Rosebank Health

Quality Report

Rosebank Surgery
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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?	Requires improvement
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 carried out an announced comprehensive inspection at Rosebank Health, also known as Rosebank Surgery on 8 January 2015. Overall the practice is rated as good.

Rosebank Health is a partnership of seven GPs. It has two purpose built surgeries one located near to the city centre of Gloucester, known as Rosebank Surgery and the other practice at St James in Quedgeley known as the Severnvale Surgery. As part of this inspection we visited both surgeries.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It required improvement in order to provide safe services.

Rosebank Health was also good for providing services for older patients, patients with long term conditions and patients with poor mental health. It also provided good services for patients of working age, the recently retired and students, patients whose circumstances made them vulnerable and mothers families and young patients.

Our key findings were as follows:

- 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.
- Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice responded when patients said they found it difficult to make a same day appointment.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

- There were clinics held within the practice where staff from the Benefits Agency attended to give advice. Patients were able to make appointments to have confidential advice. Also the GPs could refer patients to the clinics if they felt it appropriate.
- Learning from a significant event, several years ago led to the development of the 'Gold Standard Patient' initiative within the practice. If patients were having a difficult time with their health they were referred to as a Gold Standard Patient. They were sent a letter explaining how the practice would like to do everything possible to help patients make appointments, request home visits or get prescriptions more efficiently. They were asked to say they were a gold standard patient when telephoning the practice so that they received priority treatment.

We saw an area of outstanding practice:

The GPs referred some patients with poor mental health to an art service to assist with their mental well-being. We saw evidence to show this was successful as a comparison of before and after referral to the service reduced consultation rates. We were told this was popular with patients.

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

Importantly, the provider must:

- Review the way it manages medicines. We found the storage of medicines in refrigerators to be unsatisfactory.

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?

Requires improvement

The practice is rated as requires improvement 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 patients safe.

However, the practice must improve the way it manages medicines. We found the storage of medicines in refrigerators to be unsatisfactory.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from Public Health England showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the

Summary of findings

practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders took place. The practice responded when patients said they found it difficult to make a same day appointment by introducing a triage service.

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 active. 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. 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 offered home visits and rapid access appointments for those with complex needs.

There were 120 patients living in care homes all of whom had bespoke care plans that were linked to the Out of Hours service. The GPs told us this service decreased the number of hospital attendances and admissions for this group.

Learning from a significant event, several years ago led to the development of the 'Gold Standard Patient' initiative within the practice. If patients were having a difficult time with their health they were referred to as a Gold Standard Patient. They were sent a letter explaining how the practice would like to do everything possible to help patients make appointments, request home visits or get prescriptions more efficiently. They were asked to say they were a gold standard patient when telephoning the practice so that they received priority treatment.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice had developed the Rosebank Health COPD and Avoiding Unplanned Admissions Care Plan. It listed patient's personal information, their medicines and important contacts. There was information relating to staying healthy, signs of COPD flare up and action to be taken. The care plan was designed for patient's to take to hospital or give to the 999 emergency services.

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.

Summary of findings

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. Immunisation rates were relatively high for all standard childhood immunisations in comparison to other GP practices within the Clinical Commissioning Group area. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors.

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 by extending its opening hours. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice was compiling a register of patients living in vulnerable circumstances. It held a register of patients with a learning disability and had carried out annual health checks for them. It offered longer appointments for people with a learning disability and visited them at home if they did not arrive for appointments.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with

Summary of findings

poor mental health had reviews of their condition and were given longer appointments so their physical health could also be checked. They were contacted by telephone and by letter and the appointments provided the opportunity for health screening.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The GPs referred some patients to an art service to assist with their mental well-being. Most patients attended the group within the Rosebank surgery for eight weeks and an experienced artist introduced patients to new skills. We were told this was popular with patients. We saw evidence to show this was successful as a comparison of before and after referral to the service indicated reduced consultation rates.

Summary of findings

What people who use the service say

We spoke with eight patients, at each of the surgeries. None of the patients said they had any complaints however, some did make comments about the telephone system and the length of time they had to wait to see a specific GP.

Healthwatch Gloucestershire held listening events in Gloucester. They captured the views of passers-by in shopping arcades about the service they received from their GP practice. They shared these comments with us. There were mixed views about patient's experiences. Some praised both Rosebank and Severnvale surgeries making comments about the great care, being impressed with the GP, excellent GPs and reception staff. However, other patients made negative comments about waiting times, the telephone system, treatment and staff approaches.

Patients told us they felt staff were very caring and two expectant mothers we met spoke highly of the community midwifery service provided from the practice.

One mother of a young child, referred to the 'brilliant' treatment they had for their child who had always been seen the same day or had a triage appointment.

Two patients said they felt the triage system could be more organised.

Some patients told us they felt their privacy and dignity was respected and patients said treatment options were explained to them so they could give informed consent.

Areas for improvement

Action the service MUST take to improve

The practice must review the way it manages medicines. We found the storage of medicines in refrigerators to be unsatisfactory.

Rosebank Health

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to Rosebank Health

Rosebank Health is a partnership of seven GPs. It has two purpose built surgeries one located near to the city centre of Gloucester, known as Rosebank Surgery and the other practice at St James in Quedgeley known as the Severnvale Surgery. As part of this inspection we visited both surgeries.

Information taken from Public Health England in December 2014 showed Rosebank Health had in excess of 23,500 patients registered across its two surgeries. It is in an area of the fifth less group for deprivation. One being the most deprived and ten being the least deprived. Most patients (69.9%) were in employment, 43.9% patients had a long standing health condition and 19.3% of patients had caring responsibilities.

We visited each of the surgeries and noted they have level access and are suitable for patients who use wheelchairs and for children in pushchairs.

Each of the GP partners has additional qualifications and has special interests including minor surgery and vasectomy, sports medicine, asthma, contraception, occupational medicine, diabetes, kidney disease and elderly care medicine. One of the GPs has a particular interest in cardiology. There are salaried GPs working in the practice. The practice is an approved GP training practice and has experienced doctors working under supervision to train as a GP. Overall, there are nine female GPs and five male GPs.

The partners employ a manager to have overall responsibility for the management of the practice. They also employ a range of nurses and healthcare assistants along with receptionists and administrators.

Each of the surgeries has district nurses and health visitors attached. There are midwifery services and the practice has access to the community mental health team.

Each surgery had equipment to enable patients to take their blood pressure reading and present the reading to the practice that it could be monitored and recorded.

The practice scored well for the Quality and Outcomes Framework (QOF) for 2013/14 achieving 99% points. Its results were slightly down for diabetes management and peripheral arterial disease.

The practice has opted out of providing Out of Hours services and contracts this with the Out of Hours Primary care Centre based at Gloucestershire Royal hospital Accident and Emergency Department.

Why we carried out this inspection

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We visited the practice and its branch surgery on 8 January 2015.

During our visit we spoke with the GPs, practice manager, administrative staff, receptionists and nurses and spoke with patients who used the service. We observed how people were being received at reception and greeted by the GPs. We talked with carers and/or family members and reviewed the personal care or treatment records of patients.

We sent comments cards in advance of our visit however, none were completed.

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:

- 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)

Requires improvement

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 responded to national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

Alerts from the Medical and Healthcare Products Regulatory Agency (MHRA) were circulated to all GPs and nurses. If these identified an issue this was communicated to all GPs and nurses so they could respond appropriately.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of events that had occurred and we were able to review these. Significant events were reviewed with all staff during protected learning time. We saw a summary of the significant events for 2014. The summary described the nature of the event and actions taken.

This demonstrated the practice learned from significant events and the finding were reviewed with relevant staff. The practice manager managed the system for monitoring incidents.

National patient safety alerts were disseminated by the practice manager to staff. These were also discussed at practice meetings.

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 of relevant organisations were easily accessible.

We saw the practice safeguarding children policy had been updated in June 2014. It gave staff information about the practice arrangements to ensure children were protected, identified the practice 'lead' GP and described how to recognise signs of abuse.

The practice maintained a register of children in need and those with multi-agency child protection plans and a dedicated member of staff kept this up to date. There were flags placed on these patients' records as alerts to healthcare workers to be vigilant. The register included all children identified by a health visitor as a child in need, where abuse had been identified, looked after children and those who were fostered.

There was a practice lead for safeguarding children and monthly multi-disciplinary meetings were held to discuss the register. If a GP was unable to attend a child protection case conference they submitted information to assist in the meeting. The practice lead attended county wide safeguarding child liaison meetings. We saw the record of the meeting held in October 2014. It showed there were three patients reviewed and updated along with three new patients added to the list reviewed.

Staff confirmed they attended training in safeguarding children and protecting vulnerable adults and some were aware of the practice lead in this area. The practice manager confirmed to us after our visit that all staff had been reminded who the practice lead was.

The practice 'at risk adults' policy was updated in November 2014. It described how to recognise abuse of vulnerable patients and included information about domestic violence. Staff were aware of their responsibilities and confirmed they had completed training.

Staff were aware of the practice whistle-blowing policy and told us they felt they able to report concerns.

The practice website outlined how Rosebank Health was committed to providing a safe, comfortable environment where patients and staff could be confident best practice was being followed at all time and the safety of everyone was of paramount importance.

It explained how all patients were entitled to have a chaperone present for any consultation, examination or procedure where they feel one was required. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical

examination or procedure. The chaperone policy described how the practice could make a formal chaperone available. It also explained how a healthcare professional may also require a chaperone to be present in certain circumstances. Staff we spoke with who acted as chaperone had received specific training for the role and had been checked to ensure they were suitable for the role.

Medicines management

The practice must improve the way they manage medicines. At the Severnvale branch surgery we saw the medicine refrigerators in the administration room contained influenza vaccines and gels however they were not locked and not kept in a locked room. When checked the temperatures were found to be within the safe range.

A second fridge was kept inside a cupboard where there was poor air circulation and the temperature of the fridge was recorded ion Fahrenheit and there was no conversion chart accessible to convert it to centigrade and it could be outside of the safe storage range. This could mean that recorded temperatures may not be recorded accurately and could be open to error and patients could be given vaccines that were not effective.

We saw that patient group directions (PGD) were not signed by a GP. PGD are authorisation for a particular type of medicines to be administered without the need for a patient specific direction (PSD). They were circulated to staff electronically but not signed by a GP in paper format. The practice has since changed this system. We were told GPs recorded in patients notes what medicines individual patients were to be administered and nurses trained to give vaccines and other medicines by injection administered the medicines.

The practice employed prescribing assistants to manage requests for repeat prescriptions and respond to test results. They told us if there were any queries about the medicines patients requested they would bring it to the attention of a GP.

The practice did not stock any controlled medicines.

We noted prescription paper left in printers however consulting rooms and offices were locked when not in use.

Cleanliness and infection control

We observed both premises to be clean and tidy. 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.

At Severnvale surgery we saw a hand hygiene audit had been completed. It showed staff were using recognised safe techniques for hand washing.

There were guidelines for the action to be taken in the event of a sharps injury displayed in the Severnvale surgery. Staff we spoke with demonstrated an understanding of the policy and the action they should take. One member of staff told us how they incurred a needle stick injury, the advice they sought and the action taken, this was in line with the policy we saw.

One of the staff at Severnvale surgery told us how last year the cleaning contractor was contacted because the cleanliness was found to be not good enough. Since then the contractor had employed new staff and there had been improvement.

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.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

The practice recruitment policy outlined the procedure to be followed when new staff were recruited. It specified the level of checks required and we saw this followed. The practice had a specific policy relating to the checks needed to prevent illegal working including the documents that could be used to prove the right to work.

Requires improvement

Are services safe?

We were told the practice ethos was to communicate with each other. The GPs said they felt it was important to socialise and monitor colleagues to ensure each other's well-being.

One of the GPs who had been recruited to work in the practice told us how during their interview they were 'tested' on clinical scenarios.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risk assessments were completed. Risks were assessed and actions taken to minimise risk were recorded and reviewed.

We consulted an external agency who worked closely with the practice providing services. Their representative said they worked with patients who presented with risk of suicide, self-harm and self-neglect. They told us the practice staff response to crisis situations was good and timely.

We received feedback from one of the care homes the practice linked with the enhanced care home service. They told us the service patients received had always been satisfactory. They said they felt the service was safe, and staff could always rely on the assistance of the practice during working hours. They told us how they were supported by having access to a GPs mobile telephone to get assistance.

Succession planning had identified a risk that was some of the GPs were reaching retirement age. Recruitment difficulties added to the risk. The practice maintained on-going recruitment to mitigate the risk.

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).

One of the practice nurses was responsible for ensuring the emergency medicines were checked and in date.

At Rosebank surgery we checked the emergency medicines. The records of checks of the medicines were comprehensive.

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.

The practice used a clinical patient recording system. It allowed for coded recording of patient consultations, electronic patient referral to secondary care services and referral acceptance from NHS 111. It was used for appointment scheduling, prescribing and medicines management, identification of life threatening conditions and gave access to the summary care record.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

One of the GPs developed a template used within the practice, based on National Institute for Health and Care Excellence guidelines, to record 'fever'. This was embedded into the patient record and enabled the practice to ensure consistent, evidence based assessment of child patients who were ill that was beneficial to patients.

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

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) registers were monitored closely. They recorded practice 'scores' for management of chronic heart disease, heart failure, atrial fibrillation and hypertension. In addition there were registers for prescribing arrangements for patients with chronic kidney disease, diabetes, asthma and chronic obstructive pulmonary disease (COPD).

At the influenza immunisation clinics patients were asked if they had a cough. If they did they underwent a test of their respiratory function. During the clinics there were six new cases of chronic obstructive pulmonary disease identified.

The practice had an enhanced service contract for diabetes management. An audit of arrangements for patients with a diagnosis of diabetes showed an overall improvement of recording in respect of the condition. One of the practice nurses told us how they liaised with one of the GPs for diabetes management.

The practice also had an enhanced service contract for dementia care. An administrator managed the recalls for appointments for these patients. During the influenza immunisation clinics patients were asked about their 'memory'. If they told staff they were having problems they were immediately seen by a GP for a memory assessment.

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and IT/ administration manager to support the practice to carry out clinical audits.

The clinical patient management system allowed for quality audits. We saw these included prescribing and monitoring of stimulant medicines where patients had attention deficit hyperactivity disorder (ADHD), anti-psychotic prescribing, antibiotic use and controlled drug usage. We saw a summary of audits carried out in 2014 which recorded the outcomes and actions taken.

In addition there was an audit of patients with Coeliac disease which led to all patients with the disease being written to have a blood test and make an appointment with their usual GP.

The practice also audited its patients with chronic kidney disease. Generally the results were good with 90% patients having had their blood pressure checked within the last year and 75% of those being on target. When patients were diagnosed with chronic kidney disease the practice arranged for them to be reviewed within six months of diagnosis in line with current guidelines. Actions were identified to improve results and patient safety.

Good

Are services effective?

(for example, treatment is effective)

The practice conducted an audit of the prescribing of anti-psychotic medicines and monitoring their use. A template was developed to assist with on-going monitoring of use of these medicines.

This enabled the practice to keep the register of patients prescribed anti-psychotic medicines up to date.

When blood tests were carried out the results were received into the practice where they were checked. Any abnormal results were given to the GP to follow up and patients were sent a letter to make an appointment so they could have a consultation with a GP about the test results.

We saw a survey of patients who were prescribed a particular blood thinning medicine. Patients indicated they were happy with the blood testing provided in the surgery to determine the dose of medicine they needed to take. There were 100% positive responses to a question that asked if the staff listened and gave time to discuss the medicine. The anti-coagulation protocol was updated in September 2014 to indicate the arrangements to be made when patients needed blood tests at the weekend.

There were three medical secretaries employed. The GPs had voice activated systems to enable them to record information for referral letters. The secretaries prepared the letters and gave them back to the GP for checking and signing. They also made choose and book first appointments on behalf of patients who requested this.

We looked at the practice internal website (intranet). There were sections related to safeguarding and palliative care. It included a 'virtual ward' where hospital admissions, discharges and deaths were tracked. The intranet had links to other services and websites and gave staff access to telephone contact details. This enabled staff to access information which supported patients to receive the most appropriate treatments and follow up actions.

Effective staffing

We were told a new nurse manager had been appointed. The practice offered apprenticeships and there were four in post. Two of these were receptionists and two were in administrative staff roles.

A new member of staff told us their induction had followed a check list that required them to read the practice protocols to ensure they were familiar with essential processes such as fire safety.

Staff told us they attended external training. A practice nurse told us about the cervical cytology update they had completed that enabled them to conduct smear tests.

Planned future update training included health and safety, infection control, Mental Capacity Act (2005) awareness and communication. In addition there was to be the annual update training in dealing with medical emergencies and resuscitation.

Protected learning time and clinical meeting topics were scheduled every three months for 2015. The schedule showed staff were required to complete on line learning that would then be discussed at clinical meetings. These meetings included reviewing complaints and significant events so that learning from these was shared. Sometimes visiting speakers were brought into the clinical meetings to enable staff to maintain their continuing professional development requirements. One member of staff told us there was also other basic training available. A member of staff confirmed that protected learning time was held jointly with the GPs.

We were told about on-going difficulties in recruiting new partners and salaried GPs. The practice was a training practice and in the past, newly qualified GPs had remained with the practice. However this no longer seems to be the case and had added to the recruitment difficulties the practice had experienced.

Working with colleagues and other services

Staff had designated responsibilities. A healthcare assistant told us 60% of their work was phlebotomy, the taking of blood for testing. They had completed additional training to assist the nurses with immunisations. They were involved in applying simple dressings, and had received training for administering other injections and carrying out echocardiogram (ECG) readings. They took the ECG readings at the request of a GP and printed the result. If the reading was abnormal they would mark this on the reading and it would be seen by the GP straight away. If normal it would be scanned and the GP would pick it up thorough the workflow system.

A practice nurse told us about their range of duties that included immunisations including travel vaccines, cervical cytology and four layer dressings, for deep wound debridement. They also spent one day each week working

Good

Are services effective?

(for example, treatment is effective)

with a GP on the practice avoiding unplanned admissions to hospital register. The register listed 389 patients who could possibly be admitted to hospital if their health was not monitored regularly.

We spoke with a triage nurse. They told us they triaged patients by telephoning them during the morning to determine whether they needed an emergency appointment. They were trained to prescribe medicines and held a minor illness clinic.

We consulted an external agency who worked closely with the practice providing services. Their representative said they were working with the practice to make the interface between services more effective to meet the needs of patients with poor mental health. They told us how they were currently working on optimisation of the service and reduction of the waiting list.

The practice had a contract to provide an enhanced service to care homes. This included training for staff in the care home, proactive care planning, regular visits for non-urgent care and extra time for visits and the opportunity to provide a holistic service. There were 120 patients living in care homes all of whom had bespoke care plans that were linked to the Out of Hours service. The service decreased the number of hospital attendances and admissions for this group of residents. The service started as a pilot scheme but its success had led to it being extended.

We received feedback from one of the care homes the practice linked with for the enhanced care home service. They told us the service patients received had always been satisfactory. They said when they contacted the practice they were greeted in a friendly way by the receptionists and transferred to a GP. They told us about the regular reviews carried out and how they felt good communication had reduced hospital admissions. The care home told us they could get last minute visits and visits after evening surgery.

The practice offered family planning and contraceptive services including advice, contraceptive implants and intra-uterine devices. Ante natal clinics were held at each of the surgeries with midwives in attendance. There were new baby clinics and six week checks were carried out. Parents were sent letters and received phone calls as reminders for child immunisation and we were told nurses took the opportunity when possible to ensure children were up to date with immunisations. The practice achieved higher than target numbers for achieving childhood immunisation. It had a robust recall process that included telephone calls and letters being sent when immunisation was due.

The practice was signed up to be a part of the Organisational Resilience and Capacity Planning for 2014/15. This initiative was a joint piece of work that brought together NHS England, the NHS Trust Development Agency, Monitor and the Association of Directors of Adults Social Services. It is a joint plan to meet the demand of winter pressures.

Information sharing

The practice liaised with the district nursing teams and integrated care team.

The practice maintained a register of patients receiving palliative care. The register identified those who were terminally ill and further identified those who were at the end stage of life.

There were regular meetings with the palliative care team, multi-disciplinary staff also attended so they were kept informed. Another significant event where the family of a patient were unhappy about communication with the practice led to these meeting being increased in frequency from three monthly to monthly.

Patients who were at the end stages of life were visited daily by one of the district nursing team and as frequently as necessary, by a GP. The practice maintained close links with local consultants.

Learning from a significant event, several years ago led to the development of the 'Gold Standard Patient' initiative within the practice. If patients were having a difficult time with their health they were referred to as a Gold Standard Patient. They were sent a letter explaining how the practice would like to do everything possible to help patients make appointments, request home visits or get prescriptions more efficiently. They were asked to say they were a gold standard patient when telephoning the practice so that they received priority treatment.

Consent to care and treatment

The Mental Capacity Act (2005) policy outlined the core principles of the act, described the assessment of capacity and included a mental capacity assessment checklist. It referred to the principles of best interest and had specific

Good

Are services effective?

(for example, treatment is effective)

guidance around advanced directives. Staff demonstrated knowledge of capacity issues. One of the nurses confirmed they had attended training in The Mental Capacity Act 2005 and consent to treatment.

A mental health nurse held regular clinics in the practice.

Health promotion and prevention

The practice maintained a register of patients who were housebound and all patients over the age of 75 years had a named GP, care plan and regular review. Patients who were housebound were able to have home visits in the middle of the day and there was a GP allocated for this on the day after a bank holiday when there was traditionally a high volume of requests for home visits. Patients who were prescribed blood thinning medicines were able to have blood tests at home. In order to maintain continuity of care to housebound patients or patient who were too ill to visit the surgery, locums were not asked to do home visits routinely but may do so if demand was high.

The GPs referred some patients with poor mental health to an art service to assist with their mental well-being. We saw evidence to show this was successful as a comparison of before and after referral to the service reduced consultation rates. We were told this was popular with patients.

Cervical screening was available at the practice and nurses were qualified to perform the tests on behalf of the GPs. Female patients over the age of 25 years were sent reminders that a test was due. This was three yearly for women under the age of 50 and every five years for women over that age.

The practice website and brochure provide information about registering with the practice. New patients must live within the practice boundary which was shown on a map on the reverse of the brochure. The practice required new patients to complete a patient registration form and health questionnaire. They were offered a health check with a member of the healthcare team to ensure all required tests were up to date. Medical treatment was available from the date of registration.

We saw posters displayed and leaflets available for patients to take away in each of the surgeries. These related to health conditions including smoking cessation and services available locally.

There was information and home testing kits available for young people to take away in order to test for Chlamydia.

Good

Are services caring?

Our findings

Our findings

Respect, dignity, compassion and empathy

We consulted an external agency who worked closely with the practice providing services. Their representative said the service was caring particularly when it concerns patients with multiple physical and emotional needs.

We received feedback from one of the care homes the practice linked with for the enhanced care home service. They told us the service patients received had always been satisfactory. They said all of the GPs and other staff at Rosebank Health were very caring and supportive. They had never been declined assistance. They told us how reception staff had responded in a positive way to requests for help obtaining prescriptions and taking them to the pharmacy in order for medicines to be available for patients more quickly.

The practice brochure contained information relating to patient information and confidentiality. It reassured patients information about them would be held confidentiality and only passed on to others such as hospitals, social services, health agencies or medical research bodies. It stated that identifying details would be removed if they were not essential.

The practice website had a translation service with a range of fact sheets that explained the role of UK health services, the National Health Service, to those for whom English was not their first language.

Healthwatch Gloucestershire provided feedback from patients. One patient described a pleasant visit however another comment referred to a GP speaking with them and not their husband, the patient.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 services were available for patients who did not have English as a first language. There were information leaflets on the practice website that could be translated into different languages.

Patients with poor mental health had reviews of their depression and were given longer appointments so their physical health could also be checked. They were contacted by telephone and by letter and the appointments provided the opportunity for health screening. When a patient attended for the first time with depression this was logged in a calendar by one of the administrators. If they did not attend for their planned review they were contacted to make a further appointment.

Patient/carer support to cope emotionally with care and treatment

We looked at the practice carer's policy. It stated the practice aimed to actively identify and support known carers who were patients of the practice or those who were caring for patients of the practice.

The practice actively identified carers and asked them to complete a carer form. The information from this enabled carers to be identified and was then taken into account during patient consultations.

The practice referred patients with caring responsibilities to the Gloucestershire Carers Service, with their permission.

The practice obtained consent from patients before sharing information about them with their carer.

The practice website gave access to a video recording related to caring for a parent and a range of information and contact details where support could be obtained.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Our findings

Responding to and meeting people's needs

We consulted an external agency who worked closely with the practice providing services. Their representative said they found the practice to be responsive to patients with emotional difficulties.

We received feedback from one of the care homes the practice linked with for the enhanced care home service. They told us the service patients received had always been satisfactory. They told us the practice always responded to requests for emergency visits or other assistance.

The practice had developed the Rosebank Health COPD and Avoiding Unplanned Admissions Care Plan. It listed patient's personal information, their medicines and important contacts. There was information relating to staying healthy, signs of COPD flare up and action to be taken. The care plan was designed for patient's to take to hospital or give to the 999 emergency services.

Patients with chronic obstructive pulmonary disease (COPD) had care plans and were given rescue medicines. We were told the practice had robust recall arrangements for patients with COPD and they had regular telephone reviews and follow up.

There was expansion in housing locally and the practice had approval from NHS England for a 900 square meter surgery in order to meet demand and had identified a potential site nearer to the housing developments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services including the homeless and those who misused substances. There was a centre for the homeless nearby to the Rosebank surgery and GPs maintained good links to ensure patients healthcare needs were met. The practice referred patients who abused substances to a local charity for support. One of the GPs we spoke with said there was a good protocol and arrangement for referral.

The practice was in the process of compiling a register of patients whose circumstances made them vulnerable.

Patients with learning disabilities were offered an annual health check with a healthcare assistant and GP. The practice used a recognised template for capturing information about the patient's physical examination, medicines, communication and behaviour. Where patients with learning disabilities lived in a care home the health check could take place there. The GP liaised with consultants as needed.

The practice identified a high rate of patients with learning disabilities did not attend for appointments and when this was the case they arranged home visits

The practice was part of a city wide initiative called 'Choice Plus'. It gave patients with acute health problems greater choice enabling them to attend practices other than their own. It was based on clinical decision making and conversation between the person's own GP and the receiving GP. The receiving GP had access to the patients summary care record.

Clinics were held for immunisation against influenza. These were held at different times on different days. These clinics provided a forum for assessing patient's health and to identify any diseases. They were also used for monitoring long term conditions and GPs were available for consultation if needed. We were told how on three Saturday clinics provision of the immunisation enabled between 700 and 800 patients to be assessed for other health conditions.

Access to the service

Rosebank surgery opened from 8.30 am to 6 pm on Monday to Friday. The Severnvale surgery opened and closed at the same time but closed between 1pm and 2pm each day. There were extended opening hours for appointments for those who were unable to attend during the surgery opening hours. These had been increased with winter pressure funding.

To increase access to the practice receptionists started work at 8am and there were more staff answering telephones at peak times. We were told this was in an attempt to resolve patient dissatisfaction.

The practice encouraged patients to see the same GP for continuity of care however, this was not always possible and patients could be offered an earlier appointment with a different GP. Home visits were available.

If a patient requested an urgent, same day appointment they were placed on the triage list and would be contacted as soon as possible by one of the medical team. The

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice brochure explained the purpose of the triage system was to ensure that all patients were treated fairly by an appropriate member of the team and to ensure problems were dealt with urgently if necessary. It explained many problems could be resolved without the need for a visit to the surgery. One of the nurses told us the system gave patients an 'open door' to the surgery. This was because the practice would not refuse any patient a consultation.

Each of the surgeries had an electronic touch screen arrival system to enable patients to check in without queuing at the reception desk.

The practice contracted Out Of Hours services with the Out Of Hours Primary Care Centre based at the city hospital. The telephone number for the Out Of Hours service was listed in the practice brochure and displayed within the practice.

Patients could order repeat prescriptions through the practice website. Repeat prescriptions could also be requested in writing or by completing a repeat prescription request at the surgeries reception desk. It was also possible to make and cancel appointments through the website up to eight weeks in advance and slightly longer for appointments with a nurse.

Test results were available by telephoning the surgery between 11 am and 1 pm and between 4 pm and 6pm.

The practice offered early morning blood tests from 7.30 am and was signed up by the Clinical Commissioning Group to provide extended hours some evenings and at weekends for patients of working age through an enhanced contract. NHS health checks were offered. Appointments could be made and cancelled on line and repeat prescriptions could be ordered through the practice website.

There were some additional appointments available with the practice nurses. Clinics were held for patients with skin conditions and the practice hosted community ultrasound services.

There were clinics held within the practice where staff from the Benefits Agency attended to give advice. Patients were able to make appointments to have confidential advice. Also the GPs could refer patients to the clinics if they felt it appropriate.

Listening and learning from concerns and complaints

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

The process for expressing comments, concerns or suggestions was outlined in the practice brochure. It informed patients that if they did want to make a complaint, comment or suggestion they should write to the practice manager. The brochure reassured patients their care would not be compromised if they did make a complaint.

The formal complaints process was described on the practice website. It explained what the practice would do and the timescales involved. The procedure gave the contact details for NHS England, the Independent NHS Complaints Advocacy Service and Health Service Ombudsman. It also gave the contact details for the Care Quality Commission.

We saw the practice maintained a log of all complaints received, the action taken and learning implemented as an outcome. The practice received 43 complaints and expressions of concern across both surgeries for 2014. Eight of the issues were related to communication, 20 related to administration and 22 related to clinical issues. Three did not relate to these areas of practice.

The reception team leader told us, as a result of learning from complaints, they spent more time with receptionists to ensure good customer service.

Are services well-led?

Good

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

Our findings

We received feedback from one of the care homes the practice linked with for the enhanced care home service. They told us the service patients received had always been satisfactory. The feedback included that the home considered the practice to be very well led. They told us how the patients had received letters informing of their named GP and they believed this gave patients confidence. In addition they told us about the smooth running of the influenza vaccination clinic held in the home and praised the practice for this.

Vision and strategy

The practice website outlined the aims of the practice as being concerned with providing the highest quality primary healthcare in the most efficient and effective way. It encouraged shared responsibility with patients in health matters and encouraged a climate of cooperation with other health providers.

The practice employed an information technology (IT) and data manager. They led a team of nine staff to support GPs, patients and staff with administration. This included scanning documents, audits and summarising new patient notes. The IT and data manager met with the lead GP for the QOF to monitor the QOF achievements and staff were offered incentives for achieving targets such as blood pressure checks and immunisations.

There were quarterly QOF meetings held for nurses to plan their strategy for achieving their goals and ensuring patients had the tests or immunisations they needed.

Governance arrangements

A business administrator was responsible for practice policies. We found the practice policies and protocols were easily accessible on the intranet and noted staff were required to sign these to indicate they had read and understood them. The practice had in excess of 100 different policies and procedures. We read seven of these and found they had been reviewed and updated.

There were strategic planning meetings held each month. We looked at the record of the meeting held in November 2014. It showed relevant topics were discussed including issues raised at the weekly partners meetings.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw a summary of the audits undertaken in 2014. They included audits on antibiotic prescribing, prescribing of controlled drugs, and recognising chronic kidney disease. The results of audits were presented at clinical meetings throughout the year and outcomes/actions were recorded. The outcomes for patients included being recalled for tests before further prescriptions were issued.

The practice produced a quarterly strategy report. Each GP had an area of responsibility and provided an update on that area of practice. These included, safeguarding, GP training, nursing provision, occupational health complaints, finance and the Quality and Outcomes Framework.

The nursing team met every two months. There were monthly meetings for discussing child protection and safeguarding vulnerable patients that involved district nurses and health visitors.

There was a system of appraisal to monitor staff and review their development needs. Staff told us they found the process to be useful.

Leadership, openness and transparency

The practice retention strategy included broad clinical support to all staff and mutual support. One of the GPs expressed a wish to pursue a new special interest and this was responded to. One of the partners trained in the practice and chose to remain and become a partner.

When a GP needed a second opinion, we were told there was a speedy response because they used instant messaging.

One of the GPs told us how on the day of our visit they had a long surgery and complicated patient consultations. Their workload for the day was adjusted at their request and work was re-allocated to reduce the burden.

When things went wrong the practice acknowledged the problem, developed consensus of opinion and sought a remedy. For example there was a problem with communication that led to a patient being called in for a routine check that was missed because the patient presented with a different health need. When it came to light it was discussed and the patient was called in again. The event was discussed at a partners meeting.

Are services well-led?

Good

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

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

Rosebank patient participation group (PPG) was established in 2011. Its aim was to continually look at ways of improving the services and facilities offered by the practice to patients. It also aimed to promote health education and encourage other patients to give their views.

The PPG met every four months and records of meetings were available on the surgery website.

We looked at the record of the meeting held in September 2014. It showed a variety of topics were discussed and feedback was presented from a meeting of PPG chairs in the city.

We met with the chairperson of the PPG. They told us how the PPG had decided to hold 'focus groups' to present information to patients with certain conditions e.g.: diet for those with a diagnosis of diabetes and support for carers.

The PPG assisted with the influenza immunisation clinics held in the practice and were involved in discussions about practice improvements.

Since the PPG was established it had produced annual surveys, the results of which were published in the group's annual report.

The latest report showed the results of the 2013/14 survey. There were questions relating to reception greeting, telephone access, and availability of appointments and waiting times. In addition there was a question where patients were asked to rate their overall experience of their usual surgery.

The majority of patients indicated they found reception staff to be very helpful or fairly helpful (91%). In response to a question about telephone access 53% thought it was easy or fairly easy to speak with a receptionist. The majority of patients (58%) thought their surgery was good and 66% would recommend the practice to others.

The annual report for 2013/14 recorded achievements for the previous year and set an action plan for 2014/15.

The NHS friends and family test (FFT) was introduced in 2014 and provided patients the opportunity to provide feedback on the services that provided their care and treatment. The FFT feedback is designed to help NHS England to improve services. Analysis of FFT results for the practice as at 29 December 2014 showed improvement over the patient survey results for the previous year. Eighty per cent of patients who completed the FFT indicated they were likely or extremely likely to recommend the practice. Of the remainder, 11% did not respond and 9% said they were unlikely to recommend the practice to friends or family.

Management lead through learning and improvement

Educational activity and diversification of roles added to the practice retention strategy. One of the salaried GPs told us how they did research with the university of Bristol into treatment options without antibiotics for sore throat. They recruited patients who presented with a sore throat to take part in the research that proposed oral steroids be used to treat sore throat.

One of the GPs told us they were encouraged by the GP partners to make use of skills and knowledge and perform additional tasks.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines How the regulation was not being met: People who use services and others were not protected against the risks associated with unsafe or unsuitable management of medicines.