3Well Ltd - Botolph Bridge

Quality Report

Botolph Bridge Community Centre
Sugar way
Woodston
Peterborough
PE2 9QB
Tel: 01733 774500
Website: www.botolph-bridge-surgery.com

Date of inspection visit: 10 June 2016
Date of publication: 18/08/2016

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	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Requires improvement
Are services responsive to people's needs?	Requires improvement
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was the second comprehensive inspection that we had carried out at 3Well Ltd – Botolph Bridge.

On 7 May 2015, we carried out a comprehensive inspection of 3Well Ltd - Botolph Bridge. The practice was rated as good overall and rated as good for providing safe, caring, responsive and well led services and requires improvement for effective services.

As a result of the findings on the day of the inspection the practice was issued with requirement notices for regulation 17 (Good Governance).

Specifically we found that ;

There were no effective auditing and supervision of the triage and incoming patient documentation.

Since our previous inspection the practice has experienced significant difficulties in recruiting and retaining GPs and nurses. This reflects the national picture in primary care due to a shortage of clinicians. The practice told us that a protracted tendering process had resulted in the principal GP not successfully recruiting GP principles or salaried GPs. To compensate for this, the practice employed locum GPs and to meet patient demand, the practice embarked on a new model of care and started a pilot in September 2015.

During the period from May 2015 to our inspection in June 2016, we received a significant number of concerns from members of the public regarding the access to and continuity of care offered by the GPs. These concerns prompted a short notice inspection of 3 Well Ltd – Botolph Bridge on 10 June 2016.

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

- Some of the improvements needed as identified in the report of May 2015 had been made, however, some of these needed to be improved further.
- Patients were at risk of harm because systems and processes were not in place to keep them safe. The systems and processes in place to ensure good

Summary of findings

governance were ineffective and did not enable the provider to assess and monitor the quality of the services and identify, assess and mitigate against risks to people using services and others.

- Patients were placed at risk because there was insufficient clinical capacity to ensure key tasks were undertaken in a timely manner and by staff who had the appropriate clinical skills to make safe decisions. This included taking action in response to pathology and radiology results, and triaging letters coming into the practice from other providers.
- Patients were at risk because the practice did not ensure that the staff they delegated roles and responsibilities to were fully trained or appropriately qualified.
- Not all patients were positive about their interactions with staff, most said they were treated with compassion and dignity.
- Urgent triage was available on the day; however, we were concerned that a clinician did not always undertake this. Patients said that they had to wait a long time for non-urgent appointments and that they did not always get to see a GP of their choice.

The areas where the provider must make improvements are:

- Ensure there are effective systems designed to identify, assess and mitigate against risk, for example in respect of piloting a model of care that is reliant on non-clinical staff assisting the GP to manage patient encounters. The practice must ensure that related risk assessments are undertaken in sufficient depth and a comprehensive record is kept of these.
- Ensure that there are sufficient numbers of suitably qualified, competent, skilled, and experienced persons to meet the care and treatment needs of patients in a safe way.
- Ensure that clinically trained and registered staff review all radiology and pathology results in a timely manner.
- Ensure that there are effective systems in place to assess and monitor the quality of the service being provided, for example by ensuring audits are undertaken to manage the performance of staff, including those relating to hospital letters, coding of medical records and medical summaries.
- Ensure that only staff with appropriate qualifications and registration give clinical advice and guidance to patients and add/make changes to patients' medicines.
- Ensure that all staff are trained appropriately to their role and that training records are kept.
- Take proactive steps to ensure patients receive safe care and treatment by reviewing Quality and Outcome Framework (QOF) exception reporting. The practice must ensure they mitigate the risks to ensure patients' health and wellbeing.
- Embed an open culture to report all incidents of identified sub optimal care to ensure that patients are kept safe and learning is shared to encourage improvement.
- Ensure that role specific inductions are consistent and offer staff the support that they require.

The areas where the provider should make improvement are:

- Monitor and ensure that the actions required from the legionella's risk assessment provided by the landlord are carried out.
- Monitor and ensure that the cleaning schedules provided by the landlord are in place and monitored.
- Further improve the system to ensure that all safety alerts that are received are logged and appropriate actions taken are noted.
- Improve the identification of, and support for, carers.
- Review the recall systems for patients with a learning disability and for those with a diagnosis of dementia and ensure that they receive an annual review.

As a result of the findings on the day of the inspection the practice was issued with warning notices for regulation 12 (Safe care and Treatment) We will return to ensure that the practice has complied with these warning notices as soon as they expire.

I am placing this service in special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of

Summary of findings

inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service.

This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

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?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- There was insufficient staff to keep patients safe. The principle GP worked clinical sessions on two days a week (Wednesday and Friday). The other three days, a variety of locum GPs provided GP cover and practice staff were able to contact the principal GP if needed.
- Patients were at risk of harm because clinical governance, systems, and processes were not in place, robust or needed to be improved further.
- The practice had not ensured that all staff were appropriately trained and qualified to undertake their roles and the tasks that had been delegated to them.
- We found that the lack of GP and nursing team capacity, and poor patient satisfaction had left staff feeling unable to raise concerns to the management team.
- Appropriate recruitment checks had been carried out for staff including Disclosure and Barring Service (DBS) checks for those who acted as chaperones.
- Following our inspection in May 2015, the practice had improved the infection control audits; we found the practice to be visibly clean and uncluttered.
- The practice had a business continuity plan in place to manage major incidents and emergency contact numbers had been included.

Are services effective?

Inadequate

The practice is rated as inadequate for providing effective services and improvements must be made.

- Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. For example, the practice performance for:
- The percentage of patients with chronic obstructive pulmonary disease was 100% which was 3.7% above the CCG average and 4% above the national averages. However, the exception reporting for this indicator was 50.8% this was significantly higher than the CCG average of 14.1% and national average of 12.3%.

Summary of findings

We were concerned that the needs of patients with ongoing health conditions were not met, as they were unable to access services to support them. The exception reporting for the quality and outcome framework indicators for the practice was significantly higher compared with other local practices and national averages. For example, the percentage of patients aged 18 or over with a new diagnosis of depression and reviewed within the timeframes set in QOF was 54.8% which was significantly higher than the CCG average of 27.1% and the national average of 30.3%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects, lower numbers are better).

- The practice had undertaken prescribing audits in the previous 12 months. They had not undertaken audits to manage or monitor the quality of the services or outcomes for patients.
- The processes and systems to manage pathology and radiology results were not effective and we were concerned about patient safety. On the day of the inspection we found a back log of some test results, some of these results had not been viewed for six weeks prior to our inspection.
- The practice staff told us that they referred to guidance from the National Institute for Health and Care Excellence and that they used it routinely. The practice did not undertake any audits to monitor that effective care was maintained.
- Staff worked with multidisciplinary teams including community nurses, health visitors, and a care co-ordinator. The practice had 118 patients who had been identified as vulnerable and as a result of joint working, a written care plan was held in their medical records and 112 of the patients received an annual review. Joint working with community teams ensured that 80% of patients at the end of their lives died in their preferred place of care.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services, as there are areas where improvements should be made.

- The ethos of the practice and the practice staff was to care for patients; the practice had faced many challenges in trying to achieve this.
- Data from the national GP patient survey showed patients rated the practice lower than others for aspects of care. For example, 82% of patients said that they had confidence and trust in the

Summary of findings

last GP they saw or spoke to, compared to the CCG average of 95% and the national average of 95%. 96% of patients said they had confidence and trust in the last nurse they saw or spoke to compared to the CCG and national average of 97%.

- Some patients said they were treated with compassion, dignity, and respect. However, not all felt cared for, supported, and listened to.
- The practice had identified less than 1 % of their patients as carers, including young carers and provided them with a carer's pack which gave information including details of support groups.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services and improvements must be made.

- Telephone consultations and home visits were available for those that requested them.
- The premises were suitable for patients who had a disability or those with limited mobility.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. The complaints received had been dealt with in a timely and appropriate manner.
- The practice offered email consultations and on line systems to order repeat medications. Some patients told us that they had found this useful.
- Some patients reported considerable difficulty in accessing a GP and poor continuity of care.
- Patients told us that they had difficulty accessing face to face appointments and that they had long waits to get through on the telephone.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

- The practice had a vision, clear strategy, and motivation to care for patients. The goals were clear and the staff we spoke with all shared the same vision to care for patients. However our inspection findings showed this vision was not always achieved due a lack of permanent clinical capacity and the absence of effective and comprehensive processes to assess, monitor, and improve the quality and safety of services provided.

Summary of findings

- We found that there was no overarching governance framework. There was a lack of risk assessments, clinical oversight, and management in delivering the pilot model of care. We were concerned that the system and the workbook used by the non-clinically trained medical assistants was not robust and the content not appropriate for unqualified staff to use.
- The management team encouraged a culture of openness and honesty. However, the practice systems in place for reporting safety incidents, investigating and taking action needed to be embed further to enable staff to report incidences where sub optimal care may have happened. Regular meetings were held where some learning was shared.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- Arrangements and systems to monitor and improve quality and identify risk needed to be improved. The practice had undertaken prescribing audits in the previous 12 months but had not undertaken audits to mange or monitor the quality of service or outcomes for patients.

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

Inadequate

The practice is rated as inadequate for safe, effective, and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Patients told us that they had difficulty in getting through on the telephone and accessing appointments with a named GP.
- Home visits were available for those patients that needed them.
- Longer appointments were available; patients reported that for advanced booked appointments with a GP they incurred a long wait.
- We saw evidence that the practice had worked to the Gold Standards Framework for those patients with end of life care needs. Co-ordinated care for patients at the end of their lives ensured that 80% died in their preferred place of care.

People with long term conditions

Inadequate

The practice is rated as inadequate for safe, effective, and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Nursing staff had roles in chronic disease management. Performance for diabetes related indicators was 88%, The practice exception reporting rate was 33.1% which was higher than the CCG average of 12.9% and national average of 10.8%.
- Longer appointments were available when patients needed them. The practice told us that they visited patients at home for annual reviews if they were not able to attend the practice.

Families, children and young people

Inadequate

The practice is rated as inadequate for safe, effective, and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

Summary of findings

- There were systems in place to identify and review children living in disadvantaged circumstances and who were at risk. Staff we spoke with were aware of their role and responsibilities. Staff we spoke with were able to demonstrate that they understood the challenges to protect information for young people. Practice staff were aware to check with young people how they wished to be contacted.
- Immunisation rates were in line with local averages for all standard childhood immunisations.
- Young children were given priority appointments for urgent needs.
- Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Inadequate 

The practice is rated as inadequate for safe, effective, and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- Health promotion advice was offered and health promotion material available through the practice.
- NHS health checks were available and appropriate follow up arranged, promoting health prevention and healthy lifestyles.
- The practice's uptake for cervical screening was in line with the CCG and national average.
- The percentage of patients who had been screened for breast cancer was in line with the CCG and national average. Screening uptake for bowel cancer prevention was below the CCG and national average.

People whose circumstances may make them vulnerable

Inadequate 

The practice is rated as inadequate for safe, effective, and well led services. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It

Summary of findings

offered longer appointments and carried out annual health checks. There were 16 patients on the register for patients with learning disabilities; 50% of these had received an annual review.

- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. We saw the practice provided vulnerable patients with information about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse or neglect 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)

Inadequate

The practice is rated as inadequate for safe, effective, and well led service. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Staff told us that 43% of patients with dementia had received advanced care planning and appropriate reviews. However, the lack of permanent GPs compromised the practices' capacity to allocate patients an accessible named GP and continuity of care.
- Same day telephone triage was offered and practice staff told us that, where clinically indicated, an appointment with a GP was offered to ensure that any health needs were quickly assessed for this group of patients.
- The practice told patients experiencing poor mental health how to access various support groups and voluntary organisations. Staff had knowledge on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2016. The results showed the practice was performing below the local and national averages. 309 survey forms were distributed and 103 were returned. This represented 33% response rate.

- 66% of patients found it easy to get through to this practice by phone compared to the CCG average of 75% and the national average of 73%.
- 79% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 87% and the national average of 85%.
- 64% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and the national average of 85%.
- 62% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received feedback from 20 patients; these were mainly negative in their response to access to and the number of GPs available in the practice, but mostly positive about the cleanliness of the practice and the dignity that they had been shown by staff.

Areas for improvement

Action the service MUST take to improve

- Ensure there are effective systems designed to identify, assess and mitigate against risk, for example in respect of piloting a model of care that is reliant on non-clinical staff assisting the GP to manage patient encounters. The practice must ensure that related risk assessments are undertaken in sufficient depth and a comprehensive record is kept of these.
- Ensure that there are sufficient numbers of suitably qualified, competent, skilled, and experienced persons to meet the care and treatment needs of patients in a safe way.
- Ensure that clinically trained and registered staff review all radiology and pathology results in a timely manner.
- Ensure that there are effective systems in place to assess and monitor the quality of the service being provided, for example by ensuring audits are undertaken to manage the performance of staff, including those relating to hospital letters, coding of medical records and medical summaries.
- Ensure that only staff with appropriate qualifications and registration give clinical advice and guidance to patients and add/make changes to patients' medicines.
- Ensure that all staff are trained appropriately to their role and that training records are kept.
- Take proactive steps to ensure patients receive safe care and treatment by reviewing Quality and Outcome Framework (QOF) exception reporting. The practice must ensure they mitigate the risks to ensure patients' health and wellbeing.
- Embed an open culture to report all incidence of identified sub optimal care to ensure that patients are kept safe and learning is shared to encourage improvement.
- Ensure that role specific inductions are consistent and offer staff the support that they require.

Action the service SHOULD take to improve

- Monitor and ensure that the actions required from the legionella's risk assessment provided by the landlord are carried out.
- Monitor and ensure that the cleaning schedules provided by the landlord are in place and monitored.

Summary of findings

- Further improve the system to ensure that all safety alerts that are received are logged and appropriate actions taken are noted.
- Improve the identification of, and support for, carers.
- Review the recall systems for patients with a learning disability and for those with a diagnosis of dementia and ensure that they receive an annual review.

3Well Ltd - Botolph Bridge

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 adviser and a practice manager specialist adviser.

Background to 3Well Ltd - Botolph Bridge

Botolph Bridge Surgery in Woodston, Peterborough holds an Alternative Medical Provider Service (APMS) and provides healthcare services primarily to patients living in Woodston and the surrounding area. The surgery is located in a fit for purpose building and serves a population of approximately 6950 patients.The building is shared with other health services that serve the community.

The principle GP is the registered manager, and is supported by various locum GPs. The practice employs three practice nurses, two healthcare assistants (HCA), and a phlebotomist. The practice has not been able to recruit other GPs or nurse practitioners over the past 12 months. This has led to a clinical capacity issue and a development of a new model of care on two days of the week. On these days (Wednesday and Friday), the HCAs and other non-clinical staff act as assistants to the GP. These staff members, sometimes called medical assistants (MAs) take the medical history from patients and relay clinical information to and from the GP. A pharmacist is employed to support the GP with medicines management.

The practice manager, assistant practice manager and a team of reception/administration/secretarial staff support the clinical team.

The practice operates a system where all calls and email consultation requests are triaged. GP appointments are booked as clinically indicated. Appointments are available with the principal GP on Wednesday and Fridays and with locum GPs Monday, Tuesday, and Thursday.

The practice website clearly details how patients may obtain services out-of-hours.

We previously inspected this practice on 7 May 2015. We found that the practice required improvement for effective services but good overall.

Why we carried out this inspection

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

How we carried out this inspection

For example:

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?

Detailed findings

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

We also looked at how well services were provided for specific groups of people and what good care looked 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).

Before our inspection, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out a short notice inspection on 10 June 2016. During our inspection we spoke with a range of staff including the principal GP, a locum GP, a practice manager,nursing, medical assistant, reception and administration team staff. We carried out a telephone interview with a staff member on Tuesday 21 June 2016. We spoke with six patients and five members of the patient participation group. We observed how patients were being cared for and reviewed nine comment cards where patients shared their views and experiences of the service.

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.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, 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.

- The practice had specifically designed forms, available electronically or in paper form for practice staff to report incidents and near misses and reported these to the practice manager. However, evidence we found, did not assure us that staff would raise concerns from identified sub optimal care of patients that had been reported to them or identified from medical records. We were concerned that an open culture of reporting and learning from clinical incidences to ensure patient safety was not embedded. For example, practice staff told us that they had identified that the care of a patient may have been delivered better, however, they did not raise it as a learning event so that the GP and practice team could reflect on the case and if there were any learning outcomes make changes to encourage improvement.
- Minutes of a meeting held from 1 March 2016, showed that some significant events were discussed. For example, it had been identified that the hospital requested that the dose of a patient's medicine was increased. The practice identified that the patient was currently on the requested regime and that further investigation was needed. The practice told us that they had reviewed the event and recorded the outcome in the patient's medical record; however,on the day of the inspection the significant event log had not been updated to reflect this investigation and the learning outcomes shared.

Overview of safety systems and processes

The practice had systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements reflected relevant legislation and local requirements. Practice policies were accessible to all staff on the intranet and clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. Posters were displayed in the consulting rooms giving the contact details.

The principal GP was the lead for safeguarding and multi-disciplinary team meetings were held each month, minutes were available for staff. The GP attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Practice staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The GP was trained to child safeguarding level three.

Vulnerable patients were highlighted on the practice electronic system. This included children subject to child protection plans and patients with a diagnosis of dementia.

- A notice in the waiting room advised patients that chaperones were available if required. There was some inconsistency regarding the training of the staff who chaperone. However, practice staff we spoke with were able to describe accurately the actions they would take when chaperoning. It was practice policy to ensure that all staff, irrespective of role, received a Disclosure and Barring Service (DBS) check. (DBS

The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training including hand washing. We noted that the landlord (NHS Property Services) provided the cleaning services; the contractors had recently changed, and on the day of the inspection the cleaning schedules were not available. We saw that the practice manager had asked for them and that the contractor was sending them.

A comprehensive infection control audit was undertaken in September 2015, improvements were identified, and actions were noted. For example, it was noted that the practice staff were due the annual hand washing training; this was completed in October 2015.

A sharps injury policy was in place and staff were aware of the actions to take. All clinical waste was well managed.

Are services safe?

The practice held records of staff immunisation status.

- The practice system to manage safety alerts had improved since our previous inspection; however, further improvements were needed. A log was held on the practice intranet and the safety alerts, such as those from Medicines and Healthcare products Regulatory Agency (MHRA) were listed. These were cascaded to appropriate staff. However, there was only evidence that one alert had been actioned and there were no records to indicate that other MHRA patient safety alerts and updates had been considered and action taken as appropriate.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security, and disposal).

  Processes were in place for handling repeat prescriptions for patients who were taking high risk medicines. The practice told us that they performed monthly searches for patients on medicines such as methotrexate, and contacted them for a blood test if needed.

  Medicines were stored safely and records of fridge temperatures were reviewed appropriately. Stock levels and expiry dates were checked monthly. All medicines we checked were within their expiry date. Regular medicines audits were carried out with the support of the local CCG pharmacy team to ensure the practice was prescribing in line with best practice guidelines.

There was a repeat prescription policy for staff to follow. Uncollected prescriptions were highlighted to the pharmacist to ensure patient safety. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.

- A recruitment process was in place, we reviewed three personnel files, these were well presented, and had received a DBS.

Monitoring risks to patients

Some risks to patients were assessed but improvement was needed:

- There was a health and safety policy available with a poster in the office. The practice had reviewed its policy for health and safety in March 2015.
- The practice used risk assessments to monitor the safety of the premises. For example, for the control of substances hazardous to health and infection control. Testing for legionella (a bacterium that can grow in contaminated water and can be potentially fatal) had been undertaken in January 2016. We noted that there were actions identified to be taken. The practice manager had taken immediate action and contacted the landlord requesting that the actions were completed. The landlord acknowledged the request but had not included a completion date and therefore we could not include this in the report.
- A full fire risk assessment had been carried out in February 2016 with no remedial actions to be taken. Safety processes were in place for checking electrical equipment and fire safety equipment. There had been a recent fire drill.
- To meet the challenges of patient demand and the shortfall in clinical support, the practice introduced a new model of care and ran a pilot triage system on two days per week (Wednesday and Friday) from September 2015. Using this system the GP routinely dealt with 100 to 160 patient encounters each day. On Wednesday and Friday the principal GP provided medical services supported by non-clinically trained or qualified medical assistants (MA). On the others three days (Monday, Tuesday, and Thursday) the practice was reliant on locum GPs who triaged and managed all the calls requesting an appointment with a GP. The locum GPs did not use the MAs.

  The MAs we spoke with were new in post (all under three month's service). They described the pathway for a patient using the MA system: The telephone call was taken by the reception staff and added to the MA's appointment list. The MA called the patients back, completed a web based algorithm, and recorded the patient's history into the clinical system. Usually, (we saw evidence that showed not always), a printout was taken to the principal GP, who assessed the information and made a clinical judgement. The MAs were responsible for transcribing the notes from the GP onto the patients' medical records and for adding new medications. The GP was responsible for checking and signing the prescriptions. Following on from this, the MAs could be required to contact the patient by telephone to communicate the GP's advice and

instruction. There were also instances where MAs advised patients, without first speaking with the GP- in these instances the MAs used the 'workbook' that had been provided to them.

The practice told us that 90% of the patients who spoke with an MA did not speak to, or see, a GP.

On the day of the inspection, we were concerned about this pilot process for the following reasons:

- The pilot had been set up without robust clinical governance in place to ensure that the patients would receive safe care and treatment. There were no monitoring systems in place to review quality of the service, patient outcomes, and experiences.
- The pilot did not have robust risk assessments and risk escalation plans in place.
- We were concerned that the number of encounters (90%) that did not result in a contact (either telephone or face to face) from the GP was too high.
- We saw evidence that the MAs gave clinical advice to patients and were responsible for adding new medications on the patient's records without being qualified or appropriately trained to do so.
- We asked for a copy of the policy and procedure which was not provided to us. The MAs showed us the workbook that they followed. The workbook was a draft document dated January 2016; we were concerned that the content was neither robust nor appropriate for non-clinically trained staff to use. Medical records we were shown detailed that a MA had spoken with a parent of a young child, taken the history and had, following the workbook, given advice. They confirmed that they had not spoken with a GP. This meant patients were at risk of harm.

We escalated this risk to NHS England; they informed us that the pilot model of care using medical assistants in this way was suspended following our inspection. We will be able to report on this when we re–inspect.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents, we noted that staff were aware of the lack of GP or nurse cover and would call 999 or advice patients to attend the walk in centre in Peterborough should the GP not be available and an emergency situation happened.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. A copy of this was held off the premises.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice did not always assess the needs and deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice did not have a system to monitor that these guidelines were followed through risk assessments, audits, and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98.2% of the total number of points available with 31.2% exception reporting. This is above the CCG average of 20.7% and above the national average of 22%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

Data from Quality and Outcome Framework (QOF) 2014 - 2015 showed;

- The performance for diabetes related indicators was 88% The practice rate of exception reporting was 33.1% this is significantly higher than the CCG average of 12.9% and the national average of 10.8%.
- The practice had 84 patients with a diagnosis of chronic obstructive pulmonary disease and their performance for these indicators was 100% which was 3.7% above the CCG average and 4% above the national averages. Exception reporting for this indicator was 50.8% this was significantly higher than the CCG average of 14.1% and national average of 12.3%.
- Performance for mental health related indicators was 100% which was 7.6% above the CCG average and 7.2% above the national average. The exception reporting percentage for this indicator was 22%; this was above the CCG average of 13% and above the national average of 11.1%.

We discussed these results with the practice, the principal GP was not able to give us a clear explanation of the process, and the practice had not developed an action plan to monitor and encourage improvement for the practice performance 2015 – 2016. The staff member to whom he delegated the task was on leave we therefore carried out a telephone interview on Tuesday 21 June 2016. The practice told us that they invited patients to attend their appointments, three times over a six month period before exception reporting them. The practice told us that they also contacted patients via messages added to the patients prescription forms and text message. Some telephone reminders and additional letters were sent.

The practice showed us their QOF performance data for 2015 – 2016, these results did not indicate that their performance had improved. The data from 2015 – 2016 has not been verified and is not yet in the public domain and so we cannot include it in our report.

The practice had undertaken prescribing audits within the past 12 months however, they told us that they had not undertaken other audits since the previous inspection (7 May 2015), the GP explained that this was as a result of the additional workload he managed as a result of the difficulties experienced in recruiting GPs.

Effective staffing

We were concerned that the practice staff did not have the skills, knowledge, and experience to deliver effective care and treatment.

The principal GP told us that he was concerned about the number of clinically trained staff and the skill mix that was available in the practice. On the day of the inspection, there were no salaried GPs or advance nurse practitioners employed at the practice. The locum GPs that the practice usually used worked at the practice on a regular basis. They told us that two new advanced nurse practitioners would be joining the nursing team on 27 June 2016.

Inadequate

Are services effective?

(for example, treatment is effective)

- We did not see evidence of robust training records to show that the non-clinically qualified staff members had received appropriate training in the roles and tasks that had been delegated to them. For example, we were concerned that staff who undertook the role of medical assistants (MAs) had not been sufficiently trained to take the medical history from patients or communicate effectively clinical instructions from the GP. The staff were not qualified to transcribe medicines onto the medical records and they were not qualified to give clinical advice to patients without a qualified practitioner's supervision.

  We noted that there were inconsistencies in the induction that new staff members had been given.

- The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. Staff did not have access to all the appropriate training required to meet their learning needs and to cover the scope of their work, however, the management had oversight to ensure that staff had received training such as safeguarding, fire safety awareness, and basic life support. Staff had access to and made use of e-learning training modules and in-house training. All staff had received an appraisal within the last 12 months.

- A weekly meeting, which included training, was held; minutes from a meeting held on 7 June 2016 showed that practice staff had discussed the use of clinical templates. We noted, on these minutes, that the MAs had been delegated work to manage patients on the avoiding unplanned admissions register. It was not clear from the minutes the training and governance arrangements for this work. The MA we spoke with on the day of the inspection did not have any information on this project.

Coordinating patient care and information sharing

The principal GP reviewed all routine referrals that were proposed by locum GPs. Agreed routine referrals were completed within five days and most went through the choose and book system (C&B). C&B is an electronic system between primary and secondary care and does not require any paper copies to be sent. This system increased the speed of referral receipt and reduced the risk of delay and confidentiality breaches. Referrals for urgent care such as a two week wait pathway were completed within 24 hours; the practice told us that the secretaries telephoned the patient with their appointment details and posted a confirmation to them. We noted on the practice complaint log that there had been five complaints relating to referral delays. The practice had noted the actions they had taken and the lessons learnt. Feedback had been given to individual staff members including locum GPs.

The practice staff worked with other services to meet patients' needs and manage those patients with more complex needs. This included community nursing teams and health visitors. The practice worked to the Gold Standards Framework when co-ordinating end of life care for patients. Regular meetings were held to manage and plan patient care.

- We saw that written consent was obtained from those patients for minor surgery.
- Patient notes were completed by the practice on an electronic system and this ensured that emergency services staff had up to date information on vulnerable patients.

We were concerned that patients' individual records were not written and managed in a way to help ensure safety. Improvements needed were identified in the previous inspection (7 May 2015) and we saw that some had been made but further improvement was needed.

- Records were kept on an electronic system, which collated all communications about the patient including clinical summaries, and scanned copies of letters. A non-clinician triaged all the written communication received. The staff member made an assessment and only forwarded letters where they identified that action was required to the GP; the GP was responsible for carrying out those any actions. The practice did not have processes or audits in place to monitor the quality and performance of the system ensuring patients were kept safe. This lack of clinical oversight around incoming patient information could potentially put patients at risk.

- Medical summaries of patient records and coding of information onto those records was carried out by a non-clinician. The practice did not have a process or audits in place to monitor the quality and performance of this system to keep patients safe. During our inspection we were shown a medical record where sub optimal care had been identified, and we noted that a

diagnosis relating to this care had not been added to the medical record summary. The lack of clinical oversight around coding and summarising could potentially put patients at risk of harm.

- On the day of the inspection we found that the pathology and radiology results for patients were not well managed. We found that delays in reviewing and taking actions on test results received could have put patients' health and wellbeing at risk.

  Three results dated back 18, 19, and 21 April 2016. Four results dated back to 3, 20 and 27 May 24 dated back to 3 June. These results had not been reviewed or any action taken. We discussed this with the GP, who took immediate action to clear this backlog of results.

  We were concerned that the process in place to manage test results for patients was not effective or robust. We were concerned that the staff member to whom responsibility had been delegated was not appropriately trained or professionally registered to undertake this role. We asked for a copy of the policy and procedure, these were not provided on the day, however, these were sent through by email. The staff member triaged all the test results received and filed all the results they considered normal. The results that were indicated abnormal were passed to the GP. The staff member did not have a regular pattern of work. On some days they would access the results remotely using a laptop and on other days they would work in the practice. The lack of clinical oversight around pathology and radiology results could potentially put patients at risk of harm.

  Following the inspection, we received a detailed report of the investigation and assurance that the provider had taken to clear the backlog. Details of the changes they were putting in place and further reviews that they would undertake, for example review of the practice pathology policy.

Supporting patients to live healthier lives

The practice's uptake for the cervical screening programme was 82.33% which in line with the CCG average of 81.72% and the national average of 81.83%. The nursing team telephoned patients who did not attend for their cervical screening test was in place.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

- The number of women screen for breast cancer was 81.9% this was above the CCG average of 72.3% and higher than the national average of 72.2%.
- The number of patients screened for bowel cancer was 50.3% this was below the CCG average of 59.0% and lower than the national average of 58.3%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example,

- Immunisation rates for under two year olds ranged from 90.9% to 93.7% compared to with CCG range 91.9% to 95.7%
- Immunisation rates for five year olds ranged from 88.8% to 98.2% compared to with CCG range 88.5% to 95.4%

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. The practice had invited 616 patients and 166 checks had been completed. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We reviewed the most recent data available for the practice on patient satisfaction. This included information from NHS choices and the GP Survey last published 7 July 2016. The evidence showed patients were not completely satisfied with how they were treated.

We spoke with five members of the patient participation group (PPG). They told us that they were aware that patients were not satisfied with the number of GPs available and that there were significant waits to get through on the telephone. The PPG, GP, and practice manager had discussed the situation at recent meetings. The PPG were supportive to the GP and told us that they recognised that protracted contract negotiations with the local health authorities may have impacted on the practice's ability to recruit and retain staff.

With the practice support, the PPG offered a voluntary befriending service, arranged coffee mornings and luncheon outings. They also encouraged patients to join the walking group.

We received nine comment cards, some comments reflected that the practice staff were friendly and caring, most reflected that getting an appointment and seeing the same GP had been difficult.

We also reviewed the comments that we had received directly from patients either via telephone calls or through our website.

Results from the national GP patient survey (published in July 2016) showed a lower satisfaction rate for patients that felt they were treated with compassion, dignity, and respect. The practice was below the CCG and national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 75% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and the national average of 89%.
- 68% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 82% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 95% and the national average of 95%
- 70% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 91%.
- 83% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The practice was aware that many patients were not satisfied. The GP and staff recognised that the lack of clinical capacity, particularly for GPs and nurses, compromised patient satisfaction. They told us that they and NHS England had held meetings to discuss the situation. The practice told us that they had employed two new nursing staff members who would join the team on 27 June 2016.

Care planning and involvement in decisions about care and treatment

The responses we had from patients were mixed when asked if they felt involved in decision making about the care and treatment they received. Some patients 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 available to them. However, patients reported a lack of continuity of care because of the lack of regular GPs.

Results from the national GP patient survey (published in July 2016) showed a lower satisfaction rate for patients about their involvement in planning and making decisions about their care and treatment. The practice performed below the CCG and national average for its satisfaction scores on consultations with GPs and nurses. For example:

- 69% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.

Requires improvement

Are services caring?

- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.
- 68% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 82% and the national average of 82%.

The practice provided facilities to help patients be involved in decisions about their care:

- Several languages other than English were spoken by the practice staff including Lithuanian, Romanian, German, and Polish. Practice staff also told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 56 patients as carers; this was under 1% of their list size. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, a GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We were concerned that a pilot model of care being used in the practice and the use of locums did not meet the needs of the population.

- Patients told us that they had to wait a long time for the telephones to be answered. At times, there were only one or two members available to deal with all the incoming calls. This delay in answering incoming calls compounded the delays patients reported in getting calls back from the practice, as all the lines were busy. We noted from the minutes of a meeting held on 3 May 2016 that the practice had discussed this problem and that staff should make the management team aware when this happened.
- Patients told us that they had difficulty in booking face to face appointments with a GP and when they did, it was usually with a GP they did not know. Patients told us they did not have continuity of care.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice offered online services for patients to request a clinical consultation, and to order repeat medication.
- All calls and email requests for consultations were triaged, where clinically indicated same day appointments were available for children and those patients with medical problems that required early intervention.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open between 7.30am and 6.30pm Monday to Friday. The practice operated a system where all patients that requested a GP appointment received a call back from the practice and appointments were booked according to clinical assessment. Appointments with the practice nurses and healthcare assistants could be booked up to eight weeks in advance.

Results from the national GP patient survey (published in July 2016) showed that patients' satisfaction was low in relation to access of care and treatment when compared to the local and national averages.

- 66% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and the national average of 76%.
- 66% of patients said they could get through easily to the practice by phone compared to the CCG average of 75% and the national average of 73%.

People told us on the day of the inspection that they found it difficult to get an appointment when they needed them. Some patients reported that they were always dealt with over the telephone and not face to face, as they would prefer.

The practice had a system in place to assess:

- whether a home visit was clinically necessary, and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

When we inspected the practice in May 2015 we found that the practice needed to improve the system in place for handling complaints and concerns. The practice had made improvements.

- 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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

We looked at 11 complaints received since April 2016, found that these had been investigated, and appropriate action taken.

Are services well-led?

Inadequate

(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 vision and clear strategy. The practice staff we spoke with all shared the same vision to care for patients. Our inspection findings indicated this vision was not always achieved due a lack of permanent clinical staff, effective and comprehensive processes to assess, monitor, and improve the quality and safety of services provided.

The principal GP was available for four clinical sessions per week. The practice was trying to meet demand and increase clinical capacity through the development and piloting of a model of care using medical assistants. The management acknowledged that focussing on access issues had seriously challenged their ability to manage systems and monitor services to ensure effectiveness. They had prioritised addressing their immediate challenge of GP shortages, were actively recruiting, and were in discussion with NHS England.

Governance arrangements

The overarching governance framework was not robust. The systems in place were not operating effectively and did not enable the provider to have a clear oversight of the quality of the service and the risks to the health and welfare of patients and others.

Arrangements for identifying, recording, and managing risks, issues, and implementing mitigating actions needed to be improved to ensure they were robust and protected patients and others against risks to their health and welfare.

We were concerned that on a Wednesday and Friday when the principal GP undertook clinical sessions, a significant number of patients (90% of encounters) did not speak to or see a GP or advance nurse practitioner for their medical needs or concerns.

The workload of staff members was not monitored to ensure that they did not work excessive shifts on a regular basis. Practice staff we spoke with told us that they would continue working until all patients had been dealt with.

The systems needed to be improved to ensure that new staff induction was consistent and that practice staff received role specific inductions that met their needs. Some practice staff we spoke with were not confident that they had sufficient introduction to the role and responsibilities.

Although the practice had improved the systems to record and learn from significant events and complaints, we were concerned that this was not embedded into the practice culture and we were not assured that all events were identified, recorded, discussed, and learning shared to encourage improvements.

The practice had undertaken prescribing audits.

Leadership and culture

Some staff we spoke with did not feel that there was effective clinical leadership at the practice.

The management team told us they recognised the challenges that the insufficient numbers of clinically trained staff posed and the additional workload that the staff faced. The principle GP and practice manager were open about their lack of capacity and resources to make the changes that they identified to improve patient safety, care, and experience.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public, and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. However, the management team had not been able to make the changes that patients wanted. They told us that they planned and were confident that they would be able to address the issues once they had secured a long term contract with NHS England.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys during the flu clinics, and had been supportive of the practice during the negotiations with NHS England.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Good Governance. **How the regulation was not being met:** • The practice did not have a co-ordinated plan to review the high exception reporting, mitigating the risks and to ensure patients' health and wellbeing. • The practice staff did not report all identified cases of sub optimal care that they identified and therefore learning from clinical incidences to ensure patient safety was not robust. • The practice did not have robust clinical governance in place to ensure that the patients would receive safe care and treatment. There were no monitoring systems in place to review quality of the service, patient outcomes, and experiences.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing **How the regulation was not being met:** • The practice did not ensure that there were sufficient numbers of suitably qualified, competent, skilled, and experienced persons to meet the care and treatment needs of patients in a safe way. • The practice did not ensure that only staff with appropriate qualifications and registration gave clinical advice and guidance to patients and add/make changes to patients' medicines.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment **How the regulation was not being met:** The registered person did not assess the risks to the health and safety of service users receiving the care or treatment. The practice had introduced a pilot model of care in September 2015 which had put patients at risk of harm. The practice had failed to ensure that only relevant regulated professionals with appropriate qualifications planned and prescribed care and treatment, including transcribing of medicines. The practice had failed to review pathology and radiology results received in a timely manner by appropriately trained, qualified, and registered staff. The practice had failed to ensure that staff worked within the scope of their qualification, competence, skills, and experience.