Riverside Medical Practice

Quality Report

Roushill,
Shrewsbury,
Shropshire,
SY1 1PQ
Tel: **01743 352371**
Website: www.riverside-medical.co.uk

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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

We inspected this service on 19 November 2014 as part of our new comprehensive inspection programme.

The overall rating for this practice is good. We found the practice to be good in safe, effective, caring, responsive and well led areas. We found the practice provided good care for older people, patients with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health, including dementia.

Our key findings were as follows:

- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice had a strong commitment to the on-going development of skills, competence and knowledge of all staff to achieve good outcomes for patients.
- Patients felt they were treated with compassion, dignity and respect. They told us that GPs were good at listening to them and gave them enough time.
- The practice had a well-established and well trained team who had expertise and experience in a wide range of health conditions.
- There was a transparent and inclusive culture at the practice which encouraged contributions from staff and patients in the development of the service.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated 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 staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. We saw records which demonstrated that the practice had achieved one of the highest rates of diagnosis for dementia in the local Clinical Commissioning Group (CCG) area. We found that 80% of people experiencing poor mental health had received an annual physical health check at the time of the inspection and almost all patients with diabetes had received an annual review. The practice had a strong commitment to the on-going development of skills, competence and knowledge of all staff to achieve good outcomes for patients. Staff were encouraged to acquire new skills and share best practice. Staff worked with multidisciplinary teams to ensure improved outcomes for patients.

Are services caring?

Good

The practice is rated as good for caring. Patients told us they were treated with dignity and respect at all times and that they considered the practice to be very caring. We observed a patient centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. The practice referred to the Gold Standard Framework in caring for patients nearing the end of their life. This ensured their care was reviewed appropriately and that patients were supported to make decisions about their care and treatment for as long as possible.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the

Summary of findings

NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said there was continuity of care, with urgent appointments available the same day.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was involved. Staff had received inductions, regular performance reviews and attended 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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people and all patients over the age of 75 had a named GP.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes in place and referrals were made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, looked after children. Most immunisation rates were high for standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services for example appointments, as well as a full range of health promotion and screening that reflected the needs of this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice supported patients whose circumstances may make them vulnerable, such as those who were homeless or had a mental health crisis. The practice was located in the centre of Shrewsbury and enabled easy access for vulnerable patients, particularly those who were homeless or drug dependent. Staff told us about how they enabled them to access the practice without fear of stigma or prejudice and treated them in a sensitive and sympathetic manner.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It signposted vulnerable patients to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Patients were encouraged to participate in health promotion activities, such as cytology and smoking cessation. The practice had a care co-ordinator who linked patients into existing community networks to improve their wellbeing and prevent isolation and loneliness.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including those with dementia). We found that 80% of patients who experienced poor mental health had received an annual physical health check at the time of the inspection. The practice regularly worked with multi-disciplinary teams in the case management of these patients, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 17 patients on the day of our inspection and all told us they were extremely satisfied with the care and treatment they received. We reviewed the 24 patient comments cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw that all comments were positive. Patients told us that staff were efficient and helpful and always treated them with dignity and respect. They said the care they received was very good and they were listened to and involved in decisions about their care. One comment stated that they could not always see their preferred GP; however they felt that the care they received from all GPs was very good.

The results from the National Patient Survey 2014 showed that 96% of patients felt that their overall experience of the practice was good and 74% of patients would recommend the practice to someone new to the area. The practice, in conjunction with the patient participation group (Riverside Support Group) had carried out a survey in February 2014. PPGs are a way for patients and GP practices to work together to improve the service and to promote and improve the quality of the care for patients. The survey was designed to receive specific feedback from patients on access to the service and telephone consultations. We saw that as a result of the survey, telephone consultations were introduced.

Outstanding practice

- The practice had a community care co-ordinator who worked to support frail and vulnerable patients who had a long term condition. The care co-ordinator identified the needs of these patients and linked them into existing community networks. This support helped to improve their wellbeing and reduce their isolation and loneliness.
- The practice had developed a 'results protocol' which was seen to be a robust management system to deal with patients' results promptly and accurately. It was recognised locally as being a good example and had been shared with other practices.
- The practice had developed a protocol to deal professionally and sympathetically in response to the death of a patient either as an unexpected or expected death. This protocol was identified by the Clinical Commissioning Group (CCG) as a quality item and had been shared with other practices.

Riverside Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and an Expert by Experience who had personal experience of using primary medical services.

Background to Riverside Medical Practice

Riverside Medical Practice is a purpose built primary care medical centre which serves the local population by providing general practitioner services. It is situated close to the town bus station and large town centre car parks in Shrewsbury, Shropshire.

The practice has eight permanent GPs (five male and three female), a GP registrar, a practice manager, two specialist nurses, one practice nurse, one treatment room nurse, one healthcare assistant, an office manager, a senior receptionist, and reception and administrative staff. There are approximately 10,000 patients registered with the practice. The practice is open from 8.30am to 6pm Monday to Friday. It does not provide an out-of-hours service to its own patients but has alternative arrangements for patients to be seen when the practice is closed. If patients call the practice when it is closed, there is an answerphone message with contact details of the Out of Hours service, Shropdoc. Information on the out of hours service is provided to patients in the practice booklet and through the practice's website.

The practice treats patients of all ages and provides a range of medical services for example, reviews for conditions such as asthma, diabetes, epilepsy and chronic obstructive pulmonary disease (lung disease). It also offers childhood immunisations, sexual health advice and travel health vaccines.

Riverside Medical Practice is a training practice for fully qualified doctors to gain experience and higher qualifications in general practice and family medicine. It also supervises medical students.

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 data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed findings

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Before carrying out our inspection, 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 19 November 2014. During our inspection we spoke with a range of staff, four GPs, a registrar, a nurse practitioner, a practice nurse, the practice manager, the office manager, a receptionist and an administrative staff member. We also spoke with 17 patients who used the service and carers and/or family members. We reviewed 24 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We saw an example of an occasion when a member of staff had reported patient feedback in relation to a clinician's delay in making a referral for them. This was recorded as a significant event which led to discussion and a meeting with the clinician, clinical governance lead and practice manager. As a result of this an audit of referrals was carried out by the clinician which demonstrated that all referrals had been made in a timely manner. Staff told us that a re-audit was planned to ensure that this was being maintained.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the year.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice had been recording significant events for a number of years and could provide evidence of a safe track record over time.

We checked records of significant events that had occurred during the previous 12 months. Significant events were a standing item on the clinical meeting agenda and a dedicated meeting was held every three weeks to review new significant events and actions from past occasions. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All minutes from significant events meetings were available on the computer for staff to access.

Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Staff used incident forms on the practice intranet and sent completed forms to the practice or office manager. They showed us the system they used to manage and monitor incidents. We saw records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

As well as discussing significant events with staff we saw records which showed that they were discussed with people outside of the practice in order for ideas for improvement to be shared. For example, we saw that there had been an incident which involved confusion about prescribing. We saw that the practice took immediate action to reduce any risk to the patient and a new protocol was developed by the practice to reduce the risk of the incident recurring. The incident was raised at meetings with a variety of external partnership groups including the Clinical Commissioning Group (CCG) and peer groups.

National patient safety alerts were disseminated by the most appropriate person responsible for the area of concern; the GP lead for prescribing, the GP lead for governance, the senior practice nurse, the practice manager and office manager. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example, following an alert received by the lead nurse and prescribing lead GP about a medicine for nausea, action was taken to remove inappropriate prescribing. Patients were contacted to stop taking the medicine as needed and advised to speak to a GP. We saw that the medicine was removed from the practice and the action taken was recorded fully on the computer. This demonstrated a proactive and thorough approach to dealing with medical 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 relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent 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.

Good

Are services safe?

The practice had appointed a dedicated GP as a lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate that they had carried out the necessary training to enable them to fulfil this role such as an appropriate level in safeguarding children. All staff we spoke with were aware who this lead was and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy in place which was visible on the waiting room noticeboard, in consulting rooms and on the practice website. All nursing 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.

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 or carers. We saw that the practice provided specific information to support carers and involved them in decisions about health care for those they looked after.

We saw that GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures and described the action to take in the event of a potential failure. We found that the practice staff were knowledgeable about the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice.

The nurses administered vaccines using Patient Group Directions (PGD) that had been produced in line with legal requirements and national guidance. These supported the nursing staff in the administration of vaccines. A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We saw all copies of the directions were up to date and provided evidence that the nurses had received appropriate training to administer vaccines.

We saw that the practice had a repeat prescription protocol and a robust process for the management of repeat prescriptions. We saw that two members of staff had received specific training in repeat prescribing. Staff told us that the lead community pharmacist at the Clinical Commissioning Group (CCG) met regularly with the prescribing lead GP in the practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Staff told us that they were not able to fully comply with a recent infection prevention and control audit due to the age and restrictions of the building.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the lead staff member had begun to carry out infection control audits and that any improvements identified for action were completed on time. For example, we saw a completed audit for the use of aseptic techniques (methods to protect against infection) in the removal of sutures (stitches).

Good

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, the correct disposal of clinical waste. There was also a policy in place for needle stick injury.

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.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the pulse oximeter.

Staffing and recruitment

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

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. We were told that there was a rota in place for the GPs to plan their annual leave one year in advance and so ensuring that there was always sufficient GP cover to meet the needs of the patients. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and health and safety information was displayed for staff to see.

Staffing establishments were reviewed to keep patients safe and meet their needs. We saw that the practice had a stable and long standing staff group who worked as a team to ensure the requirements of the service were covered at all times. This included increasing the number of GP sessions and staff providing cover for each other during periods of annual leave.

We saw that risks were assessed and rated with mitigating actions recorded to reduce and manage the risk. For example, we saw that a health and safety risk assessment and a fire risk assessment had been carried out and shared with staff.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including 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 it was checked regularly. Staff were also clear about how to deal with emergencies to keep patients safe.

Good

Are services safe?

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of a cardiac arrest, a severe allergic reaction and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure and loss of computer systems. The document also contained relevant contact details for staff to refer to including contact details of the relevant suppliers.

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

Staff we spoke with told us that they had received fire training as part of their induction training when they commenced employment at the practice. Staff we spoke with clearly described their roles and responsibilities in keeping patients safe in the event of a fire.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. One example of this was in relation to NICE guidelines on atrial fibrillation (a heart condition that causes an irregular heartbeat). The GP lead for prescribing looked at the guidelines and emailed all the GPs with the advice on how to implement them. This included advice on the use of risk tools to assess the risk of a bleed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, mental health and dementia. The practice nurses supported this work, particularly in relation to the management of long term conditions such as diabetes and asthma. The practice had introduced a new initiative to provide nurse led clinics for patients with minor illnesses. We saw that both nurses had received extensive training to enable them to examine and diagnose minor illnesses. Appointments could be booked on the same day for these clinics. Patients told us that this was very helpful and we saw that the nurse led clinics had freed up GP time to enable them to see more patients with serious health concerns.

The practice was reactive to the needs of older people and all patients over the age of 75 had a named GP. We saw records which demonstrated that the practice had achieved one of the highest rates of diagnosis for dementia in the local Clinical Commissioning Group (CCG). We found that 80% of people experiencing poor mental health had received an annual physical health check at the time of the inspection.

One of the lead GPs showed us data from the local CCG of the practice's performance for antibiotic prescribing which showed that the practice was a low prescriber of antibiotics and was comparable to similar practices. This showed that the practice was proactively monitoring the prescribing of antibiotics. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital and patients who were receiving palliative care.

CCG data showed that the practice was in line with referral rates to secondary and other community care services for most conditions. We saw that the practice monitored their referral rates and took action to improve them when necessary. For example, we saw evidence of an audit that the practice had carried out as a result of higher than average referral rates to the dermatology team at the hospital. We saw that the practice took steps to ensure that all referrals were appropriate and carried out a re-audit which showed the referral rates had reduced.

All GPs we spoke with used national standards for patients with suspected cancers to be referred and seen within two weeks. We saw that the practice had achieved and implemented the gold standards framework (GSF) for end of life care. The GSF is a practice based system to improve the quality of palliative care in the community so that patients receive end of life care that ensures their dignity and is in line with their wishes. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We saw that there were four patients on the register. We were told that there were two named GPs for each patient so that any contact made by the patient or their carers would be directed to one of the GPs ensuring consistency of care.

The practice had a community care co-ordinator who worked to support patients who had a long term condition and who may be frail, vulnerable and at risk of regular hospital admission. The care co-ordinator identified the needs of these patients and linked them into existing community networks to improve their wellbeing and prevent isolation and loneliness. We saw evidence of a number of examples of how the work of the community care co-ordinator had provided positive outcomes for patients. For example a relative referred a patient who lived

alone and was frail with poor mobility. One of the outcomes from this contact with the care co-ordinator was maximisation of income for the patient following benefits advice.

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.

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 and medicines management. The information staff collected was then collated by the practice manager and lead GP to support the practice to carry out clinical audits.

The practice showed us two clinical audits that had been undertaken in the last two years. We saw that these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit with improved outcomes for patients. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of bisphosphonates which are medicines for patients with osteoporosis (bone disease). Following the audit, a review of patients who were prescribed this medicine was initiated to ensure patients were assessed and followed up appropriately.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, almost all patients with diabetes had received an annual review, and the practice had met all the minimum standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement.

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area.

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 attending the mandatory courses set by the practice, such as annual basic life support. We noted a good skill mix among the GPs. Two GPs had additional diplomas in sexual and reproductive medicine and others for example, had completed specialist training in mental health and minor injuries. All GPs were up to date with their yearly continuing professional development requirements and all had been revalidated. (Every GP is appraised annually and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example how to deal with emergencies and safeguarding. As the practice was a training practice,

Good

Are services effective?

(for example, treatment is effective)

doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainee we spoke with about the support they received.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles who saw patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (lung disease) and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, x-ray results and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. All relevant staff were clear about their responsibilities to pass on, read and act on any issues that arose from communications with other care providers on the day that they were received. The GP who saw these documents and results was responsible for the action required.

In addition to this, the practice had developed a 'results protocol' which was seen to be a robust management system to deal with patients' results promptly and allocated to a GP who actioned them. The 'results protocol' was seen to provide in-depth detail for clinicians on how to respond to specific results for both adults and children, whether inside or outside the normal range. Staff we spoke with told us that the system ensured a consistent approach to managing all types of results. They confirmed that the 'results protocol' was shared with other practices if they wished to use it. We saw that the 'results protocol' was followed each day. Staff confirmed that no test results were missed and felt the system worked really well.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for dealing with hospital communications was working well in this respect. The practice undertook a yearly audit of patients who had been discharged from hospital to ensure that all follow ups were appropriate and documented and no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs. These meetings were attended by palliative care nurses and other health professionals whose decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We saw that the practice used special notes to ensure that the out of hours service was also aware of the needs of these patients when the practice was closed.

The practice was part of a local GP federation which was made up of 44 practices who worked together to look at the effectiveness of GP practice in meeting the needs of patients. The practice was also working in collaboration with other practices to support those patients living in care homes.

Other services that the practice worked with were: the Child and Adolescent Mental Health Service (CAMHS), the Community Mental Health Team (CMHT), health visitors and a midwife who held a weekly ante natal clinic at the practice. We saw that the practice supported vulnerable patients who were homeless or had a drug dependency and we saw evidence of how they worked to provide an effective service to these patients. For example staff told us that they did not turn these patients away and they were seen by a GP on the same day. Staff gave us an example of one homeless patient who was seen on the same day and was referred immediately to hospital due their condition. Staff also confirmed that they worked closely with Ark, a homeless charity when appropriate. Staff gave an example of how they had referred a homeless patient to Ark who was eventually found a permanent home.

Information sharing

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

Good

Are services effective?

(for example, treatment is effective)

The practice had signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that all clinical staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example when making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was obtained. We saw evidence of completed consent forms which recorded the relevant risks, benefits and complications of the proposed procedure.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant or the practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We saw that two GPs at the practice had developed a 'Hypertension Pathway' which gave clear information to nursing staff on how to manage patients with this condition. This ensured a consistent approach was carried out by all clinical staff for these patients.

We noted a culture among the clinical staff to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic sexual health screening to patients aged 18-25 or a referral to the smoking cessation clinic in Shrewsbury to smokers. The practice also offered NHS Health Checks to all its patients aged 40-75 which were carried out by the practice nurse or the healthcare assistant. The GP was informed of all identified health concerns and followed these up in a timely manner.

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 had recently developed a register of all patients with a learning disability and we saw that 30% of these had received a check up in the last few months. Staff told us that this was an ongoing process and they were working to complete all of the reviews for these patients by the end of March 2015.

We found that the practice had signposted vulnerable patients and those with mental health problems to access various support groups and voluntary organisations such as MIND, a national mental health charity. The practice also offered other health promotion and prevention services which included cervical screening, sexual health advice, a menopause service and signposted patients to exercise for health programmes and local walking groups.

There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

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

Good

Are services effective?

(for example, treatment is effective)

current national guidance. Last year's performance for all immunisations was mostly above average for the CCG and again there was a clear policy for following up non-attenders by the named practice nurse.

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 national patient survey 2014 and from a survey to assess patients' satisfaction of services, undertaken by the practice in conjunction with the patient participation group (PPG) called Riverside Support Group. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care patients receive.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 96% of respondents describe their overall experience of this surgery as good. The practice was well above average for its satisfaction scores on consultations with GPs and nurses with 95% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 24 completed cards and all of these were extremely positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and thorough. They said staff treated them with dignity and respect and were sympathetic and understanding in times of need. One comment stated that they did not always have access to their preferred GP; however they felt that all the care received was very good. We also spoke with 17 patients on the day of our inspection. All told us they were extremely satisfied with the care provided by the practice and said they were always treated with dignity and respect.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a poster in the waiting room reminding patients to respect each other's privacy at the reception desk which helped to prevent patients overhearing potentially private conversations between patients and reception staff. We saw this was supported by patients during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager and office manager told us they would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient waiting area and information in the practice handbook about the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Staff gave us examples of how they supported patients whose circumstances may make them vulnerable such as those who were homeless or had a mental health crisis. Staff told us about how they enabled them to access the practice without fear of stigma or prejudice and treated them in a sensitive and sympathetic manner. Staff confirmed that they enabled homeless patients to use the practice address to register for NHS services and acted as a holding service for them to receive mail. Staff were seen to be extremely knowledgeable and caring about their vulnerable patients and their needs. One member of staff told us that they sometimes had homeless people who slept in the practice's car park. Staff told us that they supported them and allowed them to stay there, offering snacks to them and their animals. This demonstrated a compassionate and kind approach to vulnerable people.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example, data from the national patient survey showed 86% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at

Good

Are services caring?

explaining treatment and results which was above the local CCG average. The results from the practice's own satisfaction survey showed that all patients who responded felt they were sufficiently involved in making decisions about their care.

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

Staff told us that translation and interpreter services were available for patients who did not have English as a first language. They also told us they arranged access to signing services for those patients who needed them. We saw that a hearing loop was provided in the reception area.

The practice had a robust system for recalling patients with a long term condition such as diabetes or asthma. Patients were invited to attend the practice at least annually around their birthday for a review of their health condition. We saw that almost all of these patients had received a review and each patient had a health care plan which had been agreed with them. The practice supported patients with more than one long term condition to be able to attend their annual reviews for those conditions at the same appointment. Two patients we spoke with told us that this was very helpful to them.

The practice held a register of people who had a learning disability. We saw that there were 71 patients on the register and that there was a system in place to ensure that they received an annual health review.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88% of patients who responded said that the last GP they saw or spoke with was good at treating them with care and concern. Patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this information. They told us that staff were caring and compassionate. We heard from one patient about how sympathetic and understanding the staff at the practice had been during a difficult period for them.

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

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. We saw that the practice had developed a protocol to deal professionally and sympathetically with the death of a patient either as an unexpected or expected death. This was to ensure that all relevant professionals were informed and helped to alleviate some of the pressures for the bereaved family members. We saw that a significant event was initiated in the case of an unexpected death and investigated. This protocol was identified by the Clinical Commissioning Group (CCG) as a quality item and had been shared with other practices.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. For example, one GP showed us evidence of how the CCG had identified and supported the practice to remain in its central location to continue to provide essential services to vulnerable patients such as those who were homeless or had addiction issues. We saw that the practice was proactively working with the CCG to identify and secure a new, replacement building for the practice in the town centre and provide improved services for their most vulnerable patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Riverside Support Group. The Riverside Support Group was a group of patients at the practice who acted as a link between the practice and the patients and worked with the practice to provide a better service to meet patients' needs. We saw that this patient participation group (PPG) had worked with the practice to identify key areas that should be investigated in the annual patient satisfaction survey which was carried out in February 2014. We saw records which showed that the main objective of this survey was to assess patients' access to appointments, their preferred method(s) and patient satisfaction with services provided on a practice wide basis. The results of the survey showed that patients were reasonably responsive to new initiatives such as the introduction of a nurse led clinic. The practice also offered facilities for patients to book appointments and order repeat prescriptions on line via the practice's website as a result of patient feedback from the survey.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, such as patients with a learning disability, patients with a mental health condition and carers. The practice proactively removed any barriers that some patients faced in accessing or using the service. Staff we spoke with were knowledgeable about how to support patients who were homeless, travellers or temporary residents. For example, the practice enabled people who were temporarily resident in the area to register with the NHS by allowing them to use the practice address. Also the practice did not have a car park for patients; however it offered the limited staff parking that it had to those older patients who needed to park at the practice.

The practice had a register of patients with a learning disability who were contacted for an annual review. We saw that there was a system for flagging vulnerability in individual records such as those people who were at the end of their life.

We saw records which showed that the practice had more than double the number of patients from ethnic minority groups compared with the local CCG rates. The practice provided equality and diversity training for staff through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff meetings or appraisals as appropriate. Staff told us that translation services were available for patients who did not have English as a first language. We saw information was available for patients informing them about this service.

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams however the doors to access the practice were not automatic. Three patients told us that this made it more difficult for them to enter the premises. We saw that there were accessible toilet facilities available for all patients attending the practice.

Access to the service

Appointments were available from 8.30am to 6pm on weekdays. Comprehensive information was available to patients about appointments on the practice website and in the practice booklet. This included how to arrange

Good

Are services responsive to people's needs?

(for example, to feedback?)

routine and urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent 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 in detail on the practice website and in the practice booklet.

We saw that the practice had carried out an appointments audit in 2013 as a result of the increased demand and pressure on appointments and the complexity of consultations. As a result of this audit, telephone consultations for patients were introduced for routine clinical issues and a script was developed for the reception staff to follow to support patients to access these appointments. Three months after the introduction of the telephone consultations for patients, a reassessment was carried out. We saw that the practice considered it had been extremely successful for clinicians and patients. Patients we spoke with during the inspection and feedback from comment cards confirmed that they found the telephone consultation service very useful. Patients who had work commitments told us that it saved them taking time off work and the ability to access online services was also extremely useful. Two older patients we spoke with said that they appreciated being able to speak with a GP and not having to travel by bus into the practice.

The practice had introduced a new nurse led clinic for patients with minor illnesses, for example a sore throat or flu symptoms. Patients could make a same day appointment to see a specially trained nurse. Longer appointments were also available for patients who needed them, for example those with mental health needs or with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. The practice was open for appointments during the lunchtime period each weekday. One patient said this was extremely helpful as they could attend the practice during their lunch break at work. Two patients told us that they often had to wait for long periods to see a preferred GP; however they felt that they always received good care.

We spoke with two parents during the inspection who told us that they were always able to get a same day appointment for their child and the GP saw them promptly. We also saw that one of the nurse led clinics was provided at a time to fit around school times.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. We saw that there was a complaints leaflet in the waiting area and information about how to make a complaint on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last eight months and found that they were satisfactorily handled, dealt with in a timely way and demonstrated the practice had an open and transparent approach when dealing with complaints. For example, one complaint had been made by a patient who had received an incorrect repeat medicine on three occasions. We saw from the records that a letter of apology had been sent to the patient and discussed with staff at an administration meeting. No complaints had been referred to the Parliamentary and Health Service Ombudsman (PHSO).

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to continue to deliver high quality care and promote good outcomes for patients in new premises. We saw that this vision formed the basis of the practice's business plan for 2013/2014 and a business case had also been developed to move the practice to new premises. Staff told us that they were working with the Clinical Commissioning Group (CCG) to realise this vision.

We spoke with 11 members of staff and they all demonstrated their commitment to delivering high quality care and promote good outcomes for patients. Staff told us that patients were at the 'heart of the practice' and they ensured that systems were established to provide good, safe 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. We looked at eight of these policies and procedures and saw that they were reviewed annually and up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and GPs with leads for safeguarding, diabetes, training, prescribing, dementia and contraception. We spoke with a range of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held a variety of meetings which included a partners meeting every six weeks, clinical meetings every three weeks and an executive team meeting every three weeks to ensure swift decision making. We saw that several other meetings took place for all staff groups.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the practice had completed an audit of the prescribing of bisphosphonates, a drug which has been found to reduce the number of fragility fractures in older people. We saw that the audit had identified areas for improvement. An action plan was put in place which included the follow up of all relevant patients and had been discussed at a practice clinical meeting. This audit had been completed from August to October 2014. A re-audit was planned in 12 months to assess the impact of the changes.

The practice had robust arrangements for identifying, recording and managing risks. We saw that staff had access to risk assessments on the computer. They told us that any concerns they had about risks, they would raise them with their line manager. We saw that risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, manual handling and health and safety.

The practice held clinical governance meetings every three weeks. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw that team meetings were held regularly, at least monthly. Minutes were not always recorded for some meetings. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at any time including team meetings. All staff we spoke with said that they felt valued and that all senior staff, including GPs, were approachable and supportive.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and information governance policy. We also saw that the practice had a whistle blowing policy in place to support staff which explained how they would be supported if they needed to raise any concerns. Whistle blowing takes place when a member of staff raises concerns to their own organisation or to the public without jeopardising their employment rights.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints received. We looked at the results of the annual patient survey and 42% of patients

Are services well-led?

Good

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

agreed telephone consultations would be useful. We saw as a result of this the practice had introduced telephone consultation appointments. We also saw that 71% of patients were interested in seeing a specially trained nurse for minor illnesses. This contributed to the decision to introduce nurse led clinics in the practice.

The practice had an active patient participation group (PPG) and a virtual group which included representatives from various population groups for example older people and people of working age. The PPG met every quarter and provided feedback to the practice about the areas that should be investigated in the annual satisfaction survey. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. However, we did not see that minutes of the PPG meetings were available on the practice website to enable more patients to participate in the running of the service at Riverside Medical Centre.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

One member of the nursing team told us that the nurses had raised the possibility of completing additional training at their appraisals to enable them to provide nurse led clinics for patients. We saw that this request had been supported by the practice. Two nurses had completed a week long residential training course, spent three months observing GPs with emergency patients and co-consulting with the GPs to ensure they were suitably competent to lead the clinics. The nurse led clinics commenced on 1 April 2014 following an in-house training day for all the staff to support patients to access the new clinics.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and each staff member had protected learning time throughout the year. This was evidenced by records seen of training completed for all staff. We also saw that the practice had offered a modern day apprenticeship scheme which had led to one receptionist securing a substantive post at the end of the apprenticeship period.

The practice was a GP training practice for GP registrars and supervised medical students. GP registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine. There was a lead GP at the practice who had responsibility for the training and support of the GP registrars. We spoke with one of the registrars during the inspection. They told us that they had a full induction and felt well supported by staff at the practice. They said that they always had access to a GP or trainer if they needed their advice. The registrar informed us about a significant event they had been involved in that had led to an improvement in recording details of a particular patient group on the practice computer. This demonstrated that the practice valued the contributions of the registrars and provided an effective training programme.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, staff raised an issue about a vaccination. We saw that the practice had made the issue a significant event, carried out an investigation and took action to prevent the issue occurring again. We saw that all staff, including administration and reception staff raised significant events which demonstrated an open and transparent culture within the practice.