3Well Ltd - Botolph Bridge

Quality Report

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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.

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Overall summary

Letter from the Chief Inspector of General Practice

This was the fourth inspection that we have carried out at 3Well Ltd – Botolph Bridge.

We carried out a comprehensive inspection of 3Well Ltd - Botolph Bridge on 7 May 2015. The practice was rated as good overall with ratings of 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).

We carried out a second comprehensive inspection on 10 June 2016. This inspection was responsive to concerns raised by members of the public and to check if the practice had made the changes identified in May 2015. The practice was rated inadequate overall and for providing safe, effective, and well led services, and requires improvement for providing responsive and caring services.

Summary of findings

At our June 2016 inspection we found that 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 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. As a result of the findings on the day of the inspection the practice was issued with a warning notice for regulation 12 (Safe care and treatment) and requirement notice for regulation 17 (governance and quality assurance). The practice was placed into special measures for six months.

We conducted a focused inspection on 19 August 2016 to ensure that the practice had made the required improvements detailed in the warning notice that had been issued on 8 August 2016.

At our 19 August 2016 inspection we found that some of the improvements needed as identified in the report of June 2016 had been made, however, some of these needed to be improved further. We further identified a new issue relating to the safe prescribing and management of medicines and we were concerned that patients were at risk of harm. The systems and processes in place to ensure good 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.

As a result of our focused inspection (19 August 2016) we took urgent action to suspend 3Well Ltd Botolph Bridge from providing general medical services at 3Well Ltd Botolph Bridge.

We conducted a focused inspection on 14 November 2016 to check whether the provider had made sufficient improvements and to decide whether the suspension period should be ended. The ratings remain the same, inadequate overall and that the special measures period continues and we will inspect again to ensure that improvement requirements have been met.

This report covers our findings in relation to our focused inspection. You can read our findings from our last inspections by selecting the 'all reports' link for 3Well Ltd Botolph Bridge on our website at www.cqc.org.uk.

The key findings from our inspection on 14 November 2016 across all the areas we inspected were as follows:

- During our inspection on 19 August 2016, we found that there had been insufficient improvements made to the systems and processes to manage x-ray and pathology results, and that the practice could not evidence that a staff member delegated this work had been safely recruited. At our inspection in November we saw that the staff member was no longer employed at the practice and that GPs or advance nurse practitioners undertook this work.
- During our inspection on 19 August 2016 we identified a new concern. The practice had employed a new member of staff to undertake medicine reviews; they had been in post since July 2016. We found that the practice had not put a governance framework, practice policy, and procedure in place to ensure that patients were kept safe. This put patients at risk of harm. At our November inspection we saw that this staff member was no longer employed at the practice and that GPs and advance nurse practitioners were undertaking medicines reviews.
- During this inspection on 14 November 2016 we listened to the improvement plans the provider had developed and the plans to implement and embed these into the practice. This included risk assessments and meeting arrangements to support the practice and staff. We noted that significant improvements were outlined and some had already been implemented. These plans had been created with the support of other professionals such as GPs and a team from the Royal College of General Practitioners.
- The practice told us that the model of care used to deliver services had changed. Up until recently the practice offered a system where all requests for GP appointments were triaged by telephone first. Patients were able to choose a face to face or telephone appointment with a GP or advance nurse practitioner. The practice still offered email consultations through a web based programme.

Summary of findings

- The practice had not been successful in recruiting any GP principles, or salaried GPs. The practice told us that they had engaged GP locums to work at the practice on a regular basis.
- We reviewed some policies and procedures and found these needed further improvement. The practice submitted revised documents within 48 hours of our inspection.
- Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

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?

- We reviewed the improvement plan and documents developed by the practice to ensure that the practice governance, systems, and processes were in place to ensure that patients were kept safe. We found that improvements had been made; these improvements required embedding into the structure and culture of the practice. Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

Are services well-led?

- We reviewed the improvement plan and documents developed by the practice to ensure that the practice governance, systems, and processes were in place to ensure that patients were kept safe. We found that improvements had been made; these improvements required embedding into the structure and culture of the practice. Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined.

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 second CQC inspector, GP specialist adviser and a member of the CQC Medicines Optimisation Team.

Background to 3Well Ltd - Botolph Bridge

Botolph Bridge Surgery in Woodston, Peterborough holds an Alternative Provider Medical Services (APMS) contract 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 locum GPs and advance nurse practitioners. The practice employs practice nurses, healthcare assistants (HCAs), and a phlebotomist. The practice opening hours are 8am to 6.30pm Monday to Friday and 8am to 12.30pm on Saturdays.

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

We previously inspected this practice on three other occasions. On 7 May 2015, we found that the practice required improvement for effective services but good overall. On 10 June 2016 the practice was rated inadequate for safe, effective, and well led services and rated requires improvement for caring and responsive services. The practice was placed into special measures for six months.

As a result of our focused inspection (19 August 2016) we took urgent action to suspend 3Well Ltd Botolph Bridge from providing general medical services at 3Well Ltd Botolph Bridge.

Why we carried out this inspection

We carried out a focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This was because at the inspection on 19 August 2016 the service was identified as being in breach of the legal requirements and regulations associated with the Health & Social Care Act 2008.

Specifically breaches of Regulation 12 (Safe care and treatment) and Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014. Our concerns led us to take urgent action to suspend 3Well Ltd Botolph Bridge from providing general medical services at 3Well Ltd Botolph Bridge.

We conducted a focused inspection on 14 November 2016 to check whether the provider had made sufficient improvements and to decide whether the suspension period should be ended.

How we carried out this inspection

Before visiting, we reviewed the issues found at the 10 June 2016 inspection and the warning notices served 8 August 2016. We reviewed the issues found at the 19 August 2016 and the notice of decision to suspend 3Well Ltd Botolph Bridge. We also reviewed the information supplied by the

Detailed findings

provider as evidence of the actions taken to address those issues. We reviewed concerns that we had received from members of the public. We carried out an announced visit on 14 November 2016.

During our visit we spoke with the principal GP and the practice manager. We spoke with patients who used the service and were members of the patient participation group. We spoke with the GP who was the registered provider of 3Well Ltd Botolph Bridge during the suspension period and with a member of the Royal College of General Practitioners (RCGP) team. We viewed medical records, policies, procedures, and recruitment files.

Our inspection focused on the safe and well led domains.

Are services safe?

Our findings

During this inspection on 14 November 2016 the practice told us that they had changed the model of care used for patients to access GP appointments. Until recently the practice had triaged all requests for GP appointments. The patients were now able to choose a face to face or telephone appointment with a GP or nurse practitioner. Email consultations were also available for patients. The practice had not been successful in their recruitment drive to secure further partners or salaried GPs, but did tell us that they had secured regular locums, some engaged through an agency. The practice had enrolled a practice nurse on a minor injury and illness course early in 2017.

At our inspection on 19 August 2016, we found the improvements made to the management of pathology and radiology results were insufficient for us to be assured that patients were not at risk of harm. The practice could not demonstrate that staff employed to manage this work had been safely recruited.During this inspection on 14 November 2016, we saw that the practice no longer employed the staff member who had previously managed pathology and radiology results. GPs or advance nurse practitioners reviewed and managed all test results, with the exception of cytology (cervical smears) within the practice. The GPs and practice nurses jointly managed cytology results.

At our inspection of 19 August 2016, we identified a significant concern which put patients at risk of harm. In July 2016, the practice had employed a new staff member to undertake medicines reviews for patients, including those taking high risk medicines. The practice was unable to demonstrate that they had a robust policy and procedure in place to ensure that this staff member re-authorised medicines appropriately, safely and within their scope of practice.

During this inspection on14 November 2016, we saw the practice no longer employed pharmacy technicians and all medicine reviews were undertaken by GPs or advance nurse practitioners with an independent prescriber qualification. We identified and raised our concerns with the practice and with NHS England that there were a very significant number of patients whose medicines had previously been reviewed by the pharmacy technicians and had still not been checked by a GP. The practice had undertaken some of the reviews since our inspection 19 August 2016 but had not been able to prioritise GP time to complete this work. In addition, our searches identified that 15 out of the 77 patients taking high risk medicines had not had a review in the past 12 months.

The practice told us that they had held engagement meetings with the locum GPs who undertook regular sessions at the practice. Protected time was allocated to these GPs and advance nurse practitioners to complete clinical administration tasks such as reviewing and taking action around pathology results and hospital letters. We had received concerns from a member of the public; we reviewed the medical records for this patient. The patient had not received medicines in line with those detailed from the consultant. We identified from the clinical records that several locum GPs/advance nurse practitioners had been involved, but this had not been co-ordinated and so the patient had not received continuity of care. This patient was not on the vulnerable peoples register. The practice agreed to contact the patient, review the medicines immediately, add them to the vulnerable patients register, and discuss future care.

We viewed the newly created policies and procedures relating to medicines management including safety alerts, scanning and processing of letters. We were concerned that the policies were not specific to the practice and the language was vague. For example the words, ‘usually’ and ‘ideally’ were used throughout the documents. The practice submitted amended versions within 48 hours of the inspection; we have reviewed these and have found that further improvements are required to ensure safe practice. For example, there is no detail of the required qualifications for the advance nurse practitioner to undertake this role and how their training will be updated to enable them to prescribe appropriate medicines such as the Warwick university qualification for diabetes, Faculty of Family Planning module for contraception.

The practice showed us that, with the support of the RCGP team they had implemented risk assessments to ensure that risks to patients and staff were managed. A comprehensive risk assessment had been written as a working document to ensure that all improvements were implemented and monitored. The practice had also undertaken a risk assessment to employ a new member of staff to undertake the management of pathology results. The practice told us that this had been submitted to NHS England for approval.

Are services well-led?

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

Our findings

At our inspection on19 August 2016 the practice was unable to demonstrate that they had made sufficient improvements to drive the changes necessary for the practice to meet the requirements of Regulation 12 (Safe care and treatment) and so keep patients safe.

During our inspection on14 November 2016 we saw improvements had been made. The GP who had accepted accountability for the care of the patients during the suspension period and a team from the RCGP (including a GP, advance nurse practitioner, and practice manager) reported to us that the principle GP had engaged with them to develop an action plan to ensure safe care and treatment to patients. Comprehensive risk assessments had been introduced to give the principle GP and practice manager oversight of the practice and the improvements needed. All of these systems and process needed to be embedded into the structure and culture of the practice.

The practice told us that they had formed a peer group; this group would also act as a governance and advisory group, to review progress and to look at and advise on any new proposed changes. This group consisted of the principal GP, practice manager, other GPs (including a locum), a nurse (not currently employed), and a patient representative. Other meetings had been introduced including safeguarding and practice staff meetings.

The practice had not been successful in recruiting any GP principles or salaried GPs. The principle GP told us they recognised the lack of GPs presented a challenge in ensuring that clinical capacity matched patient demands and provided adequate cover for the administration required to keep patients safe. The practice shared the plans they had, supported by NHS England for a recruitment drive. They told us they had engaged GP locums to work at the practice on a regular basis.

Some of the changes implemented can only be assessed once the new methodology has been put into practice – then the appropriateness, workability and sustainability of the new systems and processes can be determined. We will make a further assessment when we inspect again at the end of the special measures period.

During this inspection we met with three members from the patient participation group. These members explained that the practice had involved them in the improvement process and were meeting with the practice in the near future to discuss this further.

The practice manager had received support from the RCGP team and from the management team of a local practice. They told us that this had been very educational and supportive.

The practice told us that support for the practice manager and GP peer support would be continued in the future to ensure that the GP principal and manager can deliver all the improvements requiring delivery within the remaining special measures period (ending 18 February 2017).