

# Care Quality Commission

## Inspection Evidence Table

### Nexus Health Group (1-542937588)

Inspection date: 23 and 29 October 2019

Date of data download: 11 November 2019

#### Dates of individual site visits.

##### 23 October 2019

##### Head Office (visit held at Aylesbury Medical Centre)

Aylesbury Medical centre

Dun Cow surgery

##### 29 October 2019

Surrey Docks Health Centre.

Manor Place Surgery.

Commercial Way Surgery

Decima Street Surgery.

Artesian Health Centre.

Princess street Practice.

## Overall rating: Requires Improvement

At our last inspection in November 2018 we rated the service as Inadequate.

During the inspection on 13 June 2019 we found the practice had made improvements. During this inspection in October 2019, we found that the practice were maintaining these improvements.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

# Safe

**Rating: Good**

## Safety systems and processes

Safe was rated as inadequate at our last inspection in November 2018. During this inspection, we found the systems for managing medicines was thorough, staff were completing training as required, the systems for managing patient test results had been improved and there was evidence of learning from significant events across the service. Therefore, Safe is now rated as Good.

**The practice had 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
There were policies covering adult and child safeguarding which were accessible to all staff.	Y
Policies took account of patients accessing any online services.	N/A
Policies and procedures were monitored, reviewed and updated.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
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:	
<ul style="list-style-type: none"><li>Concerns identified at our previous inspection relating to safeguarding systems and Disclosure and Barring Checks had been rectified. We viewed a data base that was used for monitoring staff records. A sample of records viewed showed that where required a DBS check had been completed and in instances where staff had been identified as not requiring a DBS in accordance to the organisations policy, risk assessments had been completed.</li><li>We noted that staff were receiving training for safeguarding to their required level. Systems and processes were in place for monitoring this. However, during our inspection, a small number of staff were not able to fully explain what safeguarding entailed, when prompted they were able to explain that they would seek help from the onsite managers and the team leads.</li></ul>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>Our previous inspection identified concerns with recruitments checks for staff at various locations. Since September 2019 the provider had employed a human resources manager. All HR files for Nexus staff were now being centrally managed from one of the providers locations and held by the HR team. During our inspection we met with this team and they explained the system that was in place and the plans they had for future monitoring of personnel records.</li> </ul>	

Safety systems and records	Y/N/Partial
<p>There was a record of portable appliance testing or visual inspection by a competent person.</p> <p>Date of last inspection: between January – November 2019.</p>	Y
<p>There was a record of equipment calibration.</p> <p>Date of last calibration: between November 2018- September 2019.</p>	Y
<p>There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.</p>	Y
<p>There was a fire procedure.</p>	Y
<p>There was a record of fire extinguisher checks.</p> <p>Date of last check: between January -October 2019.</p>	Y
<p>There was a log of fire drills.</p> <p>Date of last drill: between February – October 2019.</p>	
<p>There was a record of fire alarm checks.</p> <p>Date of last check: between April -September 2019.</p>	
<p>There was a record of fire training for staff.</p> <p>Date of last training: Various dates</p>	Y
<p>There were fire marshals.</p>	Y
<p>A fire risk assessment had been completed.</p> <p>Date of completion: between August – October 2019</p>	Y
<p>Actions from fire risk assessment were identified and completed.</p>	Y
<p>Explanation of any answers and additional evidence:</p>	

Health and safety	Y/N/Partial
<p>Premises/security risk assessment had been carried out.</p> <p>Date of last assessment: between September – October 2019</p>	Y

Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: between September- October 2019.	Y
Explanation of any answers and additional evidence:	

## Infection prevention and control

### Appropriate standards of cleanliness and hygiene were met/not met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: between January- August 2019.	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
There was a system to notify Public Health England of suspected notifiable diseases.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Partial
<ul style="list-style-type: none"> <li>Explanation of any answers and additional evidence:</li> <li>Infection control and update training were taking place as required. We noted that action plan areas had been identified during the audits per site. For all sites the action plans were either completed or had target dates for completion. The infection control lead nurse kept a central log for all of the actions that required actioning for monitoring purposes.</li> <li>We found that at one of the sites (Artesian Health Centre) there was some uncollected clinical waste. We were told that the building was shared with another service. However, the provider was alerted to this and swift action was taken to resolve the matter. The provider sent us further communication after our inspection detailing that the matter was under review with the responsible contractor to avoid further occurrence.</li> </ul>	

## Risks to patients

### There were adequate 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.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
The practices were equipped to deal with medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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.	Y
There was a process in the practice for urgent clinical review of such patients.	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:	
<b><u>All sites:</u></b>	
<ul style="list-style-type: none"> <li>There were arrangements for planning and monitoring the number and mix of staff needed. We noted that the provider had recently had a recruitment drive and had successfully recruited a number of practice nurses for each of the sites as well as other clinical and non-clinical staff.</li> </ul>	

## Information to deliver safe care and treatment

### 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
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented and 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
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>At our previous inspection, there was a lack of centralised overview of clinical correspondence and tasks. The concerns identified were around workflow management around results. We noted that a workflow monitoring process had been introduced and was being monitored at provider level. All workflow items were being reviewed and actioned within a standard timeframe. Weekly monitoring was in place to identify any breaches. We viewed records where breaches were logged by a clinical Governance lead per site. The Nexus Executive Board followed up persistent breaches to make improvements.</li> <li>We reviewed the global overview for clinical workflow/tasks on the patient recording system across all eight of the Nexus sites. At all sites we found that test results and workflow systems for letter and referrals were being dealt with appropriately and there were no concerns.</li> <li>The provider had nominated a lead staff member per site to be responsible for the monitoring of two week wait referrals. Their role involved keeping a log of all two week wait referrals and appointments and these were being followed up with every single patient. Staff we spoke with explained that this process helped identify any discrepancies in the process and reduced the risks for delaying any care. Logs we viewed confirmed weekly searches were undertaken to ensure safety netting of all referrals.</li> </ul>	

## Appropriate and safe use of medicines

### The practice had 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) (01/07/2018 to 30/06/2019) (NHS Business Service Authority - NHSBSA)	0.57	0.57	0.87	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). (01/07/2018 to 30/06/2019) (NHSBSA)	6.9%	6.9%	8.6%	No statistical variation
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/01/2019 to 30/06/2019) (NHSBSA)	4.97	5.17	5.63	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/01/2019 to 30/06/2019) (NHSBSA)	1.41	1.48	2.08	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.	Y
Staff had the appropriate authorisations 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 for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about	Y



Medicines management	Y/N/Partial
changes to a patient's medicines including changes made by other services.	
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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
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 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 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.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>At our previous inspection in November 2018, we found concerns with medicines management. A follow up inspection was undertaken in June 2019. That inspection found that robust systems had been introduced in the management of medicines. During this inspection central records demonstrated that improvements had been maintained. We viewed log sheets for high risk medicines monitoring between September and October 2019. These logs confirmed compliance was being maintained and they also provided early indications to any areas that required follow up.</li> </ul>	

## Track record on safety and lessons learned and improvements made

### The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
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.	Y
Number of events recorded in last 12 months:	62 Across all sites.
Number of events that required action:	62
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. The lead staff for managing incident reporting explained incidents or near misses were recorded on a specific significant event analysis system. These were recorded per particular site and filtered according to the specific area they related to, for example, information governance. Clinical leads from each site would in turn feedback significant events identified as requiring shared learning across all sites.</li> </ul>	

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
<b><u>Aylesbury Medical centre:</u></b>	
Recruitment data breach.	Policies were reviewed, and action taken to ensure they had been no data breach. This learning was shared across to the relevant staff.
An empty oxygen tank.	The policy was updated to ensure there was always two oxygen tanks per site and the nurses responsible for monitoring emergency equipment were to be informed each time the oxygen was used.

Event	Specific action taken
<b><u>Surrey Docks Health Centre:</u></b>	
Referral sent as an email which had another patient email address attached.	Appropriate action taken, Nexus lead for duty of candour was informed and patients contacted and apologised. IT department reminded all staff to take extra care when sending emails.
Wrong patient booked in on arrival on system, which resulted in the correct patient having to wait longer because nurse was not aware they had arrived.	Apologies given to patient and seen by nurse. Email sent to the Operations Manager to make staff aware to ensure this was not repeated.

Event	Specific action taken
<b><u>Princess Street Practice:</u></b> Receptionist found a labelled urine sample pot in back of filing drawers.	Reviewed the risk of multi-tasking and mixing items. The importance of regular clearing was identified and shared across.
Error in vaccinating a child who had already attended and had repeat vaccinations.	Action taken to report the incident to the parent and they were reviewed by a doctor. No harm had been caused. Action taken to ensure that the patients records are always checked prior to delivering care.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y
<b>Explanation of any answers and additional evidence:</b> Alerts were dealt with centrally by the pharmacy/ medicines team and a lead GP. The central team monitored that the alerts were being dealt with per site. The most recent alerts that had been received and acted on related to Emerade and Hormone Replacement Therapy (HRT).	

## Effective

## Rating: Requires Improvement

At our previous inspection in November 2018, we rated the practice as Requires improvement for providing effective services due to concerns related to the lack of oversight of clinical correspondence. During this inspection we found that significant improvements had been made, however we have rated Families, children and young people and the Working age people as requires improvement due to low clinical outcomes. Therefore, effective is rated as Requires Improvement.

### Effective needs assessment, care and treatment

**Patients' needs were assessed, and care and treatment was delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools.**

	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.	Y
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
Explanation of any answers and additional evidence:	

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) (01/07/2018 to 30/06/2019) <small>(NHSBSA)</small>	0.37	0.35	0.75	Tending towards variation (positive)

**Findings**

- The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs. Health Care Assistants (HCAs), with close supervision from the Practice leads undertook holistic health assessments for the frail elderly population. The Nurses, HCAs, named GPs and patients jointly developed care plans. Holistic care assessments were also carried out at home.
- A nurse lead carried out case management for older people across Nexus.
- Sites offered in house phlebotomy to elderly patients who found it difficult to travel to hospital.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.

**Surrey Docks Health Centre:**

- This site looks after patients at a nearby residential home and provides an annual on-site flu vaccination clinic in the home.

## People with long-term conditions

## Population group rating: Good

### Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- Health care assistants also lead on ambulatory blood pressure monitoring for accurate identification of high blood pressure.
- The practices undertake virtual clinics with the diabetes team, COPD and asthma team. They also work closely with the community Heart Failure team, Community Matron and District Nurses.
- The practice uses Consultant Connect service and the HOT clinic helpline to discuss cases where urgent advice is needed.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately.
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) (QOF)	76.4%	76.9%	79.3%	No statistical variation
Exception rate (number of exceptions).	5.6% (223)	7.7%	12.8%	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 (01/04/2018 to 31/03/2019) (QOF)	79.7%	80.8%	78.1%	No statistical variation
Exception rate (number of exceptions).	7.5% (302)	5.9%	9.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	86.1%	84.0%	81.3%	No statistical variation
Exception rate (number of exceptions).	7.4% (297)	7.2%	12.7%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	73.4%	75.2%	75.9%	No statistical variation
Exception rate (number of exceptions).	1.4% (45)	2.0%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.9%	91.0%	89.6%	No statistical variation
Exception rate (number of exceptions).	4.2% (57)	5.6%	11.2%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	82.1%	83.1%	83.0%	No statistical variation
Exception rate (number of exceptions).	3.2% (264)	3.1%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.6%	90.9%	91.1%	No statistical variation
Exception rate (number of exceptions).	4.7% (24)	6.2%	5.9%	N/A

#### Any additional evidence or comments

### Families, children and young people

### Population group rating: Requires Improvement

#### Findings

- The practice had not met the minimum 90% target for four childhood immunisation uptake indicators. The unverified data showed that we were currently performing above the 90% target for the current year. However, improvements are still required.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.
- 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.
- Some sites had a regular in-reach Consultant Paediatric clinic. The clinic was held jointly with a GP. Other sites could refer to the service. This provided an opportunity for shared learning and upskilling of the clinical team. The GPs could email the service for clinical advice and refer appropriate children to the clinic. Particular emphasis was on the management of asthma, eczema, and constipation.
- Young people could access services for sexual health and contraception.
- Staff had the appropriate skills and training to carry out reviews for this population group.



Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	736	839	87.7%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	698	815	85.6%	Below 90% minimum
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) (01/04/2018 to 31/03/2019) (NHS England)	704	815	86.4%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	692	815	84.9%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

#### Any additional evidence or comments

- Childhood immunisation uptake rates were below the World Health Organisation (WHO) targets. However, the unverified data showed to us showed that were currently performing above the 90% target for the current year. However, improvements are still required. Staff explained that they were currently working ahead of cohort schedule. This allowed them to alert families that the immunisations were due ahead of time and resulted in an increased uptake rate.

#### Working age people (including those recently retired and students)

#### Population group rating: Requires Improvement

#### Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need

to attend the surgery.

- The practice had also started to roll out e-consultation at sites whereby patients could email the surgery with queries; which was part of the Nexus wide strategy.

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) (01/04/2017 to 31/03/2018) (Public Health England)	62.5%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	61.8%	60.8%	72.1%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	41.4%	40.5%	57.3%	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. (01/04/2017 to 31/03/2018) (PHE)	66.7%	73.1%	69.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	55.8%	53.6%	51.9%	No statistical variation

#### Any additional evidence or comments

- The practice advised they had worked to make improvements to the uptake of cervical smears, the unvalidated data showed to us demonstrated that the current uptake was around 74% for cervical smears.
  - Data showed that the performance for bowel cancer was below the national average of 57% with the practice's performance being 41%.
- We have therefore rated this population group as requires improvement.

**People whose circumstances make them vulnerable**

**Population group rating: Good**

#### Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those

whose circumstances may make them vulnerable.

- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed young patients at local residential homes.

### **People experiencing poor mental health (including people with dementia)**

**Population group rating: Good**

#### **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.
- Same day and longer appointments were offered when required.
- 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.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.

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 (01/04/2018 to 31/03/2019) (QOF)	90.8%	90.8%	89.4%	No statistical variation
Exception rate (number of exceptions).	9.2% (86)	7.4%	12.3%	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 (01/04/2018 to 31/03/2019) (QOF)	91.0%	90.9%	90.2%	No statistical variation
Exception rate (number of exceptions).	9.2% (86)	6.6%	10.1%	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 (01/04/2018 to 31/03/2019) (QOF)	73.4%	82.6%	83.6%	No statistical variation
Exception rate (number of exceptions).	3.2% (8)	3.9%	6.7%	N/A


## 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)	552.9	No Data	539.2
Overall QOF score (as a percentage of maximum)	98.9%	No Data	96.4%
Overall QOF exception reporting (all domains)	5.7%	No Data	No Data

	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
Quality improvement activity was targeted at the areas where there were concerns.	Y

The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y
--	---

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

<p>A number of audits had been carried out at each of the sites. Examples of audits resulting in improvements were in the following areas;</p> <p>Urinary Tract infections – antibiotic prescribing. This audit was a review of antibiotic prescriptions for Urinary Tract Infections, aimed at reducing inappropriate broad-spectrum antibiotic use. The two cycle audits findings where that; prescribing had improved and the whole clinical team were aware of current guidelines. The findings were shared externally with the district nursing teams and all relevant partners.</p> <p>Assessment of possible sepsis in children. The audit was carried out to ensure clinical staff were working according to current guidance when screening for sepsis. The findings from the audit improved the information that was assessed and documented in an assessment. The practice found that the new clinical system was vital in that it flagged up possible sepsis based on clinical codes used during a child's assessment.</p>
--

## Effective staffing

**The practice was able to demonstrate that staff had the skills, knowledge and experience to carry out their roles.**

	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.	Y
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.	Y
Induction 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.	Y
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
Explanation of any answers and additional evidence:	

## Coordinating care and treatment

### Staff worked 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 (01/04/2018 to 31/03/2019)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

## Helping patients to live healthier lives

### Staff were consistent and 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
Patients had access to appropriate health assessments and checks.	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	93.9%	94.8%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.8% (106)	0.5%	0.8%	N/A

### 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
Policies for any online services offered were in line with national guidance.	Y

## Caring

**Rating: Good**

Kindness, respect and compassion

Our last inspection rated Caring as Good. At this inspection we have still rated Caring as Good.

**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
Staff displayed understanding and a non-judgemental attitude towards 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	
Total comments cards received.	17
Number of CQC comments received which were positive about the service.	12
Number of comments cards received which were mixed about the service.	3
We received two comment cards which were negative about the services However, it was not clear which site they related to.	2

Source	Feedback
Patients interviews	Patients across the practices reported improved access with appointments. Other feedback also commented on the care that the service provided, which they felt meet their needs.
CQC Comments Cards	The majority of cards we received were positive about the service experienced. However, three patients had given mixed feedback relating to lack of appointments and delays in getting the phones being answered. Two comment cards were negative about the care they had received. However, from the information provided some of feedback related to a number of community and secondary care services.





## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
76445	469	100	21.3%	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 general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2019 to 31/03/2019)	87.2%	87.0%	88.9%	No statistical variation
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 (01/01/2019 to 31/03/2019)	80.5%	83.6%	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 (01/01/2019 to 31/03/2019)	93.5%	94.2%	95.5%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2019 to 31/03/2019)	78.1%	79.3%	82.9%	No statistical variation

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

Any additional evidence
The service in conjunction with the PPG were currently undertaking rolling patient surveys. There were also other plans to introduce a Nexus wide patient surveys. The Information Technology system was being developed to support this.

### 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 patients.	<p>Aylesbury Medical Centre: Six patients all reported positive feedback with good access for appointments.</p> <p>Surrey Docks Health Centre: Three patients reported being happy with the care provided by Nexus. Appointments were reported to be readily available when required.</p> <p>Princess street Practice: Patients reported being happy with the service provided, commenting on increased access.</p>

### 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 (01/01/2019 to 31/03/2019)	89.5%	90.8%	93.4%	No statistical variation

### Any additional evidence or comments

The provider had reviewed the patient data from the GP national patient survey. A variety of improvements were being taken in those areas found to be falling short. Such as more training for reception staff and the introduction of e- consultations.

	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.	Y
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.	1,516 making 2% of the population.
How the practice supported carers (including young carers).	Written information was available to direct carers to the various avenues of support available to them. Staff reported that once patients had been identified, they were coded on the computer system to alert the need for further services.
How the practice supported recently bereaved patients.	Across all sites, staff confirmed that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

### 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.	Y

Explanation of any answers and additional evidence:

## Responsive

## Rating: Requires Improvement

### Responding to and meeting people's needs

Our last inspection we rated Responsive as Requires improvement due to patient experiences and access to appointments. improvements had been made to increase access. However, the majority of patient feedback was still low. We have judged that improvements are still required. Therefore, all population groups are rated as requires improvement,

### The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
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
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y
Explanation of any answers and additional evidence:	

### Practice Opening Times

The practices were open between 8am- 18:30 Monday- Friday with a number of extended opening hours being offered across the sites.

## National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
76445	469	100	21.3%	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 (01/01/2019 to 31/03/2019)	96.3%	93.7%	94.5%	No statistical variation

### Any additional evidence or comments

--

## Older people

**Population group rating: Requires Improvement.**

### Findings

- All 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.
- The practice provided effective care coordination to enable older patients to access appropriate services.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- There was a medicines delivery service for housebound patients.

## People with long-term conditions

**Population group rating: Requires Improvement.**

### Findings

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice provided effective care coordination to enable patients with long-term conditions to access appropriate services.
- The practice liaised regularly 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**

**Population group rating: Requires Improvement.**

### **Findings**

- Additional nurse appointments were available from 7am and until 8pm from other sites for school age children so that they did not need to miss school.
- 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. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of 10 could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

## **Working age people (including those recently retired and students)**

**Population group rating: Requires Improvement.**

### **Findings**

- 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.
- The practice was offering triage for appointments to the local Extended Hours service for minor illnesses which was open from 8am:8pm.



**People whose circumstances make them vulnerable**

**Population group rating: Requires Improvement.**

**Findings**

- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice provided effective care coordination to enable patients living in vulnerable circumstances to access appropriate services.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

**People experiencing poor mental health  
(including people with dementia)**

**Population group rating: Requires Improvement.**

**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 groups within the area and signposted their patients to these accordingly.

## Timely access to the service

### People were 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.	Y
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:	

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone (01/01/2019 to 31/03/2019)	60.8%	N/A	68.3%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2019 to 31/03/2019)	45.4%	60.2%	67.4%	Tending towards variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2019 to 31/03/2019)	58.1%	60.2%	64.7%	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 (01/01/2019 to 31/03/2019)	55.6%	65.4%	73.6%	Tending towards variation (negative)

### Any additional evidence or comments

- The national, GP survey results showed that the practices had performed low on experiences of making an appointment and patients who were satisfied with the appointments they were offered.
- Since our last inspection action had been taken to improve patient experience when booking appointments. There had been a drive to recruit additional non-clinical staff to manage patient bookings and telephone lines. The practices were aware of the areas that required improvements still.
- The practice had undertaken an audit of reception staff in May 2019. Action had been taken

following this audit which had identified some training needs in some instances. In response to this audit and the National GP Patient Survey results the practice had provided reception staff with customer service training and training on communication in March and April 2019. The whole practice had also reviewed and reflected on complaints to help them understand the issues patients experienced and then look at how to improve this moving forward. The practice reported they had only received one complaint about reception staff since this audit.

Source	Feedback
For example, NHS Choices	<p><u>Aylesbury Medical Centre:</u> Since our last inspection, one patient had provided feedback relating to poor attitude of some reception staff when attempting to book appointments. The practice had responded to this.</p> <p><u>Dun Cow Surgery:</u> Four patients had left very positive comments relating to the conduct of staff and reception staff who they thought were caring. However, they were two negative comments, which the practice had responded to.</p> <p><u>Surrey Docks Health Centre:</u> Patients had left mixed, the majority of it was positive. In instance where the feedback was positive, the practice had responded.</p> <p><u>Manor Place Surgery:</u> The majority of the most recent feedback was poor and rated the practice poorly. The practice had responded to the feedback.</p> <p><u>Commercial Way Surgery:</u> Mixed feedback, with some patients commenting on how excellent the service was. There was also negative feedback relating to appointments, telephone wait times and prescriptions. The practice had responded, re-directing patients on how to get further help.</p> <p><u>Decima Street Surgery:</u> Largely negative comments relating to lack of appointments. The practice had responded to these comments.</p> <p><u>Artesian Health Centre:</u> Comments left in the last few months have been largely positive.</p>

## Listening and learning from concerns and complaints

**Complaints were listened and responded to and used to improve the quality of care.**

Complaints	
Number of complaints received in the last year.	59 across all sites
Number of complaints we examined.	15
Number of complaints we examined that were satisfactorily handled in a timely way.	15
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	N/A

	Y/N/Partial
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: <ul style="list-style-type: none"> <li>Information about how to make a complaint or raise concerns was available and it was easy to do. The complaint policy and procedures were in line with recognised guidance. Eleven complaints were received in the last year. The organisation held annual complaints review meetings. We viewed the log of the previous year's meetings and saw that learning points had been identified for recurrent themes, with action taken to make improvements.</li> </ul>	

Example(s) of learning from complaints.

Complaint	Specific action taken
Staff Attitude/behaviour/values	Further training on customer service had been identified for staff and staff were dealt with in accordance to policy.
Communications	Telephone system reviewed.

## Well-led

## Rating: Good

At our last inspection in November 2018, we rated the practice as Inadequate for Well Led. This was because there was a lack of effective centralised oversight and governance in respect of key areas of the organisation including the management of patients test results and other clinical correspondence.

During this inspection we found improvements had been made. The organisation had developed and centralised their governance to ensure there was adequate oversight and monitoring of risks and performances. We have now rated the practice as Good.

### Leadership capacity and capability

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"><li>During this inspection Leaders demonstrated they had the experience, capacity and skills to deliver the Organisations strategy and address risks to it. They were knowledgeable about issues and priorities relating to the quality of services. Leaders understood the challenges the organisation faced and were addressing them. Staff confirmed that Leaders at all levels were visible and approachable.</li><li>Leaders worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. The organisation held clinical multidisciplinary meetings at all sites, bi-monthly partners meetings, monthly Executive Board and management meetings, monthly Clinical Governance meetings and non-clinical staff team meetings on site. Risk was constantly under review with weekly clinical team meetings being held.</li></ul>	

### Vision and strategy

**The practice had a clear vision and credible strategy to provide high quality sustainable care.**

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y

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: <ul style="list-style-type: none"> <li>The organisation had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients. There was a clear vision and set of values.</li> <li>The service had a realistic strategy and supporting business plans to achieve priorities. The service developed its vision, values and strategy jointly with patients, staff and external partners. Staff were aware of and understood the vision, values and strategy and their role in achieving them. The strategy was in line with health and social priorities across the region. The service planned its services to meet the needs of the practice population and monitored progress against delivery of the strategy.</li> </ul>	

## Culture

### The practice had a culture which drove high quality sustainable care.

	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.	Y
When people were affected by things that went wrong they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence:	

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

Source	Feedback
Staff interviews	The majority of staff spoken with reported feeling supported and were given opportunities to further develop their career. Staff described feeling part of a whole organisation, Nexus and felt that the leaders had worked hard to make improvements in the last year.

## Governance arrangements

**There were clear responsibilities, roles and systems of accountability to support good governance and management.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>There were clear responsibilities, roles and systems of accountability to support good governance and management. The service had lead teams for each of the key areas and this promoted accountability as well as continuation.</li> </ul>	

## Managing risks, issues and performance

**There were clear and effective processes for managing risks, issues and performance.**

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. Our interviews with the senior leadership and records viewed demonstrated that risk was constantly under review and performance monitoring was undertaken at all levels.</li></ul>	

## Appropriate and accurate information

**There was a demonstrated commitment to using data and information proactively to drive and support decision making.**

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>We saw the service had provided the responsibility of budget holding for each department to ensure financial decisions were made by the staff leading the departments.</li></ul>	



## Engagement with patients, the public, staff and external partners

**The practice involved the public, staff and external partners to sustain high quality and sustainable care.**

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
The practice had an active Patient Participation Group.	Y
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.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• Since our last inspection the service had implemented a new senior manager responsible for patient engagement. They had arranged and held meetings with patients to address some of the concerns identified at our last inspection relating to the merger of the eight practices to become Nexus. These meetings had also addressed patient concerns relating to the PPG approach previously taken. Action from these meetings were to include quarterly site PPG meetings. There had been a joint meeting between staff and patients on "Patient engagement". We note noted that another open day for engagement was scheduled for December 2019.</li></ul>	

## Continuous improvement and innovation

**There were evidence of systems and processes for learning, continuous improvement and innovation.**

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"><li>• There was a focus on continuous learning and improvement at all levels within the organisation. We saw that the organisation as a whole had undertaken a nurse recruitment drive, which provided opportunities for staff development within the organisation. The organisation had also participated and been involved with the Suspicion of Sepsis Insights dashboard with Imperial College Partners. (The SOS Insights Dashboard can accurately measure the number of patients admitted to hospital who are at risk of sepsis).</li></ul>	

## 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 Bands	Z-score threshold
Significant variation (positive)	$\leq -3$
Variation (positive)	$> -3$ and $\leq -2$
Tending towards variation (positive)	$> -2$ and $\leq -1.5$
No statistical variation	$< 1.5$ and $> -1.5$
Tending towards variation (negative)	$\geq 1.5$ and $< 2$
Variation (negative)	$\geq 2$ and $< 3$
Significant variation (negative)	$\geq 3$

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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- 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). This indicator does not have a CCG average and is scored against the national target of 80%.

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>

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases, at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

## 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.