Stable Fold Surgery

Quality Report

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Date of inspection visit: 9 December 2014
Date of publication: 19/02/2015

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

Ratings

Overall rating for this service	Good
Are services safe?	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

Stable Fold Surgery was inspected on the 9 December 2014. This was a comprehensive inspection. We rated the practice overall as good. We rated Stable Fold Surgery as good in relation to being safe, effective, caring, responsive and well-led.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- People's 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.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with their GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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 areas of outstanding practice for example:

- Use of "Chat Clinics" to encourage patients reluctant to undertake some screening test.

There were areas of practice where the provider needs to make improvements and the provider should:

- Ensure recruitment arrangements include all necessary employment checks for all staff.

Summary of findings

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 report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough trained staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence(NICE) guidance was referenced and used routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. The practice had an effective appraisal system in place for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice, GPs and nurses and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other external organisations.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision, understood their responsibilities and strived to be a high quality practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures stored electronically to govern activity and regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG) which improved communication between the practice and it's patients. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

What people who use the service say

We received 22 completed patient comment cards and spoke with 11 patients at the time of our inspection visit. We spoke with older people, mothers with babies, vulnerable people and people of working age.

Patients we spoke with and who completed Care Quality Commission (CQC) comment cards were positive about the care and treatment provided by the GPs and nurses and the assistance provided by other members of the practice team. They told us that they were treated with dignity and respect and that the care provided by the GP was of the highest standard. There was a strong patient participation group (PPG) who improved communication between the practice and it's patients. This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care. Requests for volunteers were advertised through the practice website and on posters displayed in the waiting area.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey showed that the practice achieved better than average results for the area, these results included;

83% of respondents found the receptionists at the practice helpful

98% of respondents said the last appointment they got was convenient

94% of respondents said the last GP they saw or spoke to was good at listening to them

87% of respondents described their overall experience of this surgery as good

Areas for improvement

Action the service SHOULD take to improve

There was a failure to adopt in full the recruitment checks that the practice policy outlined.

Outstanding practice

Use of "Chat Clinics" to encourage patients reluctant to undertake some screening test.

Stable Fold Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and a specialist advisor (a GP). Our inspection team also included an Expert by Experience who is a person who uses services them self and wants to help CQC to find out more about people's experience of the care they receive.

Background to Stable Fold Surgery

Stable Fold Surgery is located in the village of Westhoughton on the outskirts of Bolton. At the time of this inspection we were informed 7,440 patients were registered with the practice.

The practice consists of six GPs (three male and three female). These GPs are providing general medical services to registered patients at the practice. The GPs are supported in providing clinical services by two practice nurses (female). Clinical staff are supported by the Practice Manager and their team who are responsible for the general administration and organisation of systems within the practice.

The practice is in the process of joining the rest of the 51 GP practices within Bolton CCG with a plan to regularly meet to share information and identify best practice.

The practice is open Monday, Tuesday and Friday 8.00am to 6.30pm, with an additional two and a half hours on Thursday evenings (8.30pm); the practice closes at lunchtime on a Wednesday.

Out of hours service is provided by Bury and Rochdale doctors on call (BARDOC). Telephone **0161 783 4242.**

Why we carried out this inspection

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

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 (QOF) 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?
- 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:

Detailed findings

- 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 9 December 2014. During our visit we spoke with the GPs, nursing staff, the Practice Manager and reception staff, we also spoke with patients who used the service and two members of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record

Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that in 2012-2013 the provider was appropriately identifying and reporting significant events. The Practice Manager told us they completed incident reports and carried out significant event analysis as part of their ongoing professional development. We looked at minutes of team meetings and confirmed that these issues were discussed and any learning was put into practice.

The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were received electronically by the Practice Manager and emailed to the clinical staff for their information. The alerts were then printed off and placed in a folder in the staff room. We talked to the Practice Manager and one of the GPs about how these could be better managed in terms of identifying who was responsible for each alert, they told us that they would review the system.

Learning and improvement from safety incidents

The practice had systems in place to monitor patient safety. Minutes of meetings evidenced that significant events and changes to practice were discussed with all practice staff including the nurses and administration staff if that was deemed appropriate. Action was taken to reduce the risk of recurrence in the future. The GP completed evaluations and discussed changes their practice could make to enable better outcomes for their patients. If it was deemed necessary, events and lessons learned were shared with multi-professional agencies outside the practice, for example Bolton CCG.

Significant events that we reviewed showed the date the event was discussed; a description of the event, what had gone well, what could have been done differently, a full reflection of the event and what changes had been carried out. For example we saw that an incident had resulted in concern for relatives of a patient because of poor communication. We saw that the matter had been investigated and that alternative communication methods had been introduced to better inform relatives.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. One of the GPs and the Practice Manager took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and speaking with external safeguarding agencies, such as the local social services, CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3) safeguarding training had been completed by the GP safeguarding lead. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Staff were also aware of how to raise issues about staff within the practice via the whistleblowing procedure.

Reception staff and practice nurses were available to chaperone patients who requested this service and information about this service was available in the waiting area. Staff had been trained by one of the two experienced nurses in the intricacies of chaperoning. We had reservations about the receptionists' ability to recognise appropriate clinical examinations. When we spoke to reception staff they told us that they were confident in performing a role as a chaperone, and told us that the clinicians would always explain in full to the patient and chaperone what they were doing and why.

Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. Management of medicines was the responsibility of the practice nurses. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly by the GPs as they were identified by the reception staff. A procedure was operated to enable patients to request and obtain their repeat prescriptions either online or in person. We noted that the box for patients to leave their repeat prescription requests was

insecure as it was in a public area and unlocked. The Practice Manager told us that this would be rectified. The practice had identified that some patients preferred to choose which pharmacist they used and this was facilitated in the new electronic system introduced in July 2014. 48% of all prescriptions were now managed electronically. This had proved to speed up prescription times, reduce paperwork for reception staff and increase patient satisfaction. Patients who still wished to collect their precsriptions in person had the option to do so. Patients preferences were coded onto their patient notes to avoid them receiving repeat requests. A system was in place to prevent patients re ordering repeat prescriptions before an appropriate period of time had elapsed. Any medication errors were treated as significant events. We spoke to the Practice Manager about uncollected prescriptions and were told it was not practice policy to investigate these; however they were going to review this policy.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. We found appropriate action had been taken to achieve this and a daily check and record was made to ensure the appropriate temperature range was maintained. We noted that both fridges used for storing vaccines were not hard wired, however the power sockets for the fridges were placed so that they could not be inadvertently switched off. A cold chain policy was in place to ensure that the drugs requiring storage at particular temperatures were dealt with appropriately. Staff we spoke to were clear on the policy and how to implement it.

We saw that a documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date. No controlled drugs were kept on site.

Cleanliness and infection control

Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our inspection. A system was in place for managing infection prevention and control. We saw that a recent audits relating to infection control had been completed by the Practice Manager; this was done to ensure actions taken to prevent the spread of potential infections were maintained. We noted that there had been an improvement in overall infection control audit score in the last year having risen from 69% in November 2013 to 94% in October 2014.

We also saw that practice staff were provided with equipment (for example disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We talked to reception staff about handling samples provided by patients, they had a sound knowledge of how to deal with these and a documented protocol was in place

We looked at the treatment rooms used for carrying out minor surgical procedures. We found these rooms to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance, most equipment was single use only. We looked at medical equipment that was stored in readiness for use and found that it was all within the manufacturers' recommended use by date. The Practice Manager had identified that a small number of taps required the fitting of hands free devices for more effective operation. Appropriate signs were displayed to promote effective hand washing techniques.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. The Practice Manager told us that there had been a conscious drive to replace, where possible, any re-useable instruments with single use ones. Sharps boxes were provided for use and were positioned out of the reach of small children. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing (PAT) and calibration of equipment such as spirometers to measure lung capacity. Documentation evidenced that equipment was regularly inspected to ensure it remained effective. Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments.

Good

Are services safe?

Staffing and recruitment

The provider recruitment policy was in place and up to date. We looked at two staff files and saw that some of the employment checks that were required to be carried out had not been completed, for example a declaration that person is medically fit to undertake their role. The GPs had disclosure and barring service (DBS) checks undertaken annually by the NHS England as part of their appraisal and revalidation process. Revalidation is whereby licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice. The nurses also had DBS checks completed, however the reception staff did not have such checks undertaken. We talked with the Practice Manager about the need for this to be carried out or a documented rationale why such checks were not required. National guidance states that clinical staff and those dealing with vulnerable people should have checks on their character and suitability to carry out their role.

The practice had sufficient staff to enable the personal medical service needs of patients to be met. The staff team were well established and most had worked at the practice for many years. The staff were also multi skilled which enabled them to cover each other in the event of planned and unplanned absence. The staff we spoke to told us of the improvements made to team working by the current Practice Manager, they told us this had improved the overall effectiveness of the practice.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the Practice Manager if an accident occurred and ensure that it was recorded. The practice had a health and safety policy, which staff had read and signed to say that they had understood its contents. This and all other practice policies were available to all staff at any time via the computer portal.

Arrangements to deal with emergencies and major incidents

Basic life support training was done every year with all staff and this included using a defibrillator. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. Fire safety training had been undertaken and the Practice Manager was the identified fire Marshall on the day of our inspection.

We saw emergency equipment and emergency drugs which were available and staff knew where these could be located. We saw that emergency drugs and equipment were regularly checked by the practice nurses to ensure it was operative and within the manufacturer's recommended usage date. We noted that contrary to national guidance oxygen was not available. We were told by the practice that this would be addressed and that oxygen used to be available but had been removed due to the fire risk it caused.

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. The plan was available for all staff. Each member of staff we spoke with was aware of the policy relating to emergency procedures. This demonstrated there was an effective approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses. Cardiovascular and other regular health checks and screenings were on-going in line with national guidance. The practice had a documented system for reviewing patients with specific conditions The Practice Manager showed us how each group of patients were easily identified electronically for review by the coding on their patients notes. Conditions for review included mental illness and multiple sclerosis. Patients with multiple conditions were allocated longer appointments and more regular reviews in order to review their more complex needs. Each condition was allocated a specific consultation time with these being cumulated if there was more than one condition for review. For example a patient with diabetes would be allocated 20 minutes; one with chronic obstructive pulmonary disease (COPD) would be allocated 30 minutes. A patient with both conditions would receive a 50 minute consultation. We saw that the practice ensured that checks on patients' blood were completed before the reviews to ensure the GP had as much information available as possible. Patients were sent text messages where possible to remind them of their review appointments, this was backed up with a telephone call from a receptionist.

Care Plans were in place for patients who were identified as needing them, these included patients over 75 and those with specific conditions such as COPD, asthma, atrial fibrillation and heart failure. The GPs told us they led in specialist clinical areas such as joint injections and dermatology (the treatment of skin complaints). The practice nurses were both experienced and had specific skills including palliative care, accident and emergency and wound care. The nurses were also trained to provide a yellow fever and rabies service to patients. The practice also provided two 24 hour blood pressure monitoring devices. These allowed a fuller picture of a patient's blood pressure whilst in normal daily life rather that it being recorded under the stressful conditions of a doctor's appointment.

Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

Multi-disciplinary meetings were held regularly to discuss individual patient cases making sure that all treatment options were covered. GPs at the practice had different areas of responsibility for example one GP attended the monthly CCG meetings and fedback information to their colleagues, whilst another GP attended prescribing meetings and did the same. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidelines at staff meetings and local forums where appropriate.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly significant, it was flagged to appear on the patient's home screen so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to cost effectiveness for example Lipitor to Atorvastatin (Cholesterol medicines) and medicine reviews for effectiveness such as an audit of Clopidogrel (a blood thinning medicine). Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that where audits identified actions these were clearly described and communicated to staff. If necessary a timescale for re-auditing was identified. We noted in the previous 12 months there had been 51 medicines effectiveness audits, 26 cost effectiveness audits, seven high dose reviews and nine ad hoc audits including reviews of antibiotic and opiate prescribing.

Good

Are services effective?

(for example, treatment is effective)

We saw no evidence of peer review within the practice and we discussed this with the Practice Manager and one of the GPs. They both confirmed that they would discuss this issue at the next practice meeting with a view to introducing some peer reviews of GPs treatments.

The GPs and nurses had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as joint injections, skin conditions, post natal care and safeguarding patients. They provided advice and support to colleagues in respect of their individual area. We saw on the day of our inspection that a child immunisation clinic was running and we spoke to the two nurses treating patients. They told us about their previous experience and expertise in different areas of medical practice.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice. We spoke with two members of the five strong PPG who told us how they had joined the group due to the excellent care, professionalism and dedication of the GPs and Nurses. One of the PPG members told us how they believed one of the GPS had saved the life of their partner due to their prompt action and professionalism.

Effective staffing

All the staff we spoke to at the practice were very complimentary and happy about the training opportunities available to them. Staff undertook mandatory training to ensure they were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role and progress to other roles within the practice. Most staff were multi-skilled and able to carry out the role of their colleagues at short notice if required. The GPs had specialisms they had developed over time such as joint injections and dermatology.

Most staff were long serving but there was an induction process for any new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care. We saw that the Practice Manager maintained a clear colour coded wall chart documenting staff commitments and how absences would be covered. They told us that this gave them a clear view of staffing requirements and enabled them to grant things like annual leave based on the projected staffing levels.

The GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the general medical council (GMC), that they were up to date and fit to practice. The GPs we spoke to told us they undertook regular clinical appraisals. The practice nurses confirmed that they were also supported to attend updates to training that enabled them to maintain and enhance their professional skills.

All patients we spoke with were complimentary about the staff and we observed that staff appeared competent, comfortable and knowledgeable about the role they undertook.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services and professionals from other disciplines to ensure all round care for patients. Minutes of meetings evidenced that district and palliative nurses attended team meetings to discuss the palliative patients registered with the practice. This evidenced good information sharing and integrated care for those patients at the end of their lives.

We saw that a clinical information system was used and was updated by the practice in a timely manner so that information about patients was as current as possible. This meant that the practice and other services such as out of hours care providers were in receipt of the most current information about patients.

Information sharing

GPs met regularly with the practice nurses and the Practice Manager. Information about risks and significant events was shared openly and honestly at these meetings. The GPs and Practice Manager attended CCG meetings and disseminated what they had learned in practice meetings. This kept all staff up to date with current information around enhanced services, requirements in the community and local families or children at risk. Patients and individual cases were discussed by the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the Practice Manager attended local area meetings. Feedback from these meetings was shared with practice staff where appropriate. In addition the Practice Manager regularly attended area Practice Manager meetings to share information about their role and maintain their

Good

Are services effective?

(for example, treatment is effective)

professional knowledge and was a board member of the electronic prescription service (EPS) board. They had also undertaken a twelve month initiative with other Practice Managers where workshops were held to better inform managers about how to effectively meet the requirements of the Health and Social Care Act.

There was an informative practice website with information for patients including signposting, the PPG and out of hours contacts. The PPG had become an effective method of communicating information between the patients and practice staff; we saw that the minutes of the PPG meetings were available on the practice website in the form of actions and responses from the practice. We talked with two members of the PPG who confirmed that the practice was very responsive to patient feedback. Information leaflets were available within the practice waiting room and notices provided an array of support information. We saw that the results of the patient satisfaction survey were published on the practice website as was a link to the family and friends test.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment. The practice computer system identified those patients who were registered as carers and any other information relating to consent was scanned onto the system and alerts set up to notify clinicians. This included information about lasting powers of attorney (LPA) and do not attempt to resuscitate (DNAR).

GPs and clinicians had received training in the Mental Capacity Act and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The 2014 national GP patient survey indicated 85% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 76% said the last GP they saw or spoke to was good at involving them in decision making and 94% had confidence and trust in the last GP they saw or spoke to.

Health promotion and prevention

All new patients were offered a consultation and health check with of the practice nurse. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice held clinics to identify potential issues, for example a phlebotomist employed by the area hospital held a weekly clinic as did a health trainer who offered advice to promote healthy living to different groups of people. This trainer also completed work around the national initiative for people aged between 40 and 75 aimed at improving people's health and well-being from middle age.

The practice website and surgery waiting areas provided a wide variety of up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The practice also reached out to the local community to promote better health by engaging in various help and support groups. We saw that the annual flu vaccination campaign was near completion at the practice and we were told that this year's initiative had sustained a good take up rate from patients. The practice also promoted yellow fever and rabies vaccinations for those groups of patients who may have been at risk or who were travelling to countries where the disease was a risk.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to 11 patients in person and received feedback from 22 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the GPs.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of an individual consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was offered. We had some concerns relating to reception staff acting as chaperones during intimate examinations or medical procedures due to their lack of clinical expertise.

The practice had introduced "chat clinics" whereby patients who had not responded to healthcare checks were invited to chat informally with a nurse about potential benefits. These meetings also gave the nurse a chance to gain a patient's confidence and attempt to reduce the fears they might have about a particular procedure. For example a synthetic speculum (and instrument for examining body orifices) and cervix were used to explain the process of a cervical smear test. The Practice Manager told us that these clinics had been very effective in increasing the take up rate for cervical smears.

Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity. We saw that staff had received training in confidentiality, bullying and harassment, data protection and information governance. We also noted that there were practice policies to cover all these areas.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 89% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 86% of respondents said the last nurse they saw or spoke to was good at listening to them.

We saw that the practice staff had undertaken regular charity work to raise money and awareness for causes such as MacMillan nurses and Cancer research. This work was prominently displayed on the website and clearly displayed a caring and compassionate ethos.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best for their health. Patients told us how the nursing staff were always bright and happy and helped to lift their mood even when they were ill.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians and prominently displayed in the waiting areas.

The practice maintained care plans for patients who required regular or specialist treatment. The practice had a system in place for identifying people who would benefit from a care plan. We looked at some of these plans and saw that they were well written and considered appropriate measures for on-going effective health management for patients Clinical staff demonstrated excellent knowledge of appropriate referrals to other healthcare professionals.

The 2014 GP patient survey reported that 76% of respondents said the last GP they saw or spoke to at the practice was good at involving them in making decisions about their care. 70% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in making decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that staff understood patient's personal circumstances and were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. The

Good

Are services caring?

Practice Manager told us they had focussed on support for carers over the previous year and now had a dedicated area on the practice website to provide information and support for them.

We saw that there was a system for notifying staff about recent patient deaths and a list was posted in the staff room so that everyone at the practice was aware of any recent deaths. Staff told us that this was helpful when speaking to relatives and others who knew the person who had died. We were told that families who had suffered bereavement were spoken to by their GP and a card offering condolences was sent.

The 2014 GP patient survey reported that 94% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 86% say the last nurse they saw or spoke to at the practice was good at listening to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice completed regular patient satisfaction surveys, published the results on their website and promoted the family and friends test to measure what people thought about the service. The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patient's needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular locality meetings, buddy group meetings with a nearby practice, primary health care team meetings and meetings with district nurses. The practice provided enhanced services including rheumatoid arthritis injections, disease-modifying anti-rheumatic drugs (DMARDS), incisions and anti-psychotic treatments.

The GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities, multiple sclerosis and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

Patients who we spoke to who had young babies told us that if they wanted an appointment for their baby, they were given precedence and would be seen the same day.

We saw that the practice had been proactive in seeking and responding to patients. One example of this was the altering of facilities and layout in the waiting area as a result of feedback received from patients via the PPG.

Stable Fold Surgery had a reception area, a patient waiting area, several treatment/consultation rooms. The treatment rooms were designated for carrying out minor surgical procedures. There were also facilities to support the administrative needs of the practice (including a number of offices on the first floor). The building was easily accessible to patients including those with a disability. The Practice Manager told us that the surgery had been extended in recent years to provide storage and improved facilities for patients.

The practice had an effective and active PPG and we saw that information about the PPG was displayed around the reception area. A section of the practice website provided information about patient satisfaction and how it responded to patient needs and suggestions. PPG members that we spoke to told us that the practice was very good at responding to any issues raised. The PPG held meetings at the practice twice a year.

Tackling inequity and promoting equality

Staff told that there was little diversity of ethnicity within their patient population. However they were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes. One patient we spoke to told us that other members of their family who were patients at the practice did not speak English, had no problems communicating with their GP.

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing a care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia.

Access to the service

Access to the surgery was good with wide doors to the entrance for wheelchair users. There was a good appointment system where people could receive same day emergency appointments, telephone consultations with the GPs whenever possible, call backs, and home visits by the doctor. Patients we spoke to told us that they could usually get to see or speak to one of the GPs. Reception staff told us that if there were no appointments immediately available, they would offer alternatives to the patient for example a call back from a clinician. A hearing induction loop was available for use by patients with difficulty hearing.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had noted a high number of patients not attending appointments for immunisation clinics, as a result the clinic was moved from a Friday afternoon to a Tuesday morning and the non-attendance rate decreased significantly. We looked at the results of the 2014 GP survey 83% of respondents found the receptionists at the practice helpful, 98% of respondents said the last appointment they got was convenient and 90% were able to get an appointment to see or speak to someone the last time they tried. The Practice Manager had identified that there had been some negative feedback from some patients on NHS choices about the manner of some of the reception staff. In order to improve this, training on effective customer service was provided and feedback so far had been positive.

The opening hours and surgery times at the practice were prominently displayed in the reception area and on the practice website. The practice was open every weekday 8.30am to 6.30pm except for Wednesdays when they closed at lunchtime. Extended hours were operated on Thursdays until 8.30pm to provide service for people who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where the GPs used the electronic messaging system to prompt reception staff to create an appropriate appointment based on patient choice. The practice ensured that a summary of the most important information was also provided in any transfer of patients, this included any repeat medicines, recent blood pressure and pulse rate information and any significant alerts.

Listening and learning from concerns and complaints

We saw evidence that this was a practice with a learning culture. There was a clear understanding about the need and benefits of learning from significant events and partnerships with other agencies.

There was a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and the Practice Manager was the designated person responsible for handling complaints at the practice. We reviewed some complaints received and saw that they were dealt with in line with the practice policy. We saw that most complaints were brought to a conclusion which was satisfactory to the patient. We established from reception staff that they were confident with dealing with minor complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review so the opportunity to learn from them was limited.

We saw that compliments were also received regularly. We looked at thank you cards and letters of appreciation praising the staff and the care and treatment received.

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

Discussions and evidence we reviewed identified that the management team had a clear vision and purpose. The GPs we spoke with demonstrated an understanding of their area of responsibility and they took an active role in ensuring that a high level of service was provided on a daily basis. All the staff we spoke with said they felt they were valued and their views about how to develop the service were acted upon. An example of this was the introduction of a dedicated dermatology clinic for one of the GPS as one of the reception staff had identified appointments of this nature were taking a disproportionate amount of the GP's time. Once implemented the practice had noticed a significant improvement in waiting times for appointments with that GP.

The practice newsletter, website and PPG demonstrated that the practice was interested in the views of their patients and carers and these views were fed into the practice so that they could consider how the service could be improved. The staff told us they were dedicated to providing the best possible service to their patients.

GPs and the Practice Manager attended locality and Clinical Commissioning Group (CCG) meetings to

identify needs within the community and tailored their services accordingly. They worked with local safeguarding, domestic violence and other organisations to make sure they were aware of the requirements within their patient population.

Governance Arrangements

We saw that the practice had a documented statement of purpose which included their aims and purposes, some of which stipulated: 'To provide a high quality of care to our patients by continually monitoring, auditing and improving our services, to recruit, train and develop a highly motivated workforce with the skills to perform their work efficiently and effectively. To achieve key targets and core standards in all service areas, to keep our patients fully informed of changes as they occur, to consult with our patients through the PPG to ensure that patients' needs and suggestions are incorporated in any proposed development.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance, the Practice Manager told us they kept a constant check on their QOF figures to ensure they were performing well within their CCG. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had robust arrangements for identifying, recording and managing risks. The Practice Manager showed us their risk log which addressed a wide range of potential issues, such as the environment and infection prevention. We saw that the risks were regularly discussed at team meetings and updated in a timely way.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits and safety alerts. We looked at several clinical audits around different medicines; they were well documented and demonstrated a full audit cycle.

Leadership, openness and transparency

There was a clear leadership structure. We spoke with two members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Most of the team had worked together for many years and there was a very low turnover of staff. They told us that teamwork was very important and they felt as a team they were very effective in delivering high quality care. They told us that the current Practice Manager had been particularly effective at promoting team work and that clinical and non-clinical staff felt as though they were a single unit striving for the same aims.

We saw staff undertook annual appraisals. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. We discussed the potential for documented supervision meetings between appraisals as a method of evidencing staff support. The Practice Manager told us that together with the open door policy and strong informal communications between staff and management, this would be introduced.

The Practice Manager was responsible for human resource policies and procedures. We reviewed a number of policies,

Are services well-led?

Good

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

for example vetting and barring, equal opportunities and confidentiality, which were in place to support staff. Staff we spoke with told us these policies were available if they needed to refer to them on the practice portal.

Staff we spoke to were complimentary about the management style at the practice, one member of clinical staff told us that they had considered applying for a job elsewhere, but the new practice manager had been so effective, they had chosen to stay and not regretted the decision. We were told that support for learning and development was good. Staff told us that the GPs and Practice Manager encouraged other members of staff to contribute to the way the practice was run and that suggestions for meeting agenda items were sought.

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

There was an air of openness within the practice, between all staff members and between patients and staff. Patients spoken with reported that they felt comfortable providing concerns, compliments or complaints and some had done so. Information received was acted upon and we saw evidence that changes were made to working practice where ever possible.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG contained representatives from various population groups. We spoke to two members of the PPG who said that it worked effectively and was an excellent way of patients influencing the way the practice was run.

Management lead through learning and improvement

We saw a clear understanding of the need to ensure that staff had access to learning and improvement opportunities. Newly employed staff had a period of induction and mandatory training was role relevant. E-Learning was carried out where face to face training was not required. A core set of training was provided for all staff and this was monitored on an annual basis. The Practice Manager maintained an effective training plan so they had an overview of which staff required training and in what subject.

The nurses and GPs kept their continuing personal development up to date and attended other courses pertinent to their roles and responsibilities within the practice such as safeguarding vulnerable patients and current immunisation advice . This ensured that patients received treatment which was most current.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved. Where appropriate significant events had been notified to the CCG in order that learning on a wider area base could be achieved.