

Care Quality Commission

Inspection Evidence Table

Nexus Health Group (1-542937588)

Inspection date:

Site	Date
Princess Street Group Practice (Visit to review central governance systems)	1 November 2018
Manor Place Surgery	7 November 2018
Princess Street Group Practice	14 November 2018
Surrey Docks Health Centre	15 November 2018
Aylesbury Medical Centre	20 November 2018
Dun Cow Surgery	21 November 2018
Commercial Way	22 November 2018
Decima Street Surgery and The Artesian Health Centre	28 November 2018

Date of data download: 11 December 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2017/18.

Overall rating: Inadequate

Guidance: The evidence table below covers all eight Location within Nexus Health Group. Areas of

variation and/or concerns will be highlighted on a site by site basis. If the issue being described is applicable across Nexus Health Group we will highlight this as being applicable to all sites.

Safe

Rating: Inadequate

The practice was rated as inadequate for providing safe services because:-

- There was no global oversight of another electronic system for incoming results. Which had resulted in a back log of patient test results. Although this was immediately responded to by the provider we found this could have put patients at risk.
 - The practice did not have appropriate systems in place for the safe management of medicines at all sites. We were provided information after our inspection about actions being taken to address this concern.
 - Two sites did not have a system in place to monitor non- medicines safety alerts.
 - Some staff had not completed their safeguarding, fire or infection control training.
 - Necessary recruitment checks including disclosure and barring service (DBS) and immunisation status had not been undertaken for all staff.
 - There were staffing shortages at certain sites.
 - The systems for checking equipment and vaccines was not consistent across all sites. In addition, we found some expired medical emergency equipment.
- Some risks were not adequately mitigated at all sites including those and associated with legionella and fire. We were provided information after our inspection about actions being taken to address this issue.

Safety systems and processes

The practice did not have clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Partial
Policies were in place covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	N
There was active and appropriate engagement in local safeguarding processes.	Y
Systems were in place to identify vulnerable patients on record.	Y

Safeguarding	Y/N/Partial
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	N
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers. to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	
<p>We reviewed staff training at all sites and found that not all staff had completed child and adult safeguarding training. For example: -</p> <ul style="list-style-type: none"> • <u>Manor Place Surgery</u> - We reviewed five staff files. We found out of the five files one member of the administrative team had not completed level 1 safeguarding training. In addition staff were unable to provide evidence of a locum GP completing their level three safeguarding training. The lack of training was confirmed by the practice's training matrix. • . • <u>Princess Street Group Practice</u> – We reviewed five files and found one member of non-clinical staff had not received safeguarding training at this site. • <u>Surrey Docks Health Centre</u> - We reviewed the file of GP working at Surrey Docks Health Centre and found that they had not received level 3 child safeguarding training or adult safeguarding training. This was confirmed by reviewing the training matrix provided after our inspection which indicated that no safeguarding training had been completed by this staff member. 	
<p>We reviewed the DBS checks for <u>all sites</u> (checks to 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.). We found the provider had an inconsistent approach to carrying out DBS checks at the different sites. For example: -</p>	
<ul style="list-style-type: none"> • A recruitment policy provided prior to the inspection stated 'all non-clinical staff were to have a DBS check or a risk assessment completed for the individual member of staff while the DBS was in process.' • However, the DBS policy reviewed during the inspection stated DBS checks were not required for non-clinical staff who did not have one to one contact with patients including chaperones as they were never left alone with patients' • Staff we spoke to at the different sites provided different answers in respect of what the correct policy was for DBS checks. For example, one member of the management team stated all non-clinical staff required DBS checks. • <u>Aylesbury Medical Centre</u> we reviewed the recruitment file of a healthcare assistant working 	

Safeguarding	Y/N/Partial
<p>upskilled from a non-clinical to a clinical role and found the provider had not completed the DBS check. At the time of the inspection the staff confirmed the practice had not consistently undertaken DBS checks for staff who had transitioned from non-clinical into clinical roles.</p> <ul style="list-style-type: none"> • <u>Surrey Docks Health Centre</u> - We found that the operations manager at had not received a DBS check in-line with the providers recruitment policy. • 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	N
Systems were in place to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	N
Staff who required medical indemnity insurance had it in place.	Y
<p>Explanation of any answers and additional evidence:</p> <p>We reviewed a sample of files at each site to look at recruitment checks and the monitoring professional registrations and found: -</p> <ul style="list-style-type: none"> • <u>Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way</u> - regular checks of professional registrations were not being undertaken for staff who worked at these sites. • <u>Manor Place Surgery</u> - There was no proof of identification on file for a receptionist.. • <u>Surrey Docks Health Centre</u> – There was no proof of identification for a healthcare assistant. • <u>Decima Street Surgery and the Artesian Health Centre</u> - There were no CVs on file for the five staff members whose files we reviewed that worked across these two sites. There were no references on file for a recently recruited GP. There was no DBS on file for a healthcare assistant who worked at these sites. Although, we found no documented checks of professional registrations for clinical staff we were told that these were regularly undertaken <p>We reviewed the staff immunisation status and found: -</p>	

- **Surrey Docks Health Centre** - One GP had no record of their immunisation status on record.
- **Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way** - A non-clinical staff member who transitioned into a healthcare assistant role who worked at these sites was not screened and vaccinated for common communicable diseases at the time they were upskilled.
- **Princess Street Group Practice** - The managers informed us that all staff needed to have confirmed MMR status because of a recent measles outbreak in the local area.

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test:</p> <p><u>Manor Place Surgery – January 2018</u> <u>Princess Street Group Practice - September 2018</u> <u>Surrey Docks – Sept 18</u> <u>Aylesbury Medical Centre – June 2018</u> <u>Dun cow – June 2018</u> <u>Commercial way – June 2018</u> <u>Decima Street Surgery – September 2018</u> <u>Artesian</u> – Unknown. We were informed that this was the responsibility of a local secondary care service and were provided a certificate after our inspection but this included no testing date.</p>	Partial
<p>There was a record of equipment calibration. Date of last calibration:</p> <p><u>Manor Place Surgery</u> – November 2017 <u>Princess Street Group Practice</u> - February 2018 <u>Surrey Docks Health Centre</u> – September 2018 <u>Aylesbury Medical Centre</u> – September 2018 <u>Dun Cow Surgery</u> – September 2018 <u>Commercial Way</u> – September 2018 <u>Decima Street Surgery</u> – February 2018 <u>Artesian Health Centre</u> – February 2018</p>	Y
Risk assessments were in place for any storage of hazardous substances for example,	Y

liquid nitrogen, storage of chemicals.	
There was a fire procedure in place.	Partial
There was a record of fire extinguisher checks.	Partial
There was a log of fire drills.	Partial
There was a record of fire alarm checks.	Partial
There was a record of fire training for staff.	Partial
There were fire marshals in place.	Y
A fire risk assessment had been completed. Date of completion: <u>Manor Place Surgery</u> - September 2018 <u>Princess Street Group Practice</u> – September 2018 <u>Surrey Docks Health Centre</u> – Sept 18 <u>Aylesbury Medical Centre</u> – October 2018 <u>Dun Cow Surgery</u> – October 2018 <u>Commercial Way</u> - October 2018 <u>Decima Street Surgery</u> – September 2018	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
<p>We reviewed the fire procedures at each site most sites had an fire procedure in place that reflected the staff practices with the exceptions of: -</p> <ul style="list-style-type: none"> • <u>Surrey Docks Health Centre</u> – The fire policy did not include the evacuation point. However, staff were aware of where the evacuation point was and there were signs in the practice to direct patients and staff to the evacuation point. • <u>Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way</u>– The fire policies did not include the fire evacuation point. The policy was revised during the inspection to include the fire evacuation point. However, staff were aware of where the evacuation point was and there were signs in the practice to direct patients and staff to the evacuation point. <p>We looked the maintenance of the fire extinguishers at all sites and found the provider had mostly carried out the correct maintenance, with the exception of: -</p>	

- **Manor Place Surgery** – There were two fire extinguishers in the practice manager’s office which were labelled as requiring servicing in April 2017. The latest fire extinguisher servicing certificate dated 20 June 2018 said that four extinguishers were not operational. This was raised this with the operations manager who could not confirm why these extinguishers had not been checked or if these extinguishers were amongst the one referred to on the servicing document as not operational. After our inspection and in response to the warning notices issued the provider implemented a Nexus wide log of fire extinguisher checks. In addition, the company who undertook the inspections of fire extinguished confirmed that the two extinguisher had not been inspected at the last inspection. The provider told us that they were in the process of standardising fire procedures across all Nexus sites.

We reviewed the fire safety training at all sites and found some staff throughout the sites that some staff had not completed fire safety training.

We reviewed the fire alarm drills and testing and found most had carried out the appropriate fire alarm tests and fire drills with the exception of: -

- **Aylesbury Medical Centre** – The staff had not carried out any fire drills or fire alarm testing. However, the staff explained that they could not test the alarms or hold a fire drill as the alarm was linked the rest of the building that the surgery was located in and that the building managers did not test the alarms.

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: Disability access audits <u>Manor Place Surgery</u> – September 2018 <u>Princess Street Group Practice</u> – September 2018 <u>Surrey Docks Health Centre</u> – September 2018 <u>Aylesbury Medical Centre</u> – October 2018 <u>Commercial Way</u> – October 2018 <u>Dun Cow Surgery</u> – October 2018 <u>Decima Street Surgery</u> – September 2018 <u>Artesian Health Centre</u> – August 2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken.	Y

Date of last assessment:

Manor Place Surgery – September 2018
Princess Street Group Practice – September 2018
Surrey Docks Health Centre – September 2018
Aylesbury Medical Centre – October 2018
Commercial Way – October 2018
Dun Cow Surgery – October 2018
Decima Street Surgery – October 2018
Artesian Health Centre – August 2018

Explanation of any answers and additional evidence:

Legionella risk assessments

Manor Place Surgery – September 2018
Princess Street Group Practice – September 2018
Surrey Docks Health Centre – September 2018
Aylesbury Medical Centre – October 2018
Commercial Way – October 2018
Dun Cow Surgery – October 2018
Decima Street Surgery – September 2018 – no temp monitoring
Artesian Health Centre – October 2018 – the practice did not have access to the assessment on the day of the inspection. A copy of the assessment was sent after the inspection.

All sites had been monitoring water temperatures weekly since at least September 2018. Most sites showed that water temperatures had been, on many occasions, within range where legionella bacteria could survive. The exceptions to this were: -

- **Commercial Way** - temperatures were not within range where legionella could survive.
- **Decima Street Surgery** staff were not monitoring temperatures.
- **Artesian Health Centre** - we were unable to get any information regarding temperature monitoring. We were told that temperature monitoring was undertaken by a local secondary care service.
- **Aylesbury Medical Centre** - Staff stated the water supply for this practice was linked to the wider building and they had raised issues of risks related to legionella with the council who had

not taken any action to address the concerns. The practice's legionella policy stated that any remedial action would be taken by the health and safety lead, infection control lead and the chief officer but this had not been done.

All sites – The provider submitted information after our inspection in response to the warning notices issued. Policies related to legionella and water tested were implemented across Nexus and there was a clear process in place to ensure that concerns around water temperatures were escalated appropriately.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met but not all staff had received infection control training within the last 12 months.

	Y/N/Partial
An infection risk assessment and policy were in place.	Y
Staff had received effective training on infection prevention and control.	N
Date of last infection prevention and control audit: Manor Place Surgery – July 2017 NHS England completed an infection control risk assessment and produced an action plan. The action plan was last reviewed 16/10/2018 Princes Street Group Practice – 28/8/18 Surrey Docks Health Centre – 7/11/18 Aylesbury Medical Centre – 9/1/2018 Commercial Way – 1/7/18 Duncow Surgery – 1/7/18 Decima Street Surgery & Artesian Health Centre – 15/1/18	
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence: All sites – Some staff had not completed infection control training and some had not completed their twelve months infection control update.	

Risks to patients

There were gaps in systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Partial
There was an effective induction system for temporary staff tailored to their role.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Partial
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems in place to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y
Explanation of any answers and additional evidence:	
<p>There were a number of staffing vacancies across the organisation including clinical and non-clinical staffing roles we found that this was managed at most sites using locum cover. However at :</p> <ul style="list-style-type: none"> • <u>Surrey Docks Health Centre</u> We were told that the site required two more receptionists and temporary staff were not able to cover scanning documents or the new registration of patients. We found this had resulted in 80 letters dating back to 15/10/2018 and patient test results going back to 24/10/2018 that were waiting to be scanned and work flowed to the doctor to check. The site was actively recruiting and had hired temps. However temporary staff were not able to cover scanning or new registrations. Clinical roles were mostly covered by locum staff. • <u>All sites –</u> the provider submitted information after our last inspection which stated that they had reviewed the issue of recruitment and retention and had developed a working group to review this. <p>We reviewed whether reception staff were aware of the signs of a patient presenting with sepsis and found at most of the sites the reception staff had a awareness of the signs of sepsis, with the exception of: -</p> <ul style="list-style-type: none"> • <u>Surrey Docks Health Centre</u> Reception and administrative staff at Surrey Docks had not all received training on Sepsis and some staff were not aware of the early warning signs of sepsis. 	

Information to deliver safe care and treatment

Staff did not consistently have the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	N
There was a system for processing information relating to new patients including the summarising of new patient notes.	Partial
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	N
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	N
There was a documented approach to the management of test results and this was managed in a timely manner.	N
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	N
<p>Explanation of any answers and additional evidence:</p> <p>All sites - There was a lack of centralised overview of clinical correspondence and tasks. We reviewed the global inbox for test results on the electronic patient record system web. We found that there were 1023 results dating back to 2 July 2018. We could see that a proportion of these had been viewed and filed but a significant number had not been viewed. Four hundred and forty-two of these results were marked as being abnormal.</p> <p>We reviewed approximately 30 results. Most of these results were flagged as abnormal and most of them had not been viewed or filed. Some results had been viewed and filed and still no action taken. Of the results we reviewed we identified five which indicated that appropriate action to ensure the health, safety and wellbeing of the patients concerned had not been taken.</p> <p>We reviewed the global overview for clinical workflow/tasks on EMIS web across eight of the Nexus sites. This review showed that there were 4187 outstanding clinical tasks dating back to 13 February 2017 which had yet to be actioned. We undertook a review of approximately 40 unactioned tasks. Four of these highlighted concerns related to the quality of clinical care being provided by the service</p> <p>We asked to look at the global inbox within the electronic system which received and stored clinical correspondence awaiting processing at the eight sites, but were told by several members of staff that there was no way to oversee this centrally and that it was up to individual clinicians to ensure that they were actioning incoming correspondence.</p>	

The practice took action following our initial inspection on 1 November 2018 to implement a system of centralised oversight and monitoring of clinical correspondence, results and tasks. In addition, the practice developed a protocol which outline timelines for reviewing and actioning correspondence, results and tasks within specific timescales. Breaches were to be raised with the clinician involved in the first instance and escalated to the clinical lead and board if necessary.

The provider submitted a report in response to the warning notices and informed us that as at 8 January 2019 the backlog of results, tasks and electronic correspondence had been cleared and that weekly searches and reporting by the Nexus wide data team would be implemented to check adherence to the new protocol.

All sites - Although there was a standardised process for the management of clinical correspondence by administrative staff; staff at all sites provided different answers as to how this operated. There was no review mechanism operating at any site to ensure that the documented process was safe.

The practice provided information in response after our inspections in response to the warning notice issued. The practice had revised the correspondence handling protocol for non-clinical staff and had initiated a programme of audit for correspondence arriving through an electronic document system on 27 December 2018. A re-audit was completed on 7 January 2019. The first audit showed that 82% of correspondence had been appropriately handled. The second audit showed that this had increased to 90%. The provider informed that this would be audited on a fortnightly basis until a standard of compliance with the protocol had achieved 95% or above.

Manor Place Surgery – We spoke with two staff responsible for monitoring two week wait referrals. The staff confirmed that they would call the hospital in the first instance to make the patient's appointment and, if they could not reach staff at the hospital, would contact the patient and ask them to wait three to four days for the hospital to contact them with an appointment and then contact the practice if they had not heard anything after this time. The practice logged whether or not the patient had received and attended the appointments. However, there was no system in place to ensure that the practice received notification of the result of two week wait referrals.

All sites - The provider submitted evidence in response to our warning notices which indicated that the two week wait referral system across all sites had been audited which found that not all sites were checking if notification of the result had been received at the practice. The practice standardised the process for two week wait referrals across the group and undertake weekly searches across Nexus every seven days to ensure that all two week waits were accounted for.

Surrey Docks Health Centre – there was a backlog of new registrations at Surrey Docks Health Centre. We were told that this was due to staff shortages.

Artesian Health Centre and Decima Street Surgery– we were told that nursing staff did not have oversight of abnormal cervical screening results and that the process for reviewing these letters and taking further action was devolved to an administrator who would send the patient a letter to notify them that they needed to attend to provide further samples. If the patient did not attend the practice told us that this would be picked up by the colposcopy department. We were provided with a protocol for handling abnormal results which stated that clinical staff were to follow up any abnormal results.

At the time of the inspection the Nurse Manager explained they had recognised the need for the nursing team to be responsible for the monitoring and follow up of abnormal results and was planning to introduce a new system throughout the sites.

Appropriate and safe use of medicines

The practice did not have adequate systems for the appropriate and safe use of medicines, including medicines optimisation

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) NHS Business Service Authority - NHSBSA)	0.61	0.60	0.94	Variation (positive)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/10/2017 to 30/09/2018) (NHSBSA)	6.6%	7.0%	8.7%	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	N
Staff had the appropriate authorisations in place to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process in place for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Partial
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y

Medicines management	Y/N/Partial
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures in place for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols in place for verifying patient identity.	n/a
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Partial
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Partial
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Partial
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Partial
Explanation of any answers and additional evidence:	
Medicines Reviews	
We saw instances at two sites where patients were not having timely medication reviews. For example:-	
<ul style="list-style-type: none"> • Manor Place Surgery – we saw that patients prescribed ACE inhibitors and asthma medicines were not all having regular medication reviews and appropriate tests. 	
<p>All sites - The practice provided evidence in response to the warning notices issued that their prescribing group had undertaken a search of patients prescribed ACE inhibitors and found 74 patients across all sites who had not had the required testing undertaken within the last 18 months. The practice intended to re run the search on 21 January 2019 to check if patient had these completed. If patients had still not had the relevant tests completed then this would be escalated to the local prescribing lead.</p>	
<p>The practice had also implemented systems to review patients overusing salbutamol (medicine used to treat asthma) and had developed an action plan to reduce the number of patients overusing this medicine. The practice said that the percentage of patients overusing salbutamol had reduced from 546 in October 2018 (31% had not been reviewed) to 363 in January 2019.</p>	
<p>The group wide prescribing policy was updated and a template in the patient record system for medication reviews was highlighted as best practice. The practice subsequently reviewed the number of sites using the template and found that there was inconsistency around the use of the template. The practice told us they would take further action to address this issue including the monthly auditing of medication reviews and further training for staff.</p>	

- **Surrey Docks Health Centre** - Upon reviewing 11 uncollected prescriptions we found three instances where patients were not having regular medication reviews in accordance with recommended guidance and one where the service could not confirm if a patient had received a medication review or if a review had been completed in secondary care. We were told on the day of this inspection that action would be taken to follow up these patients.

Changes to medicines

At all sites the lack of centralised oversight of incoming correspondence meant that there was a risk that changes to patient's medicines would not be made in a timely way. In addition at Manor Place surgery following a review of patient records we found the staff had failed to change patients medication when advised by secondary care.

Uncollected prescriptions

We found most of the sites had a system in place to ensure that any uncollected prescriptions were reviewed with the exception of :-

- **Manor Place Surgery** - There was no formal mechanism in place for reviewing uncollected prescriptions. We were told staff would review uncollected prescriptions once every three months but upon reviewing uncollected prescriptions we found some prescriptions dated July 2018.
- **Surrey Docks Health Centre** - We found that there was no effective system in place for reviewing uncollected prescriptions. We sampled some prescriptions that were over three months old and found 80 were dated from between May and July 2018.

All sites – The practice sent information after our inspection in response to the warning notices issued to the provider. This stated that the service was in the process of developing a standardised process across Nexus for reviewing uncollected prescriptions, with particular reference to ensuring identification of vulnerable patients and patients on high risk medicines, and that operation managers/team leaders would be required to undertake quarterly audits to ensure that any new policy adopted was being implemented.

Prescription storage and security

We reviewed how prescriptions were securely stored at each site and found:

- **Manor Place Surgery** - FP10 printer prescriptions were kept in clinical rooms. These rooms were locked when no staff were present however the rooms were accessible to contract cleaning staff. We also found that blank FP10 prescriptions used for handwritten prescriptions and blank handwritten prescriptions used for issuing controlled drugs were kept in a room which was locked and accessible to all staff. There was no system in place to log the serial numbers of these prescriptions. Staff who handled prescriptions were not aware that there were 28 pads of

FP10 handwritten prescriptions or how many blank controlled drug prescriptions were in the practice.

- **Surrey Docks Health Centre** - whilst prescriptions were stored securely there was no log for handwritten prescription pads. In addition, staff did not know how many pads there were on site.
- **Aylesbury Medical Centre** – whilst prescriptions were stored securely there was no log for handwritten prescription pads. In addition, staff did not know how many pads there were on site.
- **Dun Cow Surgery** - whilst prescriptions were stored securely there was no log for handwritten prescription pads. In addition, staff did not know how many pads there were on site.
- **All sites** - The provider supplied information of action taken to address this concern after our inspection in response to the warning notices issued which said that they had reviewed their policy around the security of prescriptions to ensure that proper protocols were in place at each of the sites. In addition, reconciliation of hand written prescriptions and blue prescriptions would be undertaken every 6 months by Operations Managers/Team Leaders.

We reviewed the emergency equipment and medicines at each site and found:-

- **Manor Place Surgery** - one of the oxygen cylinders was less than half full and the working status of the defibrillator was not being checked regularly.
- **Commercial Way** - we found defib pads which expired in April 2018
- **Princess Street Group Practice** - we found that soluble aspirin stored with the site's emergency medicines had expired March 2018.
- **Artesian Health Centre** – no documented checks of working status of a defibrillator.
- **All sites** - We were provided information after our inspection which stated that the oxygen cylinder had been replenished. The provider had also implemented an oxygen cylinder log for all cylinders in Nexus which contained the noted the service date of all cylinders. All cylinders needed to be checked on a monthly basis and after any emergency. The practice had introduced a new Nexus wide policy for checking emergency equipment and were checking the defibrillator at Manor Place Surgery on a weekly basis by the site's Healthcare Assistant.

Vaccine management

Although we were told that vaccine stock levels and expiry dates were regularly checked and monitored there was no formal recording of this at the following sites: -

Medicines management	Y/N/Partial
<ul style="list-style-type: none"> • <u>Princess Street Group Practice</u> • <u>Surrey Docks Health Centre</u> • <u>Artesian Health Centre</u> 	

Track record on safety and lessons learned and improvements made

The individual sites learned and made improvements when things went wrong but we saw little evidence of learning from significant events across Nexus and not all sites had systems in place to respond to non-medicines safety alerts.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months: <u>Manor Place Surgery</u> – 11 <u>Princess Street Group Practice</u> – 23 <u>Surrey Docks Health Centre</u> - 8 <u>Aylesbury Medical Centre, Dun Cow Surgery & Commercial Way</u> - 4 <u>Decima Street Surgery and Artesian Health Centre</u> - 19	
Number of events that required action: <u>Manor Place Surgery</u> - 11 <u>Princess Street Group Practice</u> – 21 <u>Surrey Docks Health Centre</u> - 8 <u>Aylesbury Medical Centre, Dun Cow Surgery & Commercial Way</u> - 3 <u>Decima Street Surgery and Artesian Health Centre</u> - 19	
Explanation of any answers and additional evidence:	
We saw evidence of significant events which had been raised at site level, acted upon and learning	

disseminated amongst staff. We were told that clinical leads at each site would feed back any significant events which would benefit from learning being shared across sites. However, staff were not clear on what sort of events would require escalation and staff could not give any examples of learning from events that had not occurred at their own site.

Though the provider had identified concerns regarding the management of test results and correspondence from secondary care; the lack of effective action or timely review of actions put in place to address this concern undermined confidence in the provider's ability to take effective action and learn from significant events which impacted the whole of the organisation.

Examples of significant events recorded and actions by the practice.

Event	Specific action taken
Manor Place Surgery - Blood left in fridge and not sent for analysis due IT system failure	The provider ensured that all staff were briefed about what to do when there was an IT failure. Provided staff with access to non-electronic blood forms.
Princess Street Group Practice – Patient prescribed incorrect medication	The pharmacists drafted a laminate sheet which was made available in all clinical rooms for this type of medicine with generic and brand names included.
Surrey Docks Health Centre - Defibrillator pads were found that had expired.	The member of non-clinical staff who was responsible for checking emergency equipment had left and no one had taken responsibility for checking. New pads were purchased and a long serving clinical staff member assumed responsibility for checking the emergency equipment.
Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way – Medication change not made following patient discharge from hospital as neither patient nor pharmacist informed of the change	A member of staff who reviews letters regarding changes to patient medicines is now required to inform the pharmacist that a change needs to be made to the patient's medicines.
Fridge accidentally switched off	The practice contacted the manufacturer and disposed of the vaccines in accordance with the advice received. The practice then took action to make it more difficult for the fridge to be turned off accidentally.
Decima Street Surgery and Artesian Health Centre – needlestick injury. The practice allowed the patient to leave without first getting them to provide a blood sample and the patient did not return.	The practice now encourages patients to have a blood test at the time of the needlestick injury before they leave the premises

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial

Staff understood how to deal with alerts.	Partial
Explanation of any answers and additional evidence:	
<p>The Nexus prescribing group managed medicines safety alerts centrally, ensuring that appropriate alerts were cascaded and acted upon. Individual sites were required to develop their own systems for responding to safety alerts not related to medicines. However, at two sites we found:-</p> <ul style="list-style-type: none">• <u>Surrey Docks Health Centre</u> – there was no system in place to monitor and take action in response to non-medicines related safety alerts.• <u>Decima Street Surgery and the Artesian Health Centre</u> We were told that a spreadsheet of non-medicines related alerts was kept for but no member of staff could show us this.	

Effective

Rating: Requires Improvement

We have rated safe as requires improvement this is because:

- Due to concerns related to the lack of oversight of clinical correspondence we could not be assured that patients were receiving consistently high quality and effective care.
- The provider was unable to demonstrate that staff had received an appraisal or completed the necessary training for their role.

Effective needs assessment, care and treatment

Patients' needs were not consistently assessed, and care and treatment delivered consistently in line with current legislation, standards and evidence-based guidance.

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	N
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N
Appropriate referral pathways were in place to make sure that patients' needs were addressed.	Partial
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
Explanation of any answers and additional evidence: All sites - The lack of centralised oversight of incoming correspondence meant that some patients did not have their ongoing needs assessed, regular reviews of their condition and appropriate referrals completed in a timely fashion or there was a risk that this would not happen. Manor Place Surgery – There was a lack of consistent periodic medication reviews for patients with asthma and those prescribed ACE inhibitors. All sites - The practice provided evidence in response to the warning notices issued which confirmed the Nexus wide prescribing group and local prescribing leads were working to see that all patients on ACE inhibitors received regular testing. The practice was also taking action to reduce the overuse of asthma medicine and had updated their prescribing policy in respect of best practice processes around medication reviews.	

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2017 to 30/09/2018) (NHSBSA)	0.41	0.39	0.81	No statistical variation

Older people

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- The lack of effective oversight of incoming clinical correspondence meant that there was potential that patients would not be followed up or followed up in a timely manner. In addition, review of patient records demonstrated the system for following up on frail older patients discharged from hospital was inconsistent, not prompt or effective.
- The service used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a holistic health assessment which included an assessment of their physical, mental and social needs by a healthcare assistant being closely supervised by a GP or a specialist elderly care nurse. There was a Nexus wide frailty team who met to discuss and share ideas for improving the care provided to patients with complex frailty needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age. These were provided by elderly care nurses working across Nexus.
- The practice worked with other services in the management of older patients with health needs and attended regular community multidisciplinary team meetings. For day to day enquiries staff at the practice could contact a local geriatrician for advice.
- Surrey Docks Health Centre** – staff supported patients residing in local residential home.

People with long-term conditions

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- We saw instances where patients with long-term conditions had a structured annual review to check their health and medicines needs were being met.

However, there were patients at **Manor Place Surgery** whose records demonstrated they had not received a medication review in line with current guidance and recommendations, This included patients with high blood pressure who were prescribed ACE inhibitors and patients with asthma.

All sites - The practice provided evidence in response to the warning notices issued which confirmed the NEXUS wide prescribing group and local prescribing leads were working to see that all patients on ACE inhibitors received regular testing. The practice was also taking action to reduce the overuse of asthma medicine and had updated their prescribing policy in respect of best practice processes around medication reviews.

- We saw instances where patients who had attended secondary care who had long-term conditions had not been followed up appropriately or in a timely manner.
- We saw examples of clinical staff working with other health and care professionals to deliver a coordinated package of care for those with the most complex health needs.
- All the sites ran health management clinics for patients with long term conditions where reviews of all aspects of a patient's long-term condition or multiple long-term condition reviews could be completed at the same time. Examples were: -
 - **Decima Street Surgery and Artesian Health Centre** staff ran complex diabetes clinics.
 - **Decima Street Surgery** - Had a self-management pod that enabled patients to check their blood pressure, weight and height.
 - **Aylesbury Medical Centre** – Staff at this site were specialised in dermatology. Patients with certain long-term skin conditions could be treated at this sight which reduced the need for referrals to secondary care.
 - **Aylesbury Medical Centre** – Offered minor surgery and steroidal joint injections. This helped to reduce the need for patients requiring this treatment to be referred to secondary care.
 - All sites undertook virtual clinics for patients with long term conditions including asthma, COPD and diabetes. The clinics had input from secondary care specialists to review and optimise the care for patients with complex or hard to manage long term conditions.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.

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Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	76.0%	74.2%	78.8%	No statistical variation
Exception rate (number of exceptions).	7.8% (304)	7.5%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) (QOF)	78.1%	75.9%	77.7%	No statistical variation
Exception rate (number of exceptions).	8.7% (338)	6.8%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) (QOF)	83.1%	81.2%	80.1%	No statistical variation
Exception rate (number of exceptions).	9.3% (361)	7.9%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	79.2%	75.9%	76.0%	No statistical variation
Exception rate (number of exceptions).	1.7% (53)	2.1%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.3%	90.6%	89.7%	No statistical variation
Exception rate (number of exceptions).	4.7% (64)	5.7%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QoF)	81.3%	80.8%	82.6%	No statistical variation
Exception rate (number of exceptions).	3.4% (278)	3.3%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QoF)	86.0%	89.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	3.9% (20)	6.2%	6.7%	N/A

Any additional evidence or comments

Families, children and young people Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- We saw instances when children failed to attend an appointment either at the surgery or in secondary care the staff would inform the health visiting team. However, the lack of oversight of results, tasks and clinical correspondence created a risk that timely follow up would not take place. Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. However, staff told us they had improved a Nexus wide recall system which had resulted in an increase in attendance. We were provided with unverified data for 2018/19 which indicated that uptake was above the World Health Organisation targets.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access services for sexual health and contraception.
- Manor Place Surgery and Princess Street Group Practice** – both sites were located near to higher education institutions and encouraged these populations to register. Princess Street had attended the fresher week of a local college to promote their services.
- Surrey Docks Health Centre and Decima Street Surgery** had on site access to health visitor teams.

- **Decima Street Surgery** health visitors ran a children's drop-in clinic alongside the site's immunisation clinic. Both sites hosted paediatric consultant led clinics.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	764	875	87.3%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	763	901	84.7%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2017 to 31/03/2018) (NHS England)	775	901	86.0%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	774	901	85.9%	Below 90% minimum (variation negative)

Any additional evidence or comments

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. However, staff told us they had improved a Nexus wide recall system which had resulted in an increase in attendance. We were provided with unverified data for 2018/19 which indicated that uptake was above the World Health Organisation targets.

The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib)	-	-	92.8%
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster)	-	-	91.3%
The percentage of children aged 2 who have received their immunisation for Haemophilus	-	-	92.0%

influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster)			
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR)	-	-	91.8%

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England)	64.3%	66.7%	72.1%	No statistical variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE)	63.3%	61.5%	70.3%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %) (PHE)	41.2%	41.4%	54.6%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE)	79.5%	75.8%	71.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE)	64.6%	51.0%	51.6%	No statistical variation

Any additional evidence or comments

The practice told us that they had improved the recall system for cervical screening. PHE data for 2017/18 showed that the percentage of eligible women in 2017/18 was 62.5%

Artesian Health Centre and Decima Street Surgery– we were told that nursing staff did not have oversight of abnormal cervical screening results and that the process for reviewing these letters and taking further action was devolved to an administrator who would send the patient a letter to notify them that they need to attend to provide samples. If the patient does not attend the practice told us that this would be picked up by the colposcopy department.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- We saw instances where the care of vulnerable patients was handled well and co-ordinated with other agencies where necessary.
- The sites held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- However, at **Manor Place Surgery** we found instances of poor care for vulnerable patients including delays in updating medicines for patients as directed by secondary care services, lack of timely provision of information requested by other services and lack of appropriate and timely follow up of patients who had been discharged from secondary care.
- Four of the sites hosted a weekly substance misuse clinic.
- **Manor Place Surgery** staff supported patients from local substance misuse and homeless hostels. The practices demonstrated that they had a system to identify people who misused substances.
- **Surrey Docks Health Centre** staff supported people living in a local residential home.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because of the concerns regarding lack of oversight of clinical correspondence, which meant the provider had assured that patients were receiving consistently high quality and effective care.

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. However, the concerns around the management and oversight of incoming results and correspondence could have resulted in delays to care and treatment for these patients.

- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- Some staff had received specific dementia training.
- **Surrey Docks Health Centre** worked with a local community organisation which aimed to engage people in the community who felt isolated and would benefit from participating in activities. The surgery also hosted a local counsellor.
- **Aylesbury Medical Centre** participated in community multidisciplinary team meetings for patients with severe mental illness.
- **Decima Street Surgery** - was piloting with a local specialist secondary care service which was run by a specialist mental health nurse to provide holistic health assessments for patients with serious mental illness.
- **Princess Street Group Practice** held joint clinics with Community Psychiatrists in local hostels
- **Manor Place Surgery** this site hosted a counsellor weekly.

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	96.3%	91.4%	89.5%	No statistical variation
Exception rate (number of exceptions).	10.2% (96)	7.3%	12.7%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	93.0%	91.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	10.3% (97)	7.3%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	84.3%	81.2%	83.0%	No statistical variation
Exception rate (number of exceptions).	6.4% (16)	5.1%	6.6%	N/A

Any additional evidence or comments

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	550.05	-	537.5
Overall QOF exception reporting (all domains)	4.9%	4.4%	5.8%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

- **Manor Place Surgery** – Staff carried out an audit reviewed the level of compliance with guidelines for treatment of urinary tract infections. In the first cycle only 10% of patients on long-term antibiotics had received a review and only 53% of patients had the correct dose and frequency prescribed against a standard of 90%. In the second cycle compliance with these standards had increased to 88% and 83% respectively.
- **Princess Street Group Practice** – Staff carried out an audit aimed to improve the recording of the identity of adults who attend with children under 16. In the first cycle July 2017 showed that staff had recorded 60%. The findings were shared and staff reminded to record the identity of adults who attended with children. In the second cycle in October 2017 78% of children had the identity of the accompanying adult recorded.
- **Surrey Docks Health Centre** – The audit looked at the level of compliance with guidelines for treatment of urinary tract infections. In the first cycle the site had met the compliance standard in 90% of cases in most areas assessed with the exception of the dose, duration and frequency. The second cycle showed that the level of compliance had reduced due to the increase in locum staff who were not prescribing in accordance with local guidelines.
- **Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way** – The sites undertook an audit of patients on medication for attention deficit hyperactivity disorder (ADHD) to review whether they had their heart rate, blood pressure, weight and height in accordance with NIC guidelines. The audit showed that 77% of patients had this information recorded. In response to the findings these medicines were prescribed on a single issue basis and updated shared care guidelines were put in place.

A second cycle was completed in 2018 across Nexus which showed an improvement at Dun Cow

and Commercial way. In addition, it highlighted an inconsistency across Nexus to the recording of this information. In response a template within the clinical record system which prompted clinicians to fill in this information was implemented.

- **Decima Street Surgery and Artesian Health Centre** –The virtual clinic aimed to bring the blood pressure of patients with complex or hard to manage hypertension below 160/100. An audit at the reviewed suitable patients and devised a specific treatment plan. After implementation seven patients were re-reviewed following the interventions suggested in the treatment plan. All seven of the patients reviewed had reduced their blood pressure below 160/100.

Any additional evidence or comments

The provider had a centralised target group which had oversight of QOF targets and other targets set by Public Health England, the CCG and the federation. The target group provided a breakdown of performance across all of sites grouped under their historical partnerships. We found that performance was consistently in line with local and national averages across all sites and none of the sites appeared to be an outlier in terms of performance against clinical targets.

Effective staffing

The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles and that all staff had been appraised.

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	N
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff. This included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Partial
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	n/a
Explanation of any answers and additional evidence:	

All sites – A review of staff files and training matrices showed that there were either gaps in essential training or that training had expired. Training included; basic Life Support, Information governance, Infection Control, Mental Capacity Act and safeguarding.

The practice provided information of action taken after our inspection including an audit of staff training. This audit was only in relation to the completion of essential training by locum staff as this was highlighted as a concern in the warning notice issued to the provider. The provider reviewed eight locum files and found that infection control and fire safety training had not been completed by all locum staff. The provider would raise this with managers at each site who would ensure that all staff had completed this training.

Some staff whose files we reviewed had an annual appraisal. The sites where they had not completed an annual review were:-

- **Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way** - There were 12 staff working across these sites who had not received an appraisal since the organisation merged in 2016. We were told that these staff were due to have these appraisals during November and December 2018.
- **Decima Street Surgery and Artesian Health Centre** – Staff confirmed that not all staff had received an appraisal within the last 12 months.
- There were staff working across all sites whose files we reviewed who had not received an appraisal within the last 12 months with the exception of **Manor Place Surgery** where all staff whose files we reviewed had received an appraisal. For example:

Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way - There were 12 staff working across these sites who had not received an appraisal since the organisation merged in 2016. We were told that these staff were due to have these appraisals during November and December 2018.

Decima Street Surgery and Artesian Health Centre – Staff confirmed that not all staff had received an appraisal within the last 12 months.

Coordinating care and treatment

Staff did not consistently work together and with other organisations to deliver effective care and treatment.

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes
We saw records that showed that all appropriate staff, including those in different teams	Partial

and organisations, were involved in assessing, planning and delivering care and treatment.	
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Partial
Patients received consistent, coordinated, person-centred care when they moved between services.	Partial
Explanation of any answers and additional evidence:	
<p>All sites - Although we reviewed clinical records at each of the site which demonstrated instances of effective working with other agencies; the lack of effective oversight of incoming clinical correspondence and test results meant that there was potential for effective joint working to be hindered through lack of available information or delays in communication.</p> <p>Manor Place Surgery - We saw instances where requests for information and action were made by external agencies for vulnerable patients. Responses or actions were either delayed or not completed.</p>	

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y
Explanation of any answers and additional evidence:	

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QoF)	92.7%	94.5%	95.1%	No statistical variation

Exception rate (number of exceptions).	0.4% (58)	0.5%	0.8%	N/A
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Any additional evidence or comments

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Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Explanation of any answers and additional evidence:	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence:	

CQC comments cards	
<p>Total comments cards received</p> <ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – no comment cards received due to error in CQC processes • <u>Princess Street Group Practice</u> – 21 • <u>Surrey Docks Health Centre</u> – no comment cards received due to error in CQC processes • <u>Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way</u> – 6 • <u>Decima Street Surgery and Artesian Health Centre</u> – 3 	
<p>Number of CQC comments received which were positive about the service</p> <ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – no comment cards received due to error in CQC processes • <u>Princess Street Group Practice</u> – 17 • <u>Surrey Docks Health Centre</u> – comment cards not issued • <u>Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way</u> – 6 • <u>Decima Street Surgery and Artesian Health Centre</u> – 0 	
<p>Number of comments cards received which were mixed about the service</p> <ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – no comment cards received due to error in CQC processes • <u>Princess Street Group Practice</u> – 0 • <u>Surrey Docks Health Centre</u> – comment cards not issued 	

<ul style="list-style-type: none"> • <u>Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way</u> – 0 • <u>Decima Street Surgery and Artesian Health Centre</u> – 3 comments were positive about the care provided but concerns were expressed about access to appointments. 	
<p>Number of CQC comments received which were negative about the service</p> <ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – no comment cards received due to error in CQC processes • <u>Princess Street Group Practice</u> – 4 reception staff and appointment access. • <u>Surrey Docks Health Centre</u> – comment cards not issued • <u>Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way</u> – 0 • <u>Decima Street Surgery and Artesian Health Centre</u> – 0 	

Source	Feedback
Interviews with patients	Most of the 12 patients said that staff were caring and compassionate. Only patient at <u>Commercial Way</u> said that this depended on which staff member you spoke with.
NHS choices	Two of the 14 comments from the last 12 months referred to clinical and non-clinical staff being uncaring. The rest of the comments either did not mention this or stated that staff treated them with kindness dignity and respect.
Comment cards	<p>The majority of the comment cards stated that staff both clinical and non-clinical were kind, caring and compassionate.</p> <p>Two of the comment cards from Princess Street Group Practice made negative comments about reception staff.</p>

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
72934	430	97	22.6%	0.13%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a	86.0%	85.9%	89.0%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)				
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	82.3%	83.3%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	98.0%	94.8%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	75.4%	79.0%	83.8%	No statistical variation

Any additional evidence or comments

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	N

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence:	

Source	Feedback
Interviews with	One of the patients spoken to at Commercial Way felt that they were not involved

patients.	with decisions about their care and treatment. The other 11 patients felt as involved as they wanted to be.
Comment cards	No reference made in any comments to involvement with care and treatment

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)	88.8%	91.1%	93.5%	No statistical variation

Any additional evidence or comments

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	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	N
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence:	

Carers	Narrative
Percentage and number of carers identified	1413 carers across Nexus – 1.9%
How the practice supports carers	<ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – the staff said that there was nothing specific in place. • <u>Surrey Docks Health Centre</u> – The staff said there was no specific support. • <u>Princess Street Group Practice</u> –The site identified carers and coded them on the computer system. This enabled staff to direct them to local support services.

	<ul style="list-style-type: none"> • <u>Aylesbury Medical Centre, Dun Cow Surgery, Commercial Way</u> – The site identified carers and coded them on the computer system. This enabled staff to direct them to local support service and refer to the in practice primary care navigator. • <u>Decima Street Surgery and Artesian Health Centre</u> –The site identified carers and coded them on the computer system. This enabled staff to direct them to local support services.
How the practice supports recently bereaved patients	<ul style="list-style-type: none"> • <u>Princess Street Group Practice</u> –The site sent either a letter or card to the relatives of bereaved patients. • <u>Manor Place Surgery</u>– The site sent either a letter or card to the relatives of bereaved patients. • <u>Surrey Docks Health Centre</u>– The staff reported at present there did not have a system in place. However, recently they had contacted local bereavement service. The site did not have information about bereavement services in the reception area. • <u>Aylesbury Medical Centre, Dun Cow Surgery & Commercial Way Surgery</u> -Staff gave examples of how they had supported patients. This included, enabling relatives to carry out the burial within their religious beliefs. Staff confirmed there was no set policy or standardised approach. • <u>Decima Street Surgery and Artesian Health Centre</u> – no set system in place. We were told that GPs would contact patients if they were aware of bereavement and if patients proactively contacted the service then they would be offered an appointment with their preferred GP.

Privacy and dignity

The practice respected patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Partial
Explanation of any answers and additional evidence:	
<u>Princess Street Group Practice</u> - During the provider level assessment we found sacks of Lloyd George notes behind a reception desk in a patient's upstairs waiting room, which was unoccupied by staff. We were told that the notes had been placed in reception as they were awaiting collection but that	

this was not normal practice.

We raised this with the team who moved the notes to the back office which was not accessible to patients.

Responsive

Rating: Requires Improvement

The practice was rated as inadequate for providing a responsive service because:-

- Patient feedback from the national GP patient survey indicated patients could not always access care and treatment in a timely way. Although, the practice was taking steps to improve access; the staff had not implemented any actions. In addition, the practice had not undertaken their internal feedback exercise to see if access had improved.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs but problems with governance hindered the practice's ability to consistently meet patient needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Partial
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Partial
Explanation of any answers and additional evidence: - All sites - A lack of effective centralised oversight of test results, tasks and clinical correspondence meant that there had been instances where staff had not seen or taken action in response to relevant information. We saw specific instances where care for vulnerable patients and those with long term conditions had not been well co-ordinated. For example, we saw delays to care and treatment and lack of co-ordination or information sharing with care and support agencies.	

Practice Opening Times	
Opening times:	
Manor Place Surgery	
Monday	8am to 7.30pm
Tuesday	8am to 7.30pm
Wednesday	8am to 7.30pm

Thursday	8am to 6.30pm
Friday	8am to 6.30pm
<u>Surrey Docks Health Centre</u>	
Monday	8am to 7.30pm
Tuesday	7am to 8pm
Wednesday	8am to 7.30pm
Thursday	7am to 8pm
Friday	8am to 6,30pm
<u>Princess Street Group Practice</u>	
Monday	8am to 6.30pm
Tuesday	7am to 6.30pm
Wednesday	8am to 7.30pm
Thursday	7am to 7.30pm
Friday	8am– 6.30pm
<u>Aylesbury Medical Centre</u>	
Monday	7am to 6.30pm
Tuesday	7am to 8pm
Wednesday	7am to 6.30pm
Thursday	7am to 6.30pm
Friday	7am to 6.30pm
<u>Dun Cow Surgery</u>	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
<u>Commercial Way</u>	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm

Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
<u>Decima Street Surgery</u>	
Monday	8am to 6.30pm
Tuesday	8am to 6.30pm
Wednesday	8am to 6.30pm
Thursday	8am to 6.30pm
Friday	8am to 6.30pm
<u>Artesian Health Centre</u>	
Monday	8.45am to 6.30pm
Tuesday	8.45am to 8pm
Wednesday	8.45am to 8pm
Thursday	8.45am to 6.30pm
Friday	8.45am to 6.30pm

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
72934	430	97	22.6%	0.13%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	89.7%	92.8%	94.8%	No statistical variation

Any additional evidence or comments

Older people

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns

related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- Older patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.

People with long-term conditions Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- Patients with multiple conditions had their needs reviewed in one appointment at health management clinics held at various sites.
- The practice liaised regularly when necessary with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people Improvement

Population group rating: Requires

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- We found there were systems 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 accident and emergency (A&E) attendances.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- All sites, with the exception of Decima Street, Dun Cow Surgery and Commercial Way provided extended access hours. For example, patients at **Surrey Docks Health Centre** could attend a commuter clinic between the hours of 7am and 8am. Patients who would usually attend Decima Street and Dun Cow could be seen at The Aylesbury Medical Centre during their extended access hours and patients of Decima Street Surgery could be seen at The Artesian Health Centre during their extended access hours.
- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were also available to all patients at an extended access service operated by the local GP federation which provided access for patients between 8 am and 8 pm seven days a week.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- The practice would register homeless people using the practice's address.
- The practice would accommodate the needs of patients with a learning disability to ensure ease of access and that their circumstances were accommodated.
- Most sites including had a Primary Care Navigator who was a non-clinical member of staff trained to direct patients to social support and health education services within the community. This role was well developed at sites including **Princess Street Group Practice** but was in the initial phases of development at other sites like **Decima Street Surgery**.
- We were told that **Decima Street Surgery** worked with a local church which owned the premises. Staff at the surgery could refer patients to the church which provided food parcels for those in need.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

- The overall rating for this practice was inadequate due to concerns in providing safe and well-led services. However, the population groups were rated as requires improvement because concerns related to access to care and treatment and the impact of delays stemming from the lack of oversight of test results and clinical correspondence and tasks impacted on this population group.

Findings

- Priority appointments were allocated when necessary to those experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice was aware of support services within the area and signposted their patients to these accordingly.

Timely access to the service

Some patients were not able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Partial
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y
Explanation of any answers and additional evidence:	
Most patient with urgent needs had their care prioritised with the exception of patients at Manor Place Surgery , where we saw examples of vulnerable patients whose care was not appropriately prioritised.	
All sites had access to telephone interpretation or face to face interpreters which could be booked in advance. Staff who were multilingual at the sites could also be called upon to offer assistance with translation.	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient	77.4%	73.0%	70.3%	N/A

Indicator	Practice	CCG average	England average	England comparison
survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2018 to 31/03/2018)				
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	49.6%	62.0%	68.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	48.9%	61.3%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	55.4%	65.7%	74.4%	Variation (negative)

Any additional evidence or comments

All sites - Although the service had not undertaken any internal patient survey in response to poor patient feedback they were in the process of implementing improvements which it was hoped would address issues patients had around access. For example, we were told that the service was planning to implement a new e-consultation service and a new IT system which would enable facilitate digital triage using an algorithm and enable patients and staff to process more requests online.

Surrey Docks Health Centre – We were told by staff at this site that there were issues with the telephone lines. We were told that if more than four people called the surgery at once some people could be cut off. We were told that this was a priority issue for Nexus and that a company had been employed to address this issue. We were told that there were not enough staff answering the phones at present and that there were plans to recruit additional staff as the site was two receptionists short. We were told that this would be actioned by December 2018 and the upgrade to the telephone system would be rolled out across the organisation although Surrey Docks would be prioritised.

Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way- A GP at this site had completed an audit around access. The audit revealed that 40 sessions per month of pre-booked face to face appointment were wasted as a result of non-attendance and that demand for same day appointments was increasing but a number of the patients attending these appointments did not need to be seen by a GP. As a result of the audit the practice had stopped running a same day walk in service and introduced telephone triage. There was evidence that this site was continually reviewing a refining their use of triage and appointments.

Source	Feedback
Comment cards	Of the negative comments received all referred to issues with appointment availability. The other comment cards that were positive did not refer to any concerns about access.

NHS choices	There were 14 comments from the last 12 months. Five of the six negative comments related to access.
Patient interviews	Two of the 12 patients spoken to expressed concerns around appointment access stating that it was difficult to get through on the phone.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care/ Complaints were not used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	
<ul style="list-style-type: none"> • <u>Manor Place Surgery</u>– 9 • <u>Princess Street Group Practice</u> – 10 • <u>Surrey Docks Health Centre</u> - 5 • <u>Aylesbury Medical Centre, Dun Cow Surgery Commercial Way</u>– 6 • <u>Decima Street Surgery, Artesian Health Centre</u> - 23 	
Number of complaints we examined	
<ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – 3 • <u>Princess Street Group Practice</u> – 3 • <u>Surrey Docks Health Centre</u> - 2 • <u>Aylesbury Medical Centre, Dun Cow Surgery Commercial Way</u> - 3 1 didn't have a response to follow up and one did not include contact information for PHSO • <u>Decima Street Surgery, Artesian Health Centre</u> - 3 	
Number of complaints we examined that were satisfactorily handled in a timely way	
<ul style="list-style-type: none"> • <u>Manor Place Surgery</u> – 2 • <u>Princess Street Group Practice</u> – 3 • <u>Surrey Docks Health Centre</u> - 2 • <u>Aylesbury Medical Centre, Dun Cow Surgery Commercial Way</u> – 2 • <u>Decima Street Surgery, Artesian Health Centre</u> - 3 	

Information about how to complain was readily available.

Y

There was evidence that complaints were used to drive continuous improvement.

Y

Explanation of any answers and additional evidence:

We reviewed the sites response to complaints and found most had responded promptly and appropriately with the exception of:-

- **Manor Place Surgery** – One complaint from January 2018 did not have any documented response.
- **Surrey Docks Health Centre** – responses did not include information about who patients could contact if they were unhappy with the practice's response.

Examples of learning from complaints.

Complaint	Specific action taken
<u>Manor Place Surgery</u> – patients waiting too long when they attend for appointments	The provider implemented when a patient is left waiting over 30 minutes in reception a clinical member of staff will explain the reason for this to the patient and provide an apology.
<u>Princess Street Group Practice</u> – Patient not appropriate checked in	Reception staff reminded to ensure that clinical staff are aware when patients have arrived for their appointment.
<u>Surrey Docks Health Centre</u> – management of prescriptions	The provider retrained staff on the prescription process and clarified information for patients on the turnaround time for prescriptions.
<u>Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way</u> - Complaint around specific clinical technique of a member of the nursing staff	Staff member sent on update course.
<u>Decima Street Surgery and Artesian Health Centre</u> – Patient not given correct instruction for provision and labelling of sample	The process for requesting samples was reiterated to clinical and administrative staff.

Well-led

Rating: Inadequate

The practice was rated inadequate for well-led services because: -

- There was a lack of effective centralised oversight and governance in respect of key areas of the organisation including the management of test results and other clinical correspondence. When they had identified the risk in December 2017 and July 2018 they had failed to effectively respond. The provider took action following our provider level inspection to put systems in place to address this concern.
- Leaders could not show that they had the capacity and skills to deliver safe and effective care as they did not have adequate oversight of risks within the organisation and lines of responsibility were not always clear.
- While the practice had a clear vision, and were in the process of developing a strategy to put this in place; transitional arrangements were not sufficient to ensure that high quality care was being consistently provided across all sites.
- The practice did not have clear and effective processes for managing risks, issues and performance. For example, in relation to risks associated with legionella, fire safety risks and medical emergencies.
- The provider had tried to institute a Nexus wide patient participation group across all sites but this was not operating effectively.

Leadership capacity and capability

There was compassionate, inclusive leadership at all level who were aware of most of the challenges the service faced and had acted to address some of the challenges. However, there was a lack of timely and effective leadership to address issues around clinical oversight and risk.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Partial
They had identified the actions necessary to address these challenges.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme in place, including a succession plan.	Y
Explanation of any answers and additional evidence:	
We saw evidence that the leadership team understood and were focused on the challenges to delivering care. This was evident from information in the practice's original business case, discussion at meetings both at Board level and locally and the service's risk register.	
The practice's executive board was diverse and inclusive being comprised of staff from a mix of ethnic and religious backgrounds, gender and age.	
The provider had a fully staffed Executive Board and Senior Management team. The provider felt that	

this stability within the management team equipped them to deal with the challenges they faced. . However, there were certain challenges associated with the merger which the practice had identified but had failed to take adequate or timely action to mitigate these; particularly in respect of clinical governance arrangements for the management of clinical correspondence, results and tasks.

Although it was evidence that the leadership were aware of challenges, they had failed to fully appreciate the severity of certain risks particularly those associated with the oversight of clinical correspondence and the support needed to improve the quality of care being provided at particular sites within the organisation.

From reviewing and taking action in response to the concerns raised in the warning notices issued, the provider had submitted a response which had identified the need to strengthen risk management systems and processes in the organisation including the appointment of additional risk management leads; a clinical risk lead.

There was clinical leadership for areas of chronic disease management at all sites across the group.

Staff at site level said that decision making took longer since the merger as it could be difficult to achieve consensus in some areas amongst leadership within practice which had contributed to the delay in integrating services and standardising processes. The practice had also had other challenges with the integration which we were told was outside of the organisations control; for instance, the IT system.

Vision and strategy

The practice vision and strategy aimed to provide high quality sustainable care. However, deficiencies in governance and oversight undermined the practice's ability to achieve their vision

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Partial
There was a realistic strategy in place to achieve their priorities.	Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y
Explanation of any answers and additional evidence:	
The practice had clear plans in place to move the partnership forward and develop the services offered by Nexus. The practice had successfully centralised aspects of finance, prescribing and had quality groups which reviewed performance against local and national targets across the group. There was evidence of work being undertaken regarding recruitment and retention and the development of training opportunities and a career path for staff.	

The merger aimed to bring together like minded practices to ensure that the quality of care provided at the historical practice could be sustained in the future by achieving economies of scale and targeting resources in line with local and national health priorities.

However, there was a lack of understanding or oversight of key areas of risk and a lack of prioritisation in these areas; particularly related to clinical governance and oversight which compromised the quality of care provided by the organisation.

Culture

The practice had a culture which centred on the provision of high quality sustainable care but the lack of effective oversight and governance limited the services ability to achieve this aim

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Partial
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence:	
We saw instances where the practice had acted in compliance with the duty of candour but the service had no duty of candour policy in place.	

Examples of feedback from staff or other evidence about working at the practice

Source	Feedback
Staff interviewed at each site	Staff spoken to at each site told us that they were happy working at the practice, felt able to raise concerns with management.
Evidence of away days	We saw that the practice held regular away days with all staff working at the service. Staff were involved in developments within the service and were able to voice concerns and suggestions related to proposed developments of the service.
The practice visions and values	Staff were involved in the development of the practice vision and values.
Employee of the month	One staff member working at Decima Street Surgery had suggested that the employee of the month scheme which operated at this site should be rolled out across the rest of Nexus Health Group. This has been implemented.

Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems in place which were regularly reviewed.	Partial
Staff were clear about their roles and responsibilities.	Partial
There were appropriate governance arrangements with third parties.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>The provider was in transition and in the process of standardising areas of governance across the group. We saw that a number of key policies had been developed shortly before our inspection, for example the group had drafted a new clinical governance policy in October 2018.</p> <p>However, in addition to concerns around centralised oversight of results and tasks, we found that there was often a lack of clarity by staff around which policies and processes were to be used at the sites. For example:-</p> <ul style="list-style-type: none"> • Although there was a standardised process for the management of clinical correspondence by administrative staff; staff at all sites provided different answers as to how this operated. There was no review mechanism operating at any site to ensure that the documented process was safe. • Although there was a centralised prescribing group that effectively monitored prescribing across. Nexus, governance around medicines management at site level was lacking at some sites with systems not operating effectively to ensure that patients had regular medication reviews, that prescriptions were stored securely and uncollected prescriptions reviewed periodically. <p>The provider has submitted evidence since our inspection with details of actions taken to address these concerns.</p> <p>Lines of responsibility around recruitment, training and HR were not always clear with some functions being centralised and others remaining the responsibility of each site. This led to oversight in these areas or inconsistency around the processes that needed to be followed; for instance, in respect of immunisations for staff who required this, DBS checks, the completion of mandatory training and appraisals.</p> <p>It was evident that there were some areas where there was a lack of clear responsibility or processes at certain sites particularly around the review of uncollected prescriptions or the management of non-medicines related safety alerts which were not monitored centrally.</p>	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were processes in place to manage performance.	N
There was a systematic programme of clinical and internal audit.	Partial
There were effective arrangements for identifying, managing and mitigating risks.	N
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Partial
Explanation of any answers and additional evidence:	
<p>There was a comprehensive and detailed risk log in place which covered areas of business operations including clinical, operational premises, partnership issues and finance. However, there were still some key areas of risk that had not been identified or actioned or areas of risk that were identified but not appropriately prioritised or reviewed. For example,</p> <ul style="list-style-type: none"> • The practice had raised a concern about tests results not being actioned following a review of unfiled results in the practice patient record system in December 2017. The audit did not indicate any harm to patients had occurred. The practice took action to address this and re reviewed the issue in July 2018 at which point there were concerns regarding the timely reviewing of results. Standards were put in place for actioning results following an executive board meeting in August 2018. However, no review of this system was scheduled to take place until December 2018. • The provider had identified concerns about the management at Manor Place Surgery. The provider had done a review of the service provided and drafted an action plan to support the service including the provision of additional clinical support. The review undertaken did not identify concerns around the management of patients and medication reviews and some staff spoken to said that there had been little in the way of additional support provided. We were provided with information after our inspection in response to warning notices issued that confirmed additional support had not commenced when we started our inspection of the service. However, the service had seconded two GP partners to the site to help provide weekly support and additional managerial support was also being provided. • Risks related to legionella were identified but not addressed at most of the eight sites. • We found a small number of out of date items of emergency medicines and emergency equipment that was expired or not being checked. • Non- clinical staff were not consistently following the drafted policy for the management incoming clinical correspondence. It was unclear at which if any sites the policy was operating as stated and there was no review mechanism or audit in place to ensure that the policy was operating safely. <p>The provider put in systems after our inspection to ensure that there was centralised oversight of tasks, results and incoming correspondence and to ensure that this was acted upon in a timely fashion.</p>	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	N
Our inspection indicated that information was accurate, valid, reliable and timely.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence:	
<p>The lack of timely action in respect of the concerns that the practice themselves identified in November 2017 and again in July 2018 related to the oversight of incoming clinical results and correspondence demonstrated a failure to use information to hold staff to account and mitigate risk. The delay in the processing of this information meant that there was a significant risk that key information needed to ensure safe and effective patient care was not reviewed and acted upon in a timely manner.</p>	

Engagement with patients, the public, staff and external partners

Prior to the merger the practice had involved the public, staff and external partners when making decisions about the service provided. However, following the merger the patient participation group was not fully operational.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Partial
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Partial
Explanation of any answers and additional evidence:	
<p>The practice had undertaken consultation exercises with patients prior to the merger. However, some patients we spoke with during the inspection were unclear about aspects of the merger and some expressed anxiety about its implications for patient care.</p> <p>The service had created a cross Nexus Patient Participation Group (PPG) and we saw minutes from meetings that had been held throughout the year. The minutes indicated that there was more attendance from patients from some sites and some sites which were not represented. The practice acknowledged that this was a challenge and had plans in place to improve the ability for patients to engage with the practice.</p> <p>The most recent GP national patient survey showed that some scores were below local and national averages. The practice had not undertaken any internal patient survey on the basis of this feedback</p>	

although they told us that they intended to do so. The practice was able to outline action they intended to take which they hoped would improve access including the introduction of an e-consultation service and a new IT system which would enable facilitate digital triage using an algorithm and enable patients and staff to process more requests online.

The practice acknowledged that they did not have particularly strong engagement with external stakeholders which meant that the organisation was unclear on the direction of travel in respect of certain areas of the local healthcare economy. However, there were plans in place for the incoming Chief Operating officer to strengthen external engagement.

Feedback from Patient Participation Group.

Feedback

Most of the patients that we spoke with at all sites said that engagement with patients needed to improve and the way that the PPG functioned. Some patient expressed confusion about the merger, a lack in contact regarding the PPG since the merger and a lack of terms of reference for the new Nexus PPG.

Princess Street Group Practice - PPG members from this site said that they did not feel involved in changes that had been made to the structure of the PPG group and that they were not provided with minutes of meetings that were held at other sites which they were not able to attend.

Aylesbury Medical Centre, Dun Cow Surgery and Commercial Way – PPG representatives from these sites said that the practice was open and honest and involved them in decision making and responded to suggestions. However, they said that since the merger they were unclear on the terms of reference for the Nexus wide PPG.

Decima Street Surgery and Artesian Health Centre – The PPG member we spoke with at this site said that the practice was open and honest, would discuss complaint themes and provided examples of improvement suggestions that were acted upon. The PPG member said that they had not been to a meeting since the PPG merged into a single Nexus wide PPG.

Any additional evidence

Continuous improvement and innovation

There was some evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Partial
Learning was shared effectively and used to make improvements.	Partial

Explanation of any answers and additional evidence:

Not all staff at the practice had completed essential training in accordance with guidance and legislation.

The practice provided training for both trainee GPs and nurses and the supervision of pharmacists. Staff spoken to who received training spoke positively of the support and mentorship provided. The practice had successfully moved a number of staff from non-clinical to clinical roles and had upskilled those in clinical roles. The merger itself aimed to provide more opportunity and improve career prospects for GP by allowing them to specialise and train in clinical areas of interest.

The service provided multidisciplinary health management clinics for patients with long term conditions. This enabled patients to be seen in a single appointment and have all necessary checks and assessments undertaken in a single appointment. This was offered at most of the sites.

Decima Street Surgery and Artesian Health Centre – Staff at this site undertook quarterly reviews to assess the care provided to patients who had recently died. The end of life care for each patient was reviewed in detail and there were clear learning and action points from each case regarding what could have been improved e.g. improving links and communication with other services or highlighting instances where the co-ordination of care had worked well.

Manor Place Surgery – The practice had previously worked with the Refugee Assessment and Guidance Unit (RAGU) to support refugees with clinical experience obtain employment at the practice.

Examples of continuous learning and improvement

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

The percentage of practices which show variation depends on the distribution of the data for each indicator, but is typically around 10-15% of practices. The practices which are not showing significant statistical variation are labelled as no statistical variation to other practices.

N.B. Not all indicators in the evidence table are part of the GP insight set and those that aren't will not have a variation band.

The following language is used for showing variation:

	Variation Band	Z-score threshold
1	Significant variation (positive)	$Z \leq -3$
2	Variation (positive)	$-3 < Z \leq -2$
3	No statistical variation	$-2 < Z < 2$
4	Variation (negative)	$2 \leq Z < 3$
5	Significant variation (negative)	$Z \geq 3$
6	No data	Null

Note: for the following indicators the variation bands are different:

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average.

It is important to note that z-scores are not a judgement in themselves, but will prompt further enquiry, as part of our ongoing monitoring of GP practices.

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.