although patients were not always fully included in their care planning.

Data outcomes for patients were equal or above the average locally.

Patients were complimentary about how their medical conditions were managed.

Practice staff were professional and respectful when providing care and treatment.

The practice planned its services to meet the diversity of its patients. There were good facilities available, adjustments were made to meet the needs of the patients and there was an effective appointment system in place which enabled a good access to the service.

The practice had a vision and clear ethos which were understood by staff. There was a leadership structure in place and staff felt supported.

Summary of findings

We found areas where the provider SHOULD make improvements. The provider should:

- Improve privacy for patients at the reception desk to enable patients to share information with reception staff without other patients overhearing.
- Improve patient involvement in their personalised care plans to demonstrate they had been included in discussions about their care.
- Ensure patients are aware of the chaperone service available before they go into the consulting room.

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.

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained.

Significant events and incidents were responded to in a timely manner and investigated systematically and formally. There was a culture to ensure that learning and actions were communicated following such investigations.

Staff had an awareness of the Mental Capacity Act 2005 (MCA) and of their responsibilities regarding safeguarding adults and children. All staff had received training in safeguarding awareness.

There were arrangements for the efficient management, storage and administration of medicines within the practice.

Staff turnover was low. Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent.

There were clear processes to follow when dealing with emergencies. Staff had received basic life support training and emergency medicines were available in the practice.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The nursing team used clear evidence based guidelines and patient directives when treating patients.

The practice used the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme. Data showed that the practice was performing equally when compared to neighbouring practices in the clinical commissioning group (CCG). Risks to patients were assessed and care was planned and well managed.

Summary of findings

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' capacity to make informed choices about their treatment and the promotion of good health.

Patients with complex care needs and vulnerable patients had their care planned in line with NICE guidelines. Some patients had personalised care plans in place to assess and show how care would be delivered. However, some patients were not always included in these assessments or included in the care plan review.

Audits were performed and completed regarding patient outcomes, which showed a safe, consistent level of care and effective outcomes for patients.

Patients told us staff asked for their consent before any treatment was provided although they were not aware of the chaperone service available.

There was a systematic induction and training programme in place with a culture of further education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. The patients we spoke with on the day, the comment cards we received, a friends and family survey reflected this feedback. Patients described the practice as caring and said they trusted the GPs, who knew them well.

We observed a person centred culture. We found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this.

Accessible information was provided to help patients understand the care available to them.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. However, patients said their privacy was not always protected at the reception desk.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice had identified the needs of their population and provided services to meet their needs. These had included setting

Summary of findings

up a stoma clinic to provide patients with support and guidance. The practice had used facilities in the building and had employed a team of physiotherapists to provide physiotherapy services for patients of the practice and other patients in the area. The practice had also set up a satellite service in a supermarket which was located next to two of the largest employers in the town. The GPs were also running a minor surgery service which included providing a no scalpel vasectomy service on a Friday so patients could recover over the weekend.

We found the practice had a proven track record of learning from and responding in a timely way to patient feedback, complaints, incidents and informal comments.

Patients said they could get an appointment easily in advance or with a GP on the same day.

The practice reviewed and secured service improvements where these were identified. For example, a physiotherapy service with a view to avoiding necessary surgery, a vasectomy service and a satellite surgery held in a local supermarket.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised even if they were comments or concerns. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for being well led.

The practice had a formal ethos and strategy which included putting the patient at the heart of what the practice staff do.

Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure in place and a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk.

There was a culture of wanting to improve and learn following any significant event or complaint. Action and learning was shared with the staff involved. The practice welcomed feedback from patients through the surveys and from the patient participation group (PPG). The PPG said the management team were receptive to suggestions and feedback.

Staff had received induction training, regular performance reviews and attended whole staff meetings and events.

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.

The practice had a system to identify older and vulnerable patients and operated a personal lists so all patients had a named GP for continuity of care. Patients appreciated having their own allocated GP.

Pneumococcal vaccination, flu and shingles vaccinations were provided at the practice for older patients.

The GPs performed home visits for older people and for patients who required a visit following discharge from hospital. The GPs also visited patients in local care homes and nursing homes to provide medical care and treatment and to prevent unnecessary hospital admissions. Each home had a named GP and direct dial telephone number so staff could access care and advice in a timely manner to help avoid inappropriate hospital admissions. All patients in nursing homes had personal care plans (PCP) created in conjunction with the patient, nursing home staff, and where appropriate the patient's relatives.

GPs were alerted to hospital admissions or discharges for patients with a PCP so that the GPs could review the admission/discharge and put in place actions which may avert further admissions.

The practice worked with a community matron, district nursing team and coordinated the multi-disciplinary team (MDT) for the planning and delivery of vulnerable patients and palliative care for people approaching the end of life.

Blister packs for medicines were arranged by the practice for older patients who may have difficulty remembering to take their medicines.

Home visits were available for those patients who were unable to attend the surgery. There was a bus service which dropped patients at the main entrance to the health park. Once in the health park wheelchairs were available for loan to transport patients with mobility issues to the practice reception area.

People with long term conditions

Good

The practice is rated good for the care of people with long term conditions.

The practice identified patients who might be vulnerable, have multiple or specific complex or long term needs, to ensure they were offered consultations or reviews where needed.

Summary of findings

Pneumococcal vaccination and flu and vaccinations were provided at the practice for those patients in an at risk group due to their long term conditions.

The practice had chronic disease nurses who saw patients with diabetes, heart disease, hypertension, asthma, and chronic respiratory conditions. The GPs treated patients with high cholesterol and the pharmaceutical advisor saw patients regarding their stoma care. The nurses attended educational updates to make sure their lead role knowledge and skills were up to date. Practice staff worked with healthcare specialists to gain advice where appropriate.

The practice held clinics for asthma, chronic lung disorders, diabetes, stoma care and vascular disease. For more complex patients the practice offer monthly joint clinic with the local diabetic specialist nurse and offered insulin starts for new Type 1 diabetic patients, avoiding the need to attend hospital.

The practice held multi-disciplinary team meetings to discuss patients on the palliative care register and patients in the community with long term health and social needs.

Patients receiving certain medicines attended for screening services at the practice to make sure the medication they received was effective.

Families, children and young people

Good

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

There were well organised baby and child immunisation programmes available. Primary and pre-school immunisation was well promoted within the practice.

Ante-natal care was provided by a team of midwives who were based in the shared building. They had regular contact with the GPs should the need arise. The practice communicated well with health visitors.

The GPs provided medical care and treatment for two local schools and belonged to an organisation called MOSA (Medical Officer of Schools Association) which is a professional organisation concerned with the provision of medical care to mainly independent schools. The GPs visited the schools on a weekly basis.

Patients had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening for women.

There were toys to occupy children in the waiting area and quiet private areas in the practice for women to use when breastfeeding.

Summary of findings

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Working age people (including those recently retired and students)

Good

The practice were rated good for caring for people of working age, including those recently retired and students.

Advance appointments up to four weeks in advance and early morning (7.30am) appointments were available to assist patients not able to access appointments due to their work commitments. The practice ran a satellite clinic at a supermarket which was situated by two of the biggest employers in the town. This meant that patients could have an appointment closer to their workplace.

There was an online appointment booking system which was accessed through the website. Patients registered to use this service could book appointments with a GP up to one month in advance.

The practice had a virtual patient participation group (PPG) at the practice, which included a number of working age members. These patients used electronic communication to provide feedback to the practice.

Travel advice was available from the nursing staff within the practice and the practice were registered as a yellow fever centre.

Patients who received repeat medicines were able to collect their prescription from the pharmacy attached to the practice or could request for the prescription to be sent to a pharmacy of the patient's choice, which may be convenient to their work place.

Additional services such as smoking cessation, counselling and a vasectomy service were available. The vasectomy service was arranged to minimise the time patients were away from work. The practice offered regular late evening physiotherapy clinics targeting patients who needed to continue to work with a muscular skeletal problem.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable

The practice had a vulnerable patient register and reviewed these patients at the multidisciplinary team meetings or more frequently as needed.

The practice had a small number of patients whose first language was not English. The staff were aware of those patients who needed an interpreter and had access to a translation service.

Summary of findings

Patients with learning disabilities (LD) were offered a health check every year. During this time their long term care plans were discussed with the patient and their carer if appropriate. The practice staff worked with the local disabilities nurse who provided support and guidance. Patients on the practice LD register were discussed at a quarterly multidisciplinary team meeting.

Practice staff worked with a local alcohol service for support and provided detox treatment at home for some patients.

The practice promoted a 'no barriers approach' for patients accessing GP services. Patients with no fixed abode were able to access a 'homeless doctor service' in the town.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health.

A register at the practice identified patients who had mental illness or mental health problems. Patients were reviewed on a yearly basis or sooner if required.

Patients had access to an in house counsellor, were monitored when they had depression and were offered regular medication reviews.

In house mental health medicines reviews were conducted to ensure patients were prescribed and received appropriate doses. Blood tests were regularly performed on patients receiving certain mental health medications.

The practice had signed up to the dementia enhanced service to increase the rates of detection for dementia and worked with the primary care dementia practitioner who was based in the same building. Staff used recognised examination tools used for people who were displaying signs of dementia.

Summary of findings

What people who use the service say

We spoke with 12 patients during our inspection and with a member of the patient participation group.

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 19 comment cards, all of which contained positive comments. There were no negative comments.

Comment cards were detailed and stated that patients appreciated the service provided, the caring attitude of the staff, the building and the staff who took time to listen. There were many comments praising individually named GPs, nurses and the reception team. Comments also highlighted a confidence in the advice and medical knowledge and a feeling of not being rushed.

These findings were reflected during our conversations with the 12 patients we spoke with and the practice's 31 friends and family test results from December 2014 to March 2015 and the practice patient survey from 2014. The feedback from patients was consistently good. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Of the 31 friends and family test results we saw 30 patients said they were extremely likely or likely to recommend the practice. The one other result was neither likely or unlikely.

Patients were happy with the appointment system. We were told patients could either book routine appointments one month in advance or could make an appointment on the day. Parents said they could always make a same day appointment for their children.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Patients said they felt listened to and felt confident the practice would listen and act on complaints.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff respected their privacy, dignity and used gloves and aprons where needed and washed their hands before treatment was provided.

Patients said they found it easy to get repeat prescriptions processed.

Areas for improvement

Action the service SHOULD take to improve

- Improve privacy for patients at the reception desk to enable patients to share information with reception staff without other patients overhearing.
- Improve patient involvement in their personalised care plans to demonstrate they had been included in discussions about their care.
- Ensure patients are aware of the chaperone service available before they go into the consulting room.

The Three Spires 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 also included a GP specialist advisor, a practice manager specialist advisor and an expert by experience. Experts by Experience are people who have experience of using care services.

Background to The Three Spires Medical Practice

Three Spires Medical Practice was inspected on Wednesday 18 March 2015. This was a comprehensive inspection.

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

The practice is situated in the Cornish city of Truro and provides a primary medical service to approximately 14,500 patients of a diverse age group.

There was a team of eight GP partners and three salaried GPs within the organisation. Partners hold managerial and financial responsibility for running the business. There were seven male and four female GPs. The team were supported by a management team, four practice nurses and eight health care assistants. The practice also employs seven physiotherapists and two physiotherapy assistants.

Patients using the practice also had access to community staff including community matron, district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open from Monday to Friday, between the hours of 8.30am and 6.30pm. Early morning appointments from 7.30am were available for people who were unable to access appointments during normal opening times.

The practice had opted out of providing out-of-hours services to their own patients and referred them to another out of hours service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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.

Detailed findings

How we carried out this inspection

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before conducting our announced inspection of Three Spires Medical Practice, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, and the local Cornwall Clinical Commissioning Group.

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 18 March 2015. We spoke with 12 patients, seven GPs, six of the nursing team and members of the management, reception and administration team. We collected 19 patient responses from our comments box which had been displayed in the waiting room. We observed how the practice was run and looked at the facilities and the information available to patients.

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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. These alerts were circulated and discussed weekly when the GPs met, at the quarterly clinical governance meetings and at the quarterly educational days.

Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. Staff also added that there was a supportive environment when they are involved in a significant event.

We reviewed safety records, incident reports and minutes of meetings where incidents and significant events were discussed. Records showed the practice had managed these consistently over time and so could show evidence of a safe track record. A summary of these was kept to monitor trends or patterns which may develop.

Learning and improvement from safety incidents

There was an eagerness to use any incident, accident or event as an opportunity to learn from and improve the service. The practice had a clear systematic process in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during over the year. Significant events were discussed within a maximum of a week of occurrence by the GPs and formally at clinical governance and education meetings to make sure action had been taken and the event re-reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, it had been identified that a specimen had been labelled incorrectly. The patient had been recalled and given an apology. A staff meeting reminded staff to take care.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff were able to give examples of recent alerts.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in the safeguarding policies and on flow charts displayed in treatment rooms.

The practice had an appointed lead GP for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary advanced training to enable them to fulfil this role. Nursing staff were aware of the Mental Capacity Act 2005 (MCA) and were aware of their responsibilities in relation to this.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend for routine appointments the GP could raise a concern for the health visitor to follow up.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children subject to child protection plans and patients with mental health issues.

There was a chaperone policy in place and posters displayed in the GPs consulting rooms. A chaperone is a member of staff or person who acts as a witness for a patient and a medical practitioner during a medical examination or treatment. Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Not all patients were aware of this service.

Medicines management

We checked medicines stored in the practice and found that they were securely stored and were only accessible to authorised staff. Medicines requiring cold storage were stored in medicine refrigerators. We saw that fridge temperatures were being recorded on a daily basis.

Systems were in place to check that stock medicines, emergency medicines and medicines kept in doctors bags

were within their expiry date and suitable for use. Expired medicines were disposed of in line with waste regulations and appropriate equipment was available to dispose of medicines identified as being hazardous.

Vaccines were administered by the nursing team following legal requirements and national guidance which allows administration with individual prescription. These documents include the use of patient group directives (PGDs) which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. For example, flu vaccinations. We saw that the PGDs had been signed by practice staff who were working under the agreement. We saw up-to-date evidence to show that nurses had received appropriate training to administer immunisations and travel vaccines.

We saw evidence that medicines and prescribing patterns were kept under review as a way of improving patient safety and as part of the local clinical commissioning group incentive scheme. The practice used the Cornwall formulary for guidance and regularly reviewed quality of prescribing down to individual prescriber level. Any outliers were discussed at the partner meetings. The practice had performed very well compared to other practices in the clinical commissioning group (CCG) area.

Patients were pleased with the process of obtaining repeat prescriptions.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients told us they always found the practice clean and had no concerns about cleanliness. The practice was cleaned by contracted cleaners employed by the owner of the building. The practice had systems in place to monitor the quality of the cleaning and had also introduced clinical cleaning schedules for clinical areas. This was monitored by the lead nurse.

There were schedules in place to change and launder the fabric curtains in the consulting and treatment rooms.

Patients said that staff washed their hands before performing any examination or treatment. The practice had performed a hand washing audit at the beginning of March 2015 to ask patients whether they had seen staff wash their hands before providing treatment. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Staff had received infection control training and were aware of who the lead nurse for infection control was.

The lead infection control nurse had performed regular two to three monthly infection control audits. The last three audits had highlighted the need for clinical cleaning schedules to be introduced and changes in the storage of some COSHH (Control of substances hazardous to health) products. These changes had been implemented.

There were flowcharts and a policy for dealing safely with a needle stick injury.

Equipment

Staff told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. Calibration of equipment had taken place. All portable electrical equipment was routinely tested with labels demonstrating the date this had been done.

Liquid nitrogen was used at the practice for certain treatments. This was appropriately stored and handled using protective equipment. Risk assessments were in place for the management and storage of this.

Staffing and recruitment

Some members of staff had been in post for many years and said the morale was high and that Three Spires Medical Practice was a supportive place to work. The practice had a recruitment policy that set out the standards it followed when recruiting staff. Recruitment records contained clear and well structured evidence to show that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, health assessment, and registration with the appropriate professional body.

Disclosure and Barring Service checks (DBS) had been performed for the GPs, nursing staff and administration staff who worked on a one to one basis with patients. The practice had a risk assessment in place to explain why administration staff had not had a DBS check performed.

Good

Are services safe?

Staff told us about the arrangement in place to cover each other's annual leave and explained the practice had a bank of staff who would fill staffing gaps. The GPs had a system to ensure test results were checked by other GPs in the absence of an individual GP.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice did not own the building but had their own risk assessments and policy which focused on all areas of the building including areas shared with the neighbouring GP practice. For example the minor surgery suite and physiotherapy suite. There were records of all servicing contracts. These included water safety, electrical equipment, gas safety, legionella, boiler safety and fire systems.

Staff knew about how to safely dispose of general clinical waste and all staff knew how to respond in the event of a fire.

A clear system was in place to report any defects or physical issues with the premises to the owner.

There was a business continuity plan in place which explained what action was necessary in the event of incidents including major incidents, loss of power or outbreak of epidemic or pandemic. CQC were listed as an organisation who would need to be contacted.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available on each floor where care and treatment was provided. The equipment was within easy access and included access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that the emergency equipment was checked regularly by a nominated member of staff.

Emergency medicines were available at the practice and were stored centrally for easy access. The medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

Processes were in place to check whether emergency medicines and equipment were within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use.

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 and patients said suggested treatments were explained in detail to them. GPs were familiar with current best practice guidance, and knew where to access guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New NICE guidelines were shared during the educational days held at the practice and communicated by the staff email system.

Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that their actions were designed to ensure that each patient received support to achieve the best health outcome for them. The GPs and nurses used personalised care plans for patients with complex care needs or for vulnerable patients. Staff completed assessments of patients' needs in line with NICE guidelines, and reviewed the care plans when appropriate. However, some patients were not always included in these assessments or included in the personalised care plan review

The practice nurses and GPs led in specialist clinical areas such as diabetes, heart disease and asthma and were open about asking for advice and support from each other, health care specialists, other GPs, nurse specialists and pharmacists when needed. The nursing team had experience in managing long term conditions and supported the GPs well. The practice had worked with the local diabetic specialist nurse to hold joint clinics to discuss patients with complex diabetes. The nursing staff were also able to support, teach and start patients on insulin which saved them from having to attend the acute hospital.

The practice provided evidence to show patients with long term conditions were offered reviews annually or more frequently as required. Nursing staff combined some reviews for patients who had long term conditions which overlapped.

The practice used computerised tools to identify patients with complex needs or who had multidisciplinary care plans agreed. We were shown the process the practice used to review patients who had been discharged from hospital.

National data and practice computer systems showed that the practice was in line with referral rates to hospital and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were prioritised and made.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts, significant events, complaints management and medicines management. Learning from these systems was used to review patient outcomes achieved and areas to see if patient outcomes could be improved. For example, an audit of patients who had received minor surgery was performed to confirm that infection and complication rates were low and that histology results had been received in a timely way.

Audits were also performed on non-clinical areas. For example, an audit of how easy it was for patients to make an appointment. Of the 22 patients checked, 20 said it was very easy to make an appointment.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We looked at current data and saw that the practice were performing equally or slightly higher in all areas.

There was a protocol for repeat prescribing which was in line with national guidance. The practice were the second highest achievers in the CCG area for achieving efficient and effective prescribing targets. In accordance with the protocol, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. Patients said they were sent reminders on the prescription or by letter regarding these checks and thought the system worked well. The IT system flagged up relevant medicines alerts when the GP or nurse prescriber was prescribing medicines.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support and safeguarding training. There was a culture of development at the practice and all staff said they had access to the training they needed to fulfil their roles.

GPs told us they were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

Nursing staff and administration staff had received annual appraisals that identified learning needs from which action plans were developed. Staff confirmed that the practice was proactive in providing training and funding for relevant courses. The management team received informal and formal support from the GPs and each other.

The practice nurses and health care assistants were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, they showed evidence of their training in administration of vaccines, cervical cytology and travel advice. The lead nurse had an extended role in non-medical prescribing and demonstrated that they had appropriate training to fulfil this role.

The practice was a training practice for doctors who were training to qualify as GPs, doctors working to consolidate their medical training and for medical students. These doctors were offered extended appointments and had access to a GP throughout the day for support. We received positive feedback about the induction, support and management of the practice from the trainees we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, out-of-hours GP services and the out of hours service both electronically, by fax and by post. The management team provided a clear policy on managing these results. All staff we spoke with understood their roles and felt the system in place to communicate blood test results and hospital discharges worked well.

The multidisciplinary team could speak with the GPs when required. The district nurses, community matron, dementia care nurse and midwives were based in the same building as the practice and could discuss patients with the GP by telephone or in person. Practice staff said communication between healthcare professionals and the practice was good.

The practice held multidisciplinary team meetings each month to discuss the needs of complex patients, for example those with end of life care needs, patients with mental health issues or children on the at risk register. These meetings were tailored to each group of patients and were attended by the community matron, mental health workers, district nurses, social workers, and palliative care nurses. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice was involved in clinical research and worked with a clinical research network based at Exeter University. Research involvement had included rehabilitation enablement in chronic heart failure study. Three Spires was the only practice that recruited patients with heart failure and their carers for a feasibility study in 2014 and is continuing to recruit patients for the main trial that started in January 2015. Previous research had contributed to NICE guidelines being adapted for prevention of a myocardial infarction (Heart attack).

Information sharing

The practice used 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, with patient consent, in a secure and timely manner. Electronic systems were also in place for managing cervical smear appointments and hospital referrals. Staff reported that these systems were easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease

Good

Are services effective?

(for example, treatment is effective)

of use. This software enabled scanned paper communications, such as consent forms and correspondence from hospital, to be saved in the system for future reference.

The practice also shared information about significant events where relevant. For example, one significant event related to GPs missing a test result. The learning from this was communicated to the pathology service who then subsequently changed their practice to highlight all abnormal results in red.

Consent to care and treatment

We found that staff had an awareness of the Mental Capacity Act (MCA) 2005 and were aware of their responsibilities in fulfilling it. Staff had received training in the MCA.

Patients said the staff asked for consent before any procedure was performed. Staff explained how consent was formally recorded and scanned on the patient record for procedures including minor surgery, childhood immunisations. For specific interventions, for example, ear syringing the patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Staff were aware of the responsibilities they had when providing care and treatment to children. Nursing staff were aware of the Children Acts, guidelines and legal duties when fulfilling them. All 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.

Health promotion and prevention

We noted a culture between the GPs and nursing team to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering lifestyle and smoking cessation advice to smokers.

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 with a learning disability and made sure they had been offered an annual health check. 30 % of patients with a learning disability had taken up the invitation for an annual health check so far this year.

The practice's performance for cervical smear uptake was comparable to other practices in the CCG area. Practice data showed that 76.46% of eligible patients had attended for a cervical smear test. Patients said the process was well organised. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice monitored the number of patients who did not attend annually. Patients said the system worked well.

The practice had systems in place to make sure patients with mental illness also had their physical health checked. For example, 85% of these patients had received a physical health check in the last year.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance.

There was a range of leaflets and information documents available for patients within the practice These included information on family health, travel advice, long term conditions, information for carers, drug addiction, mental health support groups, services for young people and minor illnesses.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the friends and family test and from the most recent improving practice questionnaire performed by the practice in 2014. The friends and family test results showed that of the 31 respondents 30 patients had said they would be extremely likely or likely to recommend the practice. The national patient survey results stated that 96% of patients said the last GP they saw or spoke to was good and treating them with care and concern and 100% said the GP was good at listening to them. These scores were higher than the national score for this question.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 19 completed cards all of which were positive about the service experienced. Positive comments included feedback on the excellent service, high quality care, treatment and support, and lovely staff. Individual staff were praised and named on these comment cards.

We spoke with12 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients said they felt confident in the skills and knowledge of the staff and said their dignity and privacy was respected. Patients appreciated having the continuity of the same GP.

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

Staff received training on confidentiality at induction. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice staff had asked patients to stand behind the patient in front of them at the reception desk to prevent potentially private conversations between patients and reception staff being overheard, however, patients told us they felt this was still an issue.

Care planning and involvement in decisions about care and treatment

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

Staff said that the majority of patients spoke English but added that translation services were available for patients who did not have English as a first language. We saw posters in the reception area advertising this service was available.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff. The patient comment cards we received were also consistent with this feedback.

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

Staff told us that if families had suffered bereavement, their usual GP provided support. There were posters and leaflets offering advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a proven track record of responding to patient feedback. The practice used complaints, significant events, surveys, suggestions, face to face meetings with patients and the patient participation group (PPG) to improve the service. We saw many examples of where patient feedback was requested about services. For example the survey in 2013 had asked patients if they had been satisfied with the satellite GP service at a local supermarket. Feedback confirmed that although patients were happy with the service they felt the sound proofing was not as good as it could be. We saw that the practice had been in negotiations with the supermarket and had been offered additional rooms.

The practice had an active face to face and virtual patient participation group (PPG) who communicated by meetings and by email. There were nine members of the face to face group and 45 virtual members who preferred to feedback by email. We met with representatives from the face to face PPG who said they were regularly asked their opinion on services and said there was always a GP representative at the meetings.

Patients said they had been asked for feedback from surveys and knew they could give feedback to the reception staff.

The practice demonstrated areas where it had responded to patient need. For example practice staff had started a clinic with a local pharmacist for patients with stoma. A stoma is a surgically created opening on the abdomen which allows stool or urine to exit the body. The aim of the clinic was for patients to receive care and advice regarding equipment and supplies to ensure they were receiving appropriate equipment. The practice had provided administration support for this scheme and were developing a stoma care formulary for the clinical commissioning group.

The practice had been EEFO approved. (The term EEFO is not an abbreviation . EEFO is a word that has been designed by young people, to be owned by young people) EEFO works with other community services to make sure they are young people friendly. Once a service has been EEFO approved it means that service has met the quality standards set by the EEFO group. For example, confidentiality and consent, easy to access services, a welcoming environment and staff trained on issues that young people face. Part of this scheme supports the C-Card scheme. The C-card is given so that a younger person can get free condoms at different places across Cornwall & the Isles of Scilly.

The practice had employed five part time physiotherapists and had access to a physiotherapy suite on the premises to improve the access and level of physiotherapy care patients had been receiving in the county. One of the GPs led a muscular skeletal clinic with the physiotherapists to provide enhanced assessment and treatments for hip, knee and shoulder problems. The service was available to any patients referred by the GP in the county and aimed to provide non invasive methods prior to, or instead of surgery. Feedback from patients was positive.

The practice also ran a physiotherapy service under the 'any qualified provider' scheme. The practice had improved access for patients in the county to receive a patient centred lower back and neck physiotherapy service. This service had reduced the waiting times for patients to receive this treatment. The practice had received positive feedback from the service. Between January 2013 and January 2014 96% patients reported an improvement.

Truro is developing in size and population with additional houses being built to the west of the city. The practice had identified that some patients, including carers found it difficult to travel across the city or were working at the county hall and community college which was closer to a supermarket. The GPs offered morning appointments at a private room in the supermarket three days a week.

The practice held a 'no scalpel' vasectomy service each week for patients in Cornwall. The practice had responded to feedback from patients and offered these clinics on a Friday, therefore meaning patients need to take minimal time off work.

The practice had also responded to a local need by participating in a pilot 'two week wait dermatology' service for patients in Cornwall. One of the GPs had a special interest and worked with another GP and two local dermatology consultants to provide a minor surgery service for patients suspected to have skin cancer.

Tackling inequity and promoting equality

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 referred on need and that age, sex and race was not taken into account in this decision-making.

The premises and services were purpose built and had been adapted to meet the needs of people with disabilities. There was level access and designated accessible toilets which had been fitted with grab rails.

The practice had lifts to access all three floors. The waiting room had spaces which provided turning circles for patients with wheelchairs and mobility scooters. Corridors and doors were wide making the practice easily accessible and helping to maintain patients' independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

Patients were pleased with the appointment service at the practice and said they could always get a same day appointment if necessary. The patients we spoke with said when they saw the GP or nurse they never felt rushed.

Opening hours were planned around the needs of the population. The practice was open between the hours of 8.00am and 6.30pm. Appointments could be booked one month in advance. Early morning appointments were available to promote access to services to patients who worked during normal office hours. Patients could book appointments online and were sent text message reminders for appointments if patients chose to opt into this service.

Comprehensive information was available to patients about appointments on the website and within the practice. This included how to arrange urgent appointments and home visits and how to seek medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and used this process as a part of its quality monitoring system. The practice's complaints policy and procedures were displayed in the practice and were in line with recognised guidance and contractual obligations for GPs in England. A member of the management team was the designated responsible person who handled all complaints in the practice. The practice recorded all informal and formal complaints to monitor trends and any patterns. There had been 11 formal complaints received in the last year with no clear trends identified.

We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. For example two complaints related to the electronic prescription service. This complaint had checked the controls were in place to ensure prescriptions could be sent to the correct pharmacy. Practice staff were keen to use comments and verbal feedback as a way of improving services.

We saw that information was available to help patients understand the complaints system. Patients were aware of the process to follow if they wished to make a complaint, but patients said they had not needed to complain.

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 formal ethos which stated the patient was put at the heart of everything they do. Staff were able to describe the values and operational aims of the practice and included doing this for the patient and their family. Staff said they thought they met these aims.

Staff understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of staff meetings saw that staff were able to discuss and share their opinions and worked towards providing a high standard of care.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. Staff were aware of where to find these policies and could promptly locate the policies they needed.

There was a clear leadership structure in place with named members of staff in lead roles. For example, the role of practice manager was shared between an operations manager, human resources manager, project manager and office manager. There was a lead GP for safeguarding, and lead infection control nurse. Administration staff were aware of their leadership structure and knew who held key roles such as secretarial tasks and managing hospital referrals. Staff all told us they felt valued and well supported.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The organisation was organised and well-structured with schedules and systems in place for the effective running of the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at the partners meetings and action plans were produced to maintain or improve outcomes.

The practice held quarterly governance meetings and educational away days. We looked at minutes from past meetings and found that performance, learning from events and quality and risks had been discussed.

Leadership, openness and transparency

Staff described a clear leadership structure where the management team each had clearly defined roles. We spoke with staff and they were clear about their own roles and responsibilities. Staff told us they thought the practice was well led and they felt well supported and knew who to go to in the practice with any concerns.

Staff said there was a sense of team, no hierarchy and an open culture within the practice where they had opportunity to raise issues at the formal staff meetings or at any time.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards, direct feedback, the friends and family test and any complaints received. We looked at the results of the annual patient survey and found that patient's views had been used to judge the effectiveness of the service. For example, asking patients about the physiotherapy service they were able to access.

The practice had active face to face and virtual patient participation groups (PPG). The PPG said they felt they could influence changes by speaking to the management team or GPs.

The practice had gathered feedback from staff through face to face discussions, appraisals and through staff meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training, appraisal and mentoring. We looked at staff files and training records and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events and other incidents and formally shared action and

Are services well-led?

Good

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

learning from these events with the staff involved to ensure the practice improved outcomes for patients. Staff said they felt supported through this process and the culture was wanting to learn from events rather than shaming staff.