3Well Ltd - Botolph Bridge

Quality Report

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Date of inspection visit: 13 February 2017
Date of publication: 27/04/2017

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

This was the fifth 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, and 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 a requirement notice for regulation 17 (Good governance).

We carried out a second comprehensive inspection on 10 June 2016. This inspection was in response to concerns raised by members of the public and to check if the practice had made the changes required from the inspection 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.

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

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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.

At our 14 November 2016 we found that improvements had been made. We saw that a governance framework had been put in place and that medicines were authorised by GPs and nurses with a prescribing qualification. The practice had prioritised patients and had started a process of reviewing patients identified as 'may be at risk' from inappropriate reviews. We found that GPs and nurse practitioners managed pathology results and these had been managed in a timely way. The systems and processes in place to ensure good governance had improved but further improvements were needed to 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 (14 November 2016) we decided the suspension should be ended but we imposed urgent conditions on the registration of this provider. The ratings remained the same; inadequate overall and the special measures period continued.

This report covers our findings in relation to our focused inspection on 13 February 2017. 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.

This inspection was undertaken following the period of special measures and was an announced comprehensive inspection on 13 February 2017. Overall the practice is now rated as requires improvement.

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

- During part of the special measures period the principal GP had been unable to provide clinical services. The practice had employed a clinical lead GP and additional support from a practice manager. Throughout the special measures period, the practice were receiving support from the Royal College of General Practitioners team which consisted of a GP, advance nurse practitioner and a practice manager.
- On the day of inspection the practice told us that they had successfully recruited a salaried GP but they had not yet signed a contract. They had engaged locum GPs and advance nurse practitioners who provided sessions on a regular basis.
- We found that improvements had been made but there were some areas where further improvement was required. Governance systems had improved but the practice needed additional time to review, strengthen, and embed their new process to ensure that the improvements could be sustained over time.
- At our inspection in June 2016, we identified that there was not an open culture to report all incidents of potential sub-optimal care. During our inspection in February 2017 we found that not all staff members felt supported to raise concerns about patient safety. There was a system for recording significant events and complaints; these were discussed at various meetings and actions taken. However, we found that not all cases identified had been recorded as significant events and discussions had not been recorded. Those that had been recorded had been appropriately managed.
- We saw practice protocols and policies were in place and had been updated to reflect the change in clinical leads.

Summary of findings

- We saw the practice held meetings and encouraged locum clinicians to attend, some we spoke with told us they did not attend these meetings, nor did they have much involvement in multi-disciplinary team working including end of life care.
- The practice was reliant on locum GPs and advance nurse practitioners to provide appointments for patients. The system to provide clinical supervision for clinical staff needed to be improved. The practice had reviewed some consultations of locum GPs and advance nurse practitioners, but some staff we spoke with told us they had not been engaged in the process and were unaware of any sampling of their consultations or any identified learning. They were not aware of any audits relating to their prescribing practice.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines including as childhood immunisations.We saw that some of the PGD documents were out of date and had not been replaced by the updated versions available from NHS England. This meant the nurses did not have the required legal authorisation to administer the relevant vaccines which are Prescription Only Medicines. The practice took immediate action and obtained the correct versions.
- The management of medicines had been improved. GPs or nurses who had prescribing qualifications undertook all medicines changes and reviews. We found that most patients on high risk medicines had been appropriately monitored. The practice had engaged with the pharmacy situated next door to the practice to further improve communication and safe working practices.
- We saw that the practice had systems and process in place to record and action safety alerts and these had been well managed.
- The practice did not store securely, or have a system in place for tracking the use of prescription stationery throughout the practice.
- Since our last inspection, the practice manager had engaged with the NHS property management team to ensure that the premises were safe and that all checks were completed as required. This included cleaning schedules and the management of legionella disease.
- The practice had a programme of audits and searches of medical records to monitor and encourage improvements but they had failed to undertake audits to monitor the quality of the management of hospital correspondence. This had been identified as an area of improvement required in our May 2015 and June 2016 inspections.
- The clinical and management team had regular meetings to manage the performance of the practice in relation to the quality and outcome framework. The exception reporting rate was 18% which was 7% above the CCG average and 8% above the national average. This was an improvement from our June 2016 inspection where data showed the practice exception reporting was 31% which was 21% above the CCG and 22% above the national average.
- A staff member had taken a lead role as a carer's champion. This staff member contacted any new carer identified to ensure they were aware of the support that was available to them . The practice had raised the awareness of dementia and had information in several languages available. In addition to translation service, the practice had staff members who spoke other languages, for example Lithuanian, Polish and German.
- The practice had engaged the patient participation group to identify and encourage improvement. The practice had an active on line membership and members met with the practice on a regular basis. In 2015 the group received a commendation award from the national association of patient participation.

The areas where the provider must make improvements are:

- Ensure there is an open culture for all staff to be supported to raise any concerns. The practice must ensure that complete records are held including investigation, actions taken and learning shared from the events.

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- Ensure that there is regular monitoring of quality and performance to ensure that actions required from hospital correspondence and test results are completed in a timely way.
- Ensure the practice follows the policy in place to provide and undertake clinical supervision of all staff that provide care to patients at the practice and share any learning with the staff member.

In addition the provider should:

- Further engage locum staff in practice meetings including those for palliative and end of life care.
- Proactively promote the national bowel cancer screening programmes to encourage uptake.
- Monitor the newly implemented system to ensure that practice stationary is stored securely and use of prescription stationery is tracked throughout the practice.
- Monitor the recently introduced systems to ensure that the practice adopted Patient Group Directions (PGDS) are current and available to staff.

This service was placed in special measures in June 2016. Insufficient improvements have been made such that there remains a rating of inadequate for providing well lead services and remains in special measures. The service will be kept under review and if needed could be escalated to urgent enforcement action. Another inspection will be conducted within a further six months.

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.

- There was a clear system for recording significant events and approximately 50 had been recorded since April 2016. These included both clinical and non-clinical incidents. However, we were given cases identified by staff that had not been recorded, investigated and no learning shared. Where events had been recorded, actions had been taken and discussed at various meetings and changes had been made.
- The practice had defined systems, processes, and practices in place to keep patients safe and safeguarded from abuse.
- In our previous inspections in June and August 2016, we identified that the system for managing pathology, X-ray results, and hospital correspondence needed to be improved. On this inspection we saw that GPs and advance nurse practitioners working in the practice dealt with all test results and hospital letters. However, practice staff had identified delays in staff taking some actions from these. The practice had not monitor or audits to ensure that tasks were actioned in a timely way.
- In our previous inspections in June, August, and November 2016 we identified that the practice systems and processes to manage medicines safely needed to be improved. During this inspection we saw that significant improvements had been made. GPs or nurses who had prescribing qualifications undertook all medicine changes and reviews. The records we reviewed showed that patients on high risk medicines had been monitored. The practice had engaged with the pharmacy situated next door to the practice to improve safety and care for patients.
- We saw that the practice had systems and processes in place to record and action safety alerts, and we found these were well managed.
- Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines including childhood immunisations. We saw that some of the PGD documents were out of date and had not been replaced by the updated versions available from NHS England. This meant the nurses did not have the required legal authorisation to

Summary of findings

administer the relevant vaccines which are Prescription Only Medicines. The practice took immediate action and obtained the correct versions, and confirmed to us that no patient had received the wrong vaccinations.

- The practice did not store securely or have a system in place for tracking the use of prescription stationery throughout the practice.
- Since our last inspection, the practice manager had engaged with the NHS property management team to ensure that the premises were safe and that checks were completed as required. This included cleaning schedules and

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services.

- The practice had employed locum GPs and advance nurse practitioners who provided regular sessions.
- Practice staff had the skills, knowledge, and experience to deliver effective care and treatment.
- The practice assessed needs and delivered 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. However,there was scope to improve the systems in place to monitor that these guidelines were followed through clinical supervision for example, joint peer review, and review of consultation records.
- The clinical and management team had regular meetings to manage the performance of the practice in relation to the quality and outcome framework. The exception reporting rate was 18% which was 7% above the CCG average and 8% above the national average. This was an improvement from our June 2016 inspection where data showed the practice exception reporting was 31% which was 21% above the CCG and 22% above the national average.
- The practice had a programme of audits to monitor and encourage improvements but they had failed to undertake audits to monitor the quality of the management of hospital correspondence. This had been identified as an area of improvement required in our May 2015 and June 2016 inspections.

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- The practice had improved multidisciplinary team working; we saw minutes from meetings attended by a health visitor and palliative care meeting where vulnerable patients had been discussed.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the National GP Patient Survey published in July 2016 (the latest available) was lower when compared with the CCG and national averages in how patients rated the practice. This same data set was used in our June 2016 report.
- Feedback from patients about their care was mixed. Some patients said they were treated with compassion, dignity, and respect and reported they were involved in decisions about their care and treatment whilst others were negative in their response.
- A staff member had taken a lead role as a carer's champion. This staff member ensured they were aware of the support that was available to them and contacted any new carer identified.
- The practice had identified 85 patients as carers (approximately 1% of the practice list, this was an improvement from our last inspection when they had identified under 1%).
- Information for patients about the services available was easy to understand and accessible.
- The practice provided, with the support of the Patient Participation Group, community activities such as coffee mornings, a befriender group, a walking to fitness group and educational sessions.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- Some staff members were able to speak other languages and had helped patients to access care and treatment in a timely way.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement services for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified.

Summary of findings

- Requests for appointments were offered in different ways; appointments could be booked for a face to face, or by requesting a telephone consultation or via an email request. Following either the telephone consultation or email request, appointments were booked as clinically indicated.
- The practice was open from 7.30am to 7pm on Mondays, Wednesdays, and Thursday and from 7.30am to 6.30pm on Tuesdays and Thursdays. Appointments were available on Saturday morning from 8.30am to 12.30pm. Appointment times varied.
- Patients said they found it difficult to make an appointment with a named GP. Data from the GP Patient Survey published July 2016 showed that 39% of patients usually got to see or speak with their preferred GP compared with the CCG and national average of 59%.
- Urgent appointments were available the same day and telephone consultations were available for those patients who wished to access advice this way.
- 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff.
- Prescriptions could be ordered online, in writing, by phone or in person. The practice was planning to introduce the electronic prescription service which means patients will be able to collect their medicines directly from a pharmacy without having to go to the practice first.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well led.

- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. During the period of special measures a management team consisting of an employed clinical lead GP and practice manager along with a GP, advance nurse practitioner, and practice manager from the Royal College of General Practitioners had drawn up a business plan.
- There was a leadership structure in place; some of the leadership team had only been in post since December 2016.
- There had been improvements in the governance systems but some of these were insufficient. The practice needed additional time to review, strengthen, and embed their new processes to ensure that the improvements could be sustained over time.

Summary of findings

- The systems to monitor performance and quality required further improvement. Practice staff raised concerns that not all actions had been taken or taken in a timely way.
- During our inspection in June 2016 we identified that the culture for reporting all incidents of potential sub optimal care needed to be more effective. During our inspection February 2017 some staff reported to us that they did not feel supported to raise concerns about patient safety.
- We saw that the practice held meetings with the locum clinicians but some we spoke with did not attend these meetings. Minutes of the meetings were taken but some locums did not always read them.
- We saw that practice protocols and policies were in place and had been updated to reflect the change in clinical leads.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and engaged with the management team to discuss and support the improvement plans.

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

Requires improvement

The practice is rated as requires improvement. The concerns which led to these ratings apply to everyone using the practice including this group.

- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- A clinician prioritised requests for home visits and ensured appropriate and timely care for patients.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people, including rheumatoid arthritis and heart failure, were in line local and national averages.
- A staff member had taken a lead role as a carer's champion. This staff member ensured they were aware of the support that was available to them contacted any new carer identified.
- The practice provided, with the support of the PPG, community activities such as coffee mornings, a befriender group, a walking to fitness group and educational sessions.

People with long term conditions

Requires improvement

The practice is rated as requires improvement. The concerns which led to these ratings apply to everyone using the practice including this group.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- The practice used the information collected for the Quality and Outcomes Framework (QOF) to monitor outcomes for patients (QOF is a system intended to improve the quality of general practice and reward good practice). Data from 2015/2016 showed that performance for diabetes related indicators was 82%, which was 9% below the local average 8% below the national average. Exception reporting for diabetes related indicators was 18%, which was higher than the CCG average of 13% and the national average of 12%. (Exception reporting is the removal of patients from QOF calculations where, for

Summary of findings

example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had recently introduced additional diabetes clinics with an advance nurse practitioner.
- Longer appointments and home visits were available when needed.
- Patients with complex needs had a named GP and a structured annual review to check their health and medicines needs were being met. There was a recall system in place to ensure that patients were invited and attended annual reviews.
- Patients were able to have their blood pressure checked without having to make an appointment first.

Families, children and young people

Requires improvement

The practice is rated requires improvement. The concerns which led to these ratings apply to everyone using the practice including this group.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.
- Immunisation rates were high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding five years was 82%, which was in line with the local CCG and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors, and school nurses.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement. The concerns which led to these ratings apply to everyone using the practice including this group.

- 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 where possible.

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- The practice offered early and later appointments on week days and on every Saturday morning.
- The practice offered online services as well as a full range of health promotion and screening that reflected the needs for this age group.
- The practice planned to offer an electronic prescription service, which meant that patients would be able to collect their medicines from the pharmacy of their choice with visiting the practice first.
- Smoking cessation advice and support was available at the practice.
- The practice offered face to face consultations as well as telephone and email consultations for those who wished to access advice this way.

People whose circumstances may make them vulnerable

Requires improvement 

The practice is rated as requires improvement. 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.
- The practice worked with other health care professionals in the case management of vulnerable patients, and held regular multidisciplinary team meetings.
- The practice informed 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.
- The practice with the support of the PPG offered a befriender service for those who were socially isolated.
- The practice worked with the community team and held drug dependency clinics.

People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice is rated as requires improvement. The concerns which led to these ratings apply to everyone using the practice including this group.

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Summary of findings

The practice performance for indicators relating to mental health was 97%; this was 5% above the CCG average and 6% above the national average. The exception reporting for this indicator was 33% which was above the CCG average of 13% and the national average of 11%.

- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.in addition the practice offered a befriender service.
- Practice staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice had information relating to dementia in several different languages.

Summary of findings

What people who use the service say

The National GP Patient Survey results were published in July 2016. The results showed the practice performance was below the CCG and national averages. This is the same data set as used in our June 2016 report.

309 survey forms were distributed and 103 were returned. This represented a 33% completion rate.

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

As part of our inspection, we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 16 comment cards, nine of which were positive about the standard of care received. Patients felt that the practice provided a friendly, efficient, and supportive service. Seven patients were negative in their comments, some reflecting that they had received poor care and experienced difficulty in seeing a GP. Through the CQC website we received both positive and negative reports from patients.

We spoke with three patients during the inspection, two patients said the care they received was good, and that staff were kind, friendly, caring, and approachable. One patient reported poor care and difficulty in getting through to the practice by telephone.

We spoke with members of the patient participation group who reported that the practice offered excellent services and had made improvements. They reported that the management team met the challenges they faced positively and had kept them informed about any changes.

One member of the PPG group was available on the day of the inspection; we were unable to take the opportunity to talk with them on the day but asked if we could conduct a telephone call at their convenience.

Areas for improvement

Action the service MUST take to improve

- Ensure there is an open culture for all staff to be supported to raise any concerns. The practice must ensure that complete records are held including investigation, actions taken and learning shared from the events.
- Ensure that there is regular monitoring of quality and performance to ensure that actions required from hospital correspondence and test results are completed in a timely way.
- Ensure the practice follows the policy in place to provide and undertake clinical supervision of all staff that provide care to patients at the practice and share any learning with the staff member.

Action the service SHOULD take to improve

- Further engage locum staff in practice meetings including those for palliative and end of life care.
- Proactively promote the national bowel cancer screening programmes to encourage uptake.
- Monitor the newly implemented system to ensure that practice stationary is stored securely and use of prescription stationery is tracked throughout the practice.
- Monitor the recently introduced systems to ensure that the practice adopted Patient Group Directions (PGDS) are current and available to staff.

3Well Ltd - Botolph Bridge

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team included a CQC lead inspector, two CQC inspectors, a GP specialist adviser, a nurse specialist adviser, and a Care Quality Commission medicine management team member.

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 7100 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 manager, assistant practice manager (currently on maternity leave) and a team of reception/administration/secretarial staff support the clinical team.

The practice had employed a GP clinical lead and an experienced practice manager to support the practice team. In addition, during the period of special measures, a team from the Royal College of General Practitioners consisting of a GP, Advance Nurse Practitioner, and practice manager had been supporting the practice to make the improvements needed.

We previously inspected this practice on four other occasions. On 7 May 2015, we found that the practice required improvement for effective services but was 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. We conducted a focused inspection on the 19 August 2016 and we took urgent action to suspend 3Well Ltd Botolph Bridge from providing general medical services at 3Well Ltd Botolph Bridge for a period of three months. A further focused inspection was carried out on 14 November 2016, the suspension was lifted, and we imposed urgent conditions on the provider's Care Quality Commission registration.

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 was because at the inspection on 10 June 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 place 3Well Ltd Botolph Bridge in special measures for a period of six months.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed the issues found at the 15 May 2015 inspection, those found at our inspection10 June 2016, 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 reviewed the findings from the 14 November 2016 inspection and the conditions placed on the provider's registration. We also reviewed the information supplied by the provider as evidence of the actions taken to address those issues. We reviewed concerns and positive comments that we had received from members of the public. We carried out an announced visit on 13 February 2017.

During our visit we spoke with the principal GP and the practice manager. We spoke with the practice manager from the Royal College of General Practitioners support team. We spoke with the employed clinical lead GP and support practice manager who were in post to ensure the provider had met the conditions placed on his registration.

We spoke with locum GPs and advance nurse practitioners, practice nurses and non-clinical staff. We spoke with patients who used the service and with members of the patient participation group (PPG). We spoke with a representative from NHS property management team. We viewed medical records, policies, procedures, and recruitment files.

This inspection was carried out on 13 February 2017 to ensure improvements had been made and to assess whether the special measures period should be concluded.

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 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).

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.

Requires improvement

Are services safe?

Our findings

At our inspection on 10 June 2016, we rated the practice as inadequate for providing safe services as arrangements for identifying and managing risks to patients and staff needed to be implemented. When we undertook a comprehensive inspection on 13 February 2017, these arrangements had improved but not sufficiently. The practice is now rated as requires improvement.

Safe track record and learning

There was a system in place for reporting and recording significant events. However we found that not all incidents raised by practice staff had been recorded as significant events, fully investigated, changes made and learning shared.

- The practice form for reporting significant events was available to staff and provided a template for detailed reporting and investigation.
- Practice staff told us they would inform the manager of any incidents either verbally or via an incident form. However, on the day of the inspection, practice staff told us they had raised concerns in relation to potential sub optimal care of patients and high workload of staff.

We asked for the minutes of a meeting that had taken place on 18 January 2017, these were not available to us, as they had not been written. We discussed some incidents that we had been made aware of with the management team. These incidences had not been recorded as significant events nor entered onto the significant event log by the staff member or by the management team. The practice was not able to evidence that they had taken action to review the patients concerned, identify actions needed and to share learning. Following our inspection the practice provided us with detailed evidence of the reviews, actions they had taken and those they planned to take.

- We reviewed events that had been recorded relating to safety records, incident reports, patient safety alerts, and minutes of meetings where these were discussed. We saw evidence that lessons were documented and action was taken to improve safety in the practice. However, not all locum staff attended the meetings and therefore did not benefit from the identified learning.
- We saw some evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, and a written apology; however we found cases where not all of these actions had been recorded.
- Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) and guidance and alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA). The information was monitored by a designated member of staff for relevance and shared with other staff, as guided by the content of the alert. Any actions required as a result were brought to the attention of the relevant clinician(s) to ensure issues were dealt with. Clinicians we spoke with confirmed that this took place.

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 were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. There was a lead member of staff for safeguarding. The GPs told us they attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child safeguarding level three and non-clinical staff to level one.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received either a Disclosure and Barring Service (DBS) check or the practice had undertaken a risk assessment. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- 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 and control teams to keep up to date with best practice. The practice manager met regularly with the NHS property service manager, ensuring that the practice was kept safe.

- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

Medicines management

- There were arrangements in place for managing medicines, including emergency medicines and vaccines.
- Processes were in place for handling repeat prescriptions which included the review of high risk medicines.
- We saw examples of medicines audits, including an audit which showed that the practice had made improvements in the way they prescribed controlled drugs (medicines that require extra checks because of their potential for misuse).However, we did not see any audits relating to the individual prescribing practice of clinical staff.
- Prescription forms were stored securely in individual consulting rooms but the main stock was not stored in line with national guidance and there was no process in place to track the use of the forms.
- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw that six of the PGD documents were out of date and had not been replaced by the updated versions available from NHS England. This meant the nurses did not have the required legal authorisation to administer the relevant vaccines which are Prescription Only Medicines. The practice took immediate action and following our inspection provided evidence to show updated and current versions were in place. A significant event form had been completed and a system implemented to ensure that regular checks would be undertaken to ensure that practice nurses had access to the correct information.
- Two locum advance nurse practitioners had qualified as Independent Prescribers and could therefore prescribe medicines. They told us that they felt supported by the GPs in the practice. Although there was a policy in place for clinical supervision and peer review of clinical staff, the members we spoke with had not received any. The practice gave us details of some checks they had undertaken from medical records by a GP but the findings had not been shared with the staff member. We noted there were negative comments such as 'follow up missing and lack of detail makes it difficult to assess appropriateness of prescribing'.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives.
- All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice manager had engaged the NHS property service manager to ensure that all checks were completed and that regular maintenance calls were in place. A variety of other risk assessments was in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- The practice told us that recruitment was a challenge. They had not been successful in recruiting further GP principals or nurse practitioners. They told us they were in discussion with staff in relation to joining the team on a permanent basis, but on the day of the inspection the staff had not signed any contracts. On the day of the inspection we were told that two of the three practice nurses were leaving and the practice had interviews planned for new nursing staff. We saw that the practice had made significant effort to recruit new staff; they had advertised in the national and local areas and had been successful in gaining support from the NHS recruitment including the making of a video.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms, which alerted staff to any emergency.

Requires improvement

Are services safe?

- All staff received annual basic life support training and emergency medicines were easily accessible to staff in a secure area of the practice. All the medicines we checked were in date.
- 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.
- 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.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our inspection on 10 June 2016, we rated the practice as inadequate for providing effective services. Because of high exception reporting, we were concerned that the needs of patients with ongoing health conditions were not met. We had identified a back log of pathology and radiology results and were concerned the systems and processes to manage these were not effective. The practice had not undertaken audits to assure themselves that staff care was effective care in line with guidance from the National Institute for Health and Care Excellence. The practice is now rated as requires improvement for providing effective services.

Effective needs assessment

- The practice assessed needs and delivered 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. However,there was scope to improve the systems in place to monitor that these guidelines were followed. The principal GP had undertaken some reviews of care given by locum GPs and advance nurse practitioners by the practice; however they had not discussed this or the findings with the staff members. We reviewed the findings and noted that there were comments where learning may have been identified. For example, insufficient notes to assess if prescribing appropriate.

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 showed that the practice had achieved 96% of the total number of points available, which was in line with the local average and the national average of 95%. The exception-reporting rate for the practice was 17.5%, which was above the local CCG average of 7% and 8% above the national average (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). This was an improvement from our June 2016 inspection where data showed the practice exception reporting was 31% which was 21% above the CCG and 22% above the national average.

Data from 2015/2016 showed:

- Performance for diabetes related indicators was 81.5%, which was 9% below the CCG average and 8% below the national average. Exception reporting for diabetes related indicators was 10%, which was 4% above the CCG and 5% and national averages. The practice performance for 2014/2015 was 88%. The exception reporting rate was 33% which was 13% above the CCG average and 11% above the national average. From the beginning of February 2017, the practice had introduced three clinics per week for an advance nurse practitioner to review patients.
- Performance for chronic obstructive disease related indicators was 100%, which was 4% above the CCG and national average. Exception reporting for these indicators was 19%, compared with the CCG average of 14% and the national average of 13%. The practice performance for 2014/2015 was 100% with an exception reporting rate of 51% which was 14% above the CCG average and 12% above the national average.
- Performance for mental health related indicators was 99%, which was 5% above the CCG average and 6% above the national average. Exception reporting for these indicators was 33%, which was above the local average of 13% and national average of 11%. The practice performance for 2014/2015 was 100% with exception reporting rate of 22% which was 13% above the CCG average and 11% above the national average.

In our June 2016 inspection we identified that the practice must take proactive steps to ensure that patients received safe care and treatment by reviewing the Quality and Outcome Framework (QOF) exception reporting. During this inspection the practice showed us evidence that they had made improvements and reduced the exception rate. They held regular meetings involving clinical and non-clinical staff and had reviewed, and improved the recall system. The practice contacted patients at least three times by various methods, letter, text, or phone call and did not necessarily apply the exception code after this time. They reset the recall date for three months' time and continued

to encourage attendance or were proactive if the patient attended for any other reason. The practice had redesigned the recall letters giving patients information about the review due and a feedback form to return if they do not wish to attend. The practice nurses contacted any parent or guardian of children who did not attend or declined their baby immunisation reminders. The practice told us they were confident that they would further reduce the exception reporting for 2016/2017.

We looked at whether the practice had carried out a programme of quality assurance including clinical audit. In our June 2016 inspection we identified that the practice had not routinely used audits to monitor and encourage improvement.

During the period of special measures, the practice had completed a number of prescribing audits and searches to ensure that they were making the improvements needed. We saw the practice had undertaken one cycle audits in other areas, for example in relation to patients with atrial fibrillation (heart disease) and the importance of preventing strokes. The practice told us that they would continue the programme of audits that had been introduced. We noted that the practice had failed to undertake and implement a system to assess and monitor the performance of staff including those relating to hospital letters, coding of medical records and medical summaries.

Effective staffing

Staff had the skills, knowledge, and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered topics including safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training, which had included an assessment of their competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. However, we found six of the patient group directions (PGDs) were out of date and had not been replaced by the updated versions available from NHS England. This meant the nurses did not have the required legal authorisation to administer the relevant vaccines which are Prescription Only Medicines. The practice took immediate action and obtained the correct versions. The learning needs of staff were identified through a system of appraisals, meetings, and reviews of practice development needs. This included ongoing support and meetings. A schedule of appraisals was in place and written evidence of these had been retained.
- The practice system in relation to clinical supervision was not clear to staff and needed to be improved. The practice told us they had reviewed consultations of the locum GPs and advance nurse practitioners but the staff we spoke to were unaware of this. Identified learning outcomes had not been shared. We highlighted this to the practice. Immediately following our inspection they held meetings with individual staff and arranged peer review and supervision sessions.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records, and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a regular basis to discuss patients with complex needs.
- Non-clinical practice staff had responsibility for managing hospital correspondence, the summary and coding of medical records and referring relevant

Requires improvement

Are services effective?

(for example, treatment is effective)

documentation to a clinician for review. The practice had not implemented processes to monitor the quality and safety of this. We had identified this in our May 2015 and June 2016 reports.

Consent to care and treatment

There was a consistent approach to recording patients' consent to care and treatment in line with legislation and guidance.

- Practice staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear, the GP or practice nurse assessed the patient's capacity and recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, and smoking cessation. Patients were signposted to the relevant service.

- The practice's uptake for the cervical screening programme was 81%, which was in line with the CCG average of 82% and the national average of 81%. The practice rate for exception reporting was 4% which was below the CCG average of 9% and the national rate of 7%. 93% of female patients on the mental health register had received cervical screening. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening appointment. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.
- The practice also encouraged its patients to attend national screening programmes for breast and bowel cancer screening. The breast cancer-screening rate for the past 36 months was 74% of the target population, which was in line with the CCG average of 74% and the national average of 72%. The bowel cancer-screening rate for the past 30 months was 49% of the target population, which was below the CCG average of 59% and below the national average of 58%.
- Childhood immunisation rates for the vaccinations given were above CCG and national standard of 90%. For example, childhood immunisation rates for the vaccinations given to under two year olds in 2015/2016 ranged from 93% to 98%. Childhood immunisation rates for the vaccinations given to five year olds ranged from 93% to 99%.
- 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. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

At our inspection on 10 June 2016, we rated the practice as requires improvement for providing caring services. The practice is now rated as good.

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations, and treatments.
- Practice staff told us that they were aware of the need to ensure that they protected patients confidentiality at all times.
- When patients wanted to discuss sensitive issues or appeared distressed reception staff could offer them a private room to discuss their needs.
- Practice staff told us that the additional languages spoken by the reception team had helped some patient's access appropriate care quicker.

We spoke with three patients and a member from the PPG, three of whom told us they were satisfied with the care provided by the practice and said their dignity, and privacy was respected. Patients told us that staff responded compassionately when they needed help and provided support when required.

Results from the National GP Patient Survey published in July 2016 showed patient satisfaction scores were below the local and national averages. This is the same data set used in our June 2016 report. For example:

- 75% of patients said the GP was good at listening to them compared to CCG 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 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 and the 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 and the national average of 91%.
- 86% of patients said the nurse gave them enough time compared to the CCG average of 93% and the national average of 92%.
- 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%.

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 some patients reported that there had been a delay in their treatment.

Results from the National GP Patient Survey published in July 2016 showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were lower than the CCG and national average. 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%.
- 68% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG and the national average of 82%.
- 76% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average and the national average of 85%.

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

- Staff 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. Some practice staff spoke other languages and were able to help patients. For example reception staff spoke Polish and Lithuanian and had helped a patient who was at risk of frequent falls access support more quickly.

Good

Are services caring?

- Information leaflets were available in easy read format. Information relating to dementia support was available in several languages.

Patient and carer support to cope emotionally with care and treatment

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

- To improve the identification and support offered to carers, a staff member had taken on the role of a carer's champion. The practice was proactive in identifying patients with caring responsibilities and had increased the number recorded on their register. The practice had identified 85 patients as carers (approximately 1% of the practice list, this was an improvement from our last inspection when they had identified under 1%). The carer's champion telephoned any new carer, offer them support, and identified any needs they may have. Written information was available to direct carers to the various avenues of support available to them. The practice told us they looked for any young carers but did not have any on the day of the inspection.
- The practice had a palliative care register and had regular meetings had been introduced to discuss the care and support needs of patients and their families with all services involved. Practice staff told us that families who had suffered bereavement were contacted by their usual GP. This call was followed by a patient consultation at a flexible time and location to meet the family's needs. Some locum staff we spoke with told us they did not attend these meetings.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our inspection on 10 June 2016, we rated the practice as requires improvement for providing responsive services. The practice is still rated as requires improvements for providing responsive services.

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.

- The practice offered extended hours appointments each day from 7am to 8am and some evenings to 7pm. Appointments were available each Saturday morning.
- There were longer appointments available for patients who required them.
- Home visits were available for older patients and patients who had clinical needs, which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Multi-disciplinary team meetings were taking place with a range of other healthcare professionals in attendance.
- Patients were able to receive travel vaccinations available on the NHS. However, not all staff were aware of this so some patients may not have received vaccinations they were eligible to under the NHS.
- There were accessible facilities for those with a disability and translation services available.
- A range of patient information leaflets was available in the waiting area including NHS health checks, services for carers and promotion of mental health awareness.
- The practice provided a range of nurse-led services such as management of asthma, weight management, diabetes, coronary heart disease, wound management, smoking cessation clinics, and minor illness advice.
- The practice offered in-house diagnostics to support patients with long-term conditions; patients did not need to book an appointment to be able to have their blood pressure taken.

Access to the service

- The practice was open from 7.30am to 7pm on Mondays, Wednesdays, and Thursday and from 7.30am to 6.30pm on Tuesdays and Thursdays. Appointments were available on Saturday morning from 8.30am to 12.30pm. Appointment times varied. When the practice was closed, patients access the out of hours service via 111.

Results from the National GP Patient Survey published in July 2016 showed that patients' satisfaction with how they could access care and treatment were below the local and national averages. This is the same data set as used in our June 2016 report.

- 66% of patients were satisfied with the practice's opening hours compared to the CCG average 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%.
- 50% of patients felt they don't normally have to wait too long to be seen compared to the CCG average the national average of 58%.
- 66% of patients were satisfied with the surgery's opening times compared to the CCG and the national average of 76%.
- 39% of patients said they always or almost always see or speak to the GP they prefer compared to the CCG and national average of 59%.

People told us on the day of the inspection that they were able to get appointments when they needed them. However, some patients reported that they had not been able to see the same GP consistently and therefore did not have continuity of care. We saw that patients who needed to be seen were seen on the day and that patients were able to access telephone advice from the GP or advance nurse practitioner.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice's

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

website and in their information leaflet. Information about how to make a complaint was also displayed on the wall in the waiting area. Reception staff showed a clear understanding of the complaints' procedure.

We looked at documentation relating to a number of complaints received in the previous year and found that they had been fully investigated and responded to in a timely manner. Complaints were shared with some staff to encourage learning and development.

Are services well-led?

Inadequate

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

Our findings

At our inspection on 10 June 2016, we rated the practice as inadequate for providing well led services as the practice did not have a clear vision and strategy or clear leadership and staff did not feel supported by the management team. There were no overarching governance arrangements in place to support the delivery of safe care or make improvements to identified issues. When we undertook a comprehensive inspection on 13 February 2017, these arrangements had improved but not sufficiently. The practice is still rated as inadequate for providing well-led services.

Vision and strategy

The practice had a clear vision in place to provide their patients with services that were safe and well led. The practice management team we spoke with shared this vision and told us that they had been involved in working out the strategy to achieve this since the last inspection. The practice staff told us that they were working hard to achieve the improvements.

Practice staff we spoke with were committed to providing a quality service and felt that there had been a greater emphasis on improving the service since the previous inspections in June, August, and November 2016. We recognised that the practice had met some unforeseen and difficult challenges whilst addressing the required improvements identified in our reports from June, August, and November 2016. The practice had made significant improvements to ensure that patients were kept safe but there were further improvements required.

Governance arrangements

- We found that improvements had been made but there were some areas where further improvement was required. Governance systems and processes had improved but the practice needed additional time to review, strengthen, and embed their new process to ensure that the improvements could be sustained over time.
- We saw that the practice had implemented systems to ensure that patient's medicines were managed safely and that appropriate clinicians saw all test results.
- We saw that the practice held regular meetings and detailed minutes were taken and shared but not all locum staff attended these meetings or read the minutes.
- In our inspection June 2016 we identified that there was not an open culture to report all incidents of potential sub optimal care. During our inspection February 2017, we found that not all staff members felt supported to or when they raised concerns about patient safety.
- There was a system for recording significant events and complaints; these were discussed at various meetings and actions taken. However, we found that not all cases identified had been recorded as significant events and discussions had not been recorded. Where they had been recorded we saw evidence of actions taken and learning shared.
- We saw that practice protocols and policies were in place and had been updated to reflect the change in clinical leads.
- The clinical and management team had regular meetings to manage the performance of the practice in relation to the quality and outcome framework and ensure patients were monitored safely. The exception reporting rate was 18% which was 7% above the CCG average and 8% above the national average. This was an improvement from our June 2016 inspection where data showed the practice exception reporting was 31% this was 21% above the CCG and 22% above the national average.
- Although there was a policy in place to ensure clinical supervision was in place and some review of their consultations had been undertaken, the staff we spoke with had not been engaged in the process and were unaware of any sampling of their consultations or any identified learning.
- The practice had a programme of audits to monitor and encourage improvements but they had failed to undertake audits to monitor the quality of the management of hospital correspondence. This had been identified as an area of improvement required in our May 2015 and June 2016 inspections.

Are services well-led?

Inadequate

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

Some of the changes that have been recently 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.

Leadership and culture

On the day of inspection the management team told us they prioritised safe, high quality and compassionate care. They had engaged locum doctors and advance nurse practitioners to provide some continuity of care and they were actively seeking more GPs and advance nurse practitioners to join the team. On the day of inspection the practice told us that they had successfully recruited a salaried GP but they had not yet signed a contract.

- There was a leadership structure with a newly formed management team in post. In addition to the registered provider an employed GP had the responsibility of clinical lead. The practice manager was supported by another part time experienced practice manager to ensure that improvements to the systems and processes would be embedded and sustained. There were named members of both clinical and administration staff in lead roles and practice staff we spoke with were all clear about their own roles and responsibilities.
- The leadership at the practice had responded to the findings of our previous inspections and had focused on the governance arrangements at the practice. New systems and processes had been implemented and were being embedded into practice to ensure that the issues identified at the previous inspections had been resolved. The practice recognised that some further improvements were needed and had a business plan to address these. Since our last inspection significant changes had been made to the skill mix and staffing within the practice. The practice no longer employed medical assistants or pharmacy technicians.

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. We saw that the Patient Participation Group (PPG) was working with the practice to give confidence to patients that the practice was safe and caring.

The practice manager shared with us the plans they had to engage with the wider community. The practice had a programme of events planned which included talks on Powers of Attorney, and Falls Prevention (identified by public health as a concern in the area). This community work had helped patients who may be socially isolated and had in some instances given patients' confidence to undertake voluntary work.

The practice had also gathered feedback from staff through staff meetings, appraisals, and informal discussion. Practice staff told us that they felt there had been positive changes made in the previous months following the introduction of the new management team. However, some staff told us that they were concerned that the high workload of staff and insufficient monitoring of performance lead needed to be reviewed.

Continuous improvement

The practice shared with us a detailed business plan which the management team had written. In this plan the practice identified further improvements that needed to be made. For example, they planned to become a dementia friendly practice and to further improve their care of this group of patients. They told us that they planned to further improve medicines management and had applied for funding to engage a clinical pharmacist and to train staff to become prescribing clerks.

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** • **The practice did not follow the policy in place to provide and undertake clinical supervision of staff that provide regular services at the practice and share any learning with the staff member.** • **The practice did not demonstrate that there was an open culture for all staff to be supported to raise any concerns. The practice did not evidence that complete records including investigation, actions taken, and learning shared from the events were maintained.** • The practice had not undertaken regular monitoring of the quality and performance to ensure that actions required are taken in a timely way from hospital correspondence and test results.