

# Care Quality Commission

## Inspection Evidence Table

### Nexus Health Group (1-542937588)

Inspection date: 13 February 2019

**Overall rating: Unrated**

## Safe

**Rating: unrated**

### Safety systems and processes

**The provider had strengthened systems, practices and processes designed to keep people safe and safeguarded from abuse.**

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
<p>Explanation of any answers and additional evidence:</p> <p>During our previous inspection of Manor Place Surgery, we found that 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.</p> <p>At this inspection the provider supplied an updated policy for the requirements for locum staff at the service which stated that when staff booked locums they needed to ensure that they had safeguarding and basic life support training and that if the provider was booking locums via an agency they needed to download and file training documentation in advance.</p> <p>The practice had completed a review of locum files to see the level of compliance with the standard detailed in the policy. The review indicated that there was inconsistency in applying the standard across Nexus sites. The provider updated their policy and planned to re-audit locum files in March 2019 to see if compliance with the agreed standards had improved.</p> <p>We reviewed the file of a locum staff member and found that the required level of child and adult safeguarding had been completed. However, one of the long-term locums working at Manor Place Surgery had not completed basic life support training within the last 12 months.</p>	

Safety systems and records	Y/N/Partial
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There was a record of fire extinguisher checks.	Y
There was a record of fire training for staff	Y
<p>At our previous inspection of Manor Place Surgery, we found that 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, stated that four extinguishers were not operational. This was raised with the operations manager who could not confirm why these extinguishers had not been checked or if these extinguishers were amongst the ones 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 extinguishers confirmed that the two extinguishers had not been inspected at the last inspection.</p> <p>At this inspection we saw that the two fire extinguishers that had been identified during the last inspection had been serviced in June 2018. One of the extinguishers had been replaced.</p> <p>At our previous inspection we had found that a locum staff member working at Manor Place Surgery had not completed fire safety training. At this inspection we were provided with an updated policy for the requirements for locum staff at the service which stated that when staff booked long term locums (those who would be working at the service longer than a week) they needed to obtain evidence of fire safety training. We were provided with a training log for locum staff working at Manor Place Surgery and saw that all long-term locums had completed fire safety training.</p>	

Health and safety	Y/N/Partial
Legionella risk assessments	
<p>At our last inspection of Manor Place Surgery, we found that the service had been monitoring water temperatures weekly since September 2018. However, water temperatures had been, on many occasions, within the range where legionella bacteria could survive.</p> <p>At this inspection we found that the provider had replaced the water tank at Manor Place Surgery on 30 January 2019 and that water temperatures had been tested on 31 January 2019 and 4 February 2019. The documentation regarding subsequent temperature monitoring showed that water temperatures were now within the safe range with no risk of legionella bacteria developing.</p> <p>The provider had developed a new Nexus wide policy around legionella testing in February 2019 which standardised the process across Nexus requiring all sites to undertake monthly testing. There was clear guidance in the document about the action staff had to take in the event that the water temperature was out of range including a flowchart including contact information for the external support services.</p>	

## Information to deliver safe care and treatment

**The provider had put systems and processes in place to ensure that staff had 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.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
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.	Y

Explanation of any answers and additional evidence:

### **Management of incoming tasks, results and clinical correspondence**

At the previous provider level assessment of Nexus Health Group, we found that 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.

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.

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

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 independently 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.

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. 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.

At this inspection we reviewed inboxes for results, clinical tasks and the inbox for incoming clinical correspondence and found that action was being taken in line with the timescales provided in the practice's new policy. The provider confirmed that if there were any breaches of the standards by the site clinical leads or partners that this issue would be escalated to the executive board and performance management would be initiated.

### **Systems to enable non- clinical staff to process and workflow incoming correspondence**

At the previous inspection of Nexus Health Group, we found that 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 following our inspections and 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 us at that time that this would be audited on a fortnightly basis until a standard of compliance with the protocol had achieved 95% or above.

At this inspection we were provided with evidence of another audit which showed 96.1% of correspondence had been handled appropriately. Of the correspondence that did not comply with the protocol the provider found that no additional action would have been required and no harm would have been caused by the correspondence not having been reviewed by a clinician. The provider told us that they would begin auditing the process monthly but that if the standard were to drop the frequency of auditing would increase. In addition, if a new member of staff started with the practice; their work would be audited more frequently. The provider supplied an updated policy which stated that all normal results would be sent to a GP for review until further notice. This was to ensure that normal results, which might require further investigation, were acted upon.

### **Two week wait referrals**

At our inspection of Manor Place Surgery on 7 November 2018 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 if 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.

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 identified 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 Nexus and had initiated weekly searches across Nexus every seven days to ensure that all two-week waits were accounted for.

At this inspection we were shown an example of the two week wait referral spreadsheet which was used across all sites. This showed that staff were monitoring the date of the patient appointment, if the patient attended, whether or not an outcome letter had been received and if the patient was vulnerable. The two week wait policy referred to staff who were responsible for two week waits at each site. We were told that two of the operations managers would visit the sites in person to review the two week wait process on a monthly basis to ensure that the policy was being adhered to and that staff were checking the local care record to see if the outcome of the assessment had been received.

### Appropriate and safe use of medicines

**The practice had designed new systems to ensure that medicines were used safely and appropriately. There were effective systems now in place to monitor the use of prescriptions and ensure that these were stored securely and had processes to review uncollected prescriptions. Emergency equipment was regularly checked. However, systems around medication reviews were not fully embedded and not effective.**

Medicines management	Y/N/Partial
Blank prescriptions were kept securely and their use monitored in line with national guidance.	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.	N
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.	N
There was medical oxygen and a defibrillator on site and systems were in place to ensure these were regularly checked and fit for use.	Y
<p>Explanation of any answers and additional evidence:</p> <p>At our previous inspection of Manor Place Surgery on 7 November 2018 we saw that patients prescribed ACE inhibitors and asthma medicines were not all having regular medication reviews and appropriate tests.</p> <p>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 the patients had had these completed. If patients had still not had the relevant tests completed then this would be escalated to the local prescribing lead.</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 in line with CCG guidelines. 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. The practice had reviewed their asthmatic patient population and told us that any searches of patients with asthma who were overusing salbutamol would exclude patients with COPD as these patients may require additional issues of salbutamol. The practice told us that these patients would still have their salbutamol use reviewed at their annual COPD and asthma annual check.

The groupwide 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.

At this inspection we found that the practice had completed an audit of medication reviews completed at all sites. The practice's new prescribing protocol stated that practice based Pharmacists, supported by site GP Prescribing Leads, would assess five medication reviews per 10,000 patients per site to determine if they met the standard set out in the policy. Where the need for improvement was identified individual clinicians would be spoken to and site based education around medication reviews would be provided if two or more of the reviews for a certain site were identified as needing improvement. The policy outlines guidelines for clinicians undertaking medication reviews where the patient was not present.

In respect of the process for recalling patients for medication we were told that the prescribing group would undertake searches monthly to identify patients whose monitoring was overdue. Patients identified would be sent a letter and blood form to encourage them to attend for a review. If there was no response after a month the patient would be sent a text message asking them to attend for monitoring and then, after another month, if the patients still failed to attend a list of these patients who had not responded to the letter and text would be sent to the site clinical lead for further action. This process potentially added at least two to three months after the expected review date before a clinician would become directly involved with reviewing the patient.

During the inspection we undertook a search of patients prescribed lithium and found 36 patients prescribed lithium across Nexus Health Group. We narrowed the search to look for patients who had not had their lithium levels checked within the last four months. NICE guidance states lithium levels should be checked at least every three months once blood concentration levels and dosages are stable. We identified 16 patients who had not had their lithium levels checked in last four months. We reviewed the clinical records of four of these patients. The review of their records confirmed that monitoring was not being undertaken in accordance with guidance.

Using a search that the provider had created in the clinical system we found that there were 157 patients prescribed ACE inhibitors/Angiotensin Receptor Blockers (ARBs) who had not received U & E (Urea & Electrolytes – test used primarily to detect abnormalities in kidney function) testing in the last 14 months, 31 of these patients had not had U & E tests in the last two years and 19 not had U& E tests in the last three years, one of which was a child. ACE inhibitors and ARBs can cause hyperkalaemia and

impair renal function so require regular kidney function monitoring. It is recommended that this blood test is performed annually when patients are stable on medication, but it should be performed more frequently if the patient has only just commenced the medicine, is on additional medicines that affect renal function or potassium levels or they have certain other co-existing underlying medical conditions. Two of patients whose records we reviewed confirmed that U & E tests had not been completed in line with recommendations and guidance.

We used a search created by the provider to identify patients prescribed leflunomide. Patients taking this medicine should have 2-3 monthly monitoring of FBC, U+E, LFT, blood pressure and weight according to local and national guidance due to the potential toxic side effects on bone marrow, renal and liver function, as well as affecting weight and causing raised blood pressure. There were 13 patients prescribed this medication by the practice. Nine of these patients had not had their blood pressure monitored, five patients had not had a full blood count done, six patients had not had a liver function test done and 11 patients had not had their weight measured.

We used a search created by the provider to identify patients prescribed Azathioprine which showed that of 105 patients were prescribed this medication. Blood tests should be performed every three months at least for patients taking this medication according to local and national guidance, however the search identified patients who had not had blood tests for 16 weeks (four months). This medicine is a toxic immunosuppressant and requires regular monitoring to ensure that patients are not at risk of harm from the medicine adversely affecting bone marrow, renal and liver function. Results identified 53 patients had not had a Full Blood Count for four months, 56 patients had not had their U&E tested in four months and 54 patients had not had a Liver Function Test in four months. We reviewed the clinical record of one of these patients and found that they were not having monitoring completed in accordance with guidance but were still being issued prescriptions for this medicine.

We undertook a search of patients prescribed spironolactone. This medicine is a potent diuretic and can have an adverse effect on potassium levels and renal function, especially when used in combination with other diuretics or medicines that affect renal function, or if the patient has certain underlying medical conditions or is elderly. NICE guidance recommends that patients taking this medicine should have potassium and creatinine levels (U & E) checked monthly for the first 3 months, then every 3 months for 1 year and then at least every 6 months. Of the 203 patients prescribed this medication we found that 25 patients had not had their U & E tested in the last 12 months and 11 had not had this done within the last three years. We reviewed the records of two patients prescribed this medication and found that one patient had not had a review completed in line with guidance and the other had a review completed in secondary care; however, there was no reference to this review in the patient's GP record and therefore it was unclear if a GP was aware and had reviewed this.

We undertook a review of patients prescribed methotrexate. Blood tests for FBC, U&E and LFT should be performed every three months at least for patients taking this medication according to local and national guidance, however the search identified patients who had not had blood tests for 16 weeks (four months). This medicine is a highly toxic immunosuppressant and requires regular monitoring to ensure patients are not at risk of harm from the medicine adversely affecting bone marrow, renal and liver function. We found 122 patients who had this medication issued in the last six months. We undertook a search and found 17 patients who had not received a blood test within the last four months. We reviewed two of these patients and found that the medication review dates for these patients coupled with the quantities prescribed meant that there was a risk they would not have reviews completed in accordance with guidelines.

**Uncollected prescriptions**

At our inspection of Manor Place Surgery on 7 November 2018 we found that 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.

The provider 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 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.

At this inspection we reviewed the uncollected prescription process in operation at Manor Place Surgery. We were told by a member of non-clinical staff that they would review the uncollected prescriptions every four weeks. Any prescriptions that were more than four weeks old would be passed to the prescribing lead at the site who would take appropriate action. Any prescriptions that did not require further action would be passed back to a non-clinical staff member who would destroy the prescription. Any controlled drug prescriptions would be destroyed with another non clinical staff member present.

Staff were noting on the system that the patient had not collected their medication so that the practice had an audit trail of the number of issues a patient had not collected.

The provider told us that they planned to continually audit the process to ensure that the policy standard was being complied with.

**Prescription storage and security**

At our inspection of Manor Place Surgery on 7 November 2018 we found that 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 prescription pads used for handwritten prescriptions and blank handwritten prescription pads used for issuing controlled drugs were kept in a room which was locked but 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.

The provider supplied information in response to the warning notices issued of action taken after our inspection to address this concern . They said that they had reviewed their policy around the security of prescriptions to ensure that protocols were in place at each of the sites. Quarterly reviews by Operation Managers and Team Leaders were to be introduced to ensure that processes were being consistently followed and that there would be a reconciliation of handwritten prescriptions and controlled drug prescriptions every six months by Operations Managers and Team Leaders.



At this inspection we were provided with a prescription paper security report and an audit of paper prescriptions for all Nexus sites. The audit reviewed the systems in place at each site. Discrepancies were highlighted in the processes at each site and all sites ensured that their prescribing protocols were updated in light of this.

We were told by several members of staff that all prescriptions were now securely stored. We saw that logs were in place for prescriptions at Manor Place Surgery to ensure their use was being monitored and that all prescriptions were securely stored.

### **Emergency equipment**

During our inspection of Manor Place Surgery on 7 November 2018 we found that one of the oxygen cylinders was less than half full and the working status of the defibrillator was not being checked regularly.

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 noted the service date of all cylinders. All cylinders were 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 the site's Healthcare Assistant was checking the defibrillator at Manor Place Surgery on a weekly basis by.

At this inspection we reviewed the monitoring emergency equipment policy dated February 2019 which stated that each site needed to have a procedure to ensure that equipment and medication would be checked weekly and after any medical emergency.

We were provided with a protocol for Manor Place Surgery which stated that the oxygen and defibrillator should be checked monthly. However, the provider told us this would be checked weekly and the log for the defibrillator indicated that checks were being completed daily initially following our inspection but that the practice healthcare assistant was now undertaking weekly monitoring.

We saw that weekly checks were being completed of the oxygen supply at Manor Place Surgery and the log indicated that the cylinders were over three quarters full. We checked both oxygen cylinders and found that both were full.

The policy for monitoring emergency medical equipment was updated to include a fortnightly audit by the site nurse to ensure that checks of emergency equipment were being completed. These checks were then sent to the nurse manager and clinical governance lead for Nexus.

# Effective

## Rating: unrated

### 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.	Partial
The practice had a programme of learning and development.	Y
Explanation of any answers and additional evidence:  At our last inspection of Manor Place Surgery we found that the practice did not have an overview of essential training completed by locum GPs.  At this inspection we found that the practice did have an overview of locum staff training but that one locum GO had not completed Basic Life Support Training within the last 12 months.	

## Managing risks, issues and performance

The practice had addressed most of the areas of concern raised in the warning notices issued after our inspection of Manor Place Surgery. However, the policy which had been developed for reviewing patient medicines had not been fully implemented, did not cover all medicines where reviews were required and did not prompt timely intervention by a clinician. This continued to place patients at potential risk of harm.

	Y/N/Partial
There were comprehensive assurance systems in place which were regularly reviewed and improved.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
<p>Explanation of any answers and additional evidence:</p> <p>Evidence obtained at our last inspection of the provider and of Manor Place Surgery indicated that the systems around the management of risk and concerns around performance were not sufficient and did not ensure that risk was adequately prioritised. For instance, the provider identified concerns related to clinical capacity at Manor Place Surgery and the issues around oversight of clinical tasks, results and correspondence but had failed to prioritise these issues.</p> <p>At this inspection we found that the provider had taken action to address concerns around risk in most areas raised in the warning notices. For example, the provider had cleared the backlog of tasks, results and correspondence and put systems in place to ensure effective oversight of this issue. Clinical and managerial support was now being provided to staff at Manor Place Surgery and action had been taken to address concerns around risks associated with premises.</p> <p>In addition, the provider had developed a new approach to risk management which aimed to ensure that risk was appropriately prioritised and acted upon.</p> <p>However, the systems implemented for medication reviews were not sufficient to ensure that all patients received timely reviews in line with guidelines. We identified a number of patients on medicines which required regular monitoring and this had not been carried out. Some of these medicines carried considerable risk. Although the provider had developed a protocol in response to the concerns detailed in the warning notices this did not cover certain high-risk medicines. The protocol also meant that where a patient required a three-monthly medication review, there was a potential delay of six months before a clinician would take action.</p>	

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 practice's 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.