

## Inspection Evidence Table

Novum Health Partnership

(1-537784578)

Inspection Date: 11 October 2023

Date of data download: 02/10/2023

**Overall rating: Requires improvement**

## Context

The practice delivers services to approximately 21,000 patients. The practice provides services to a very vulnerable population. The practice has over 500 patients on the long-term Mental illness (LTMI) register. Information published by the Office for Health Improvement and Disparities shows that deprivation within the practice population group is in the third lowest decile (3 out of 10). The lower the decile, the more deprived the practice population is relative to others.

According to the latest available data, the ethnic make-up of the practice area is 67% White; 14% Asian; 10% Black, 6% Mixed, and 3% Other. The practice has a lower-than-average proportion of older patients. The practice has double the local and national prevalence of patients experiencing poor mental health. The practice has had challenges following increased demand post covid from a population with a high number of vulnerable patients. The practice had an unexpected staffing capacity crisis in February 2023. The practice also told us that the implementation of Extended Hours Access appointments in October 2022, through the Primary Care Network (PCN), affected the availability of appointments.

## Safe

**Rating: Inadequate**

**The practice is rated as Inadequate for providing Safe services because,**

- Systems and processes to keep people safe and safeguarded from abuse were not clear and consistently implemented.
- Care and treatment did not always reflect prescribing standards and best practice. For example, records we reviewed showed some patients had not received monitoring in line with current guidance and recommendations.
- Recruitment checks were not always carried out according to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There were gaps in systems to monitor and assess risks related to the health and safety of patients, staff and visitors.
- Safety alerts were not always managed effectively to keep patients safe.
- The practice could not demonstrate that staff received the immunisations that are appropriate for their role.

Although the practice leaders told us of plans to improve governance arrangements and showed us evidence of some individual systems being improved, ratings are based on evidence at the time of inspection.

### Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	P <sup>1</sup>
Partners and staff were trained to appropriate levels for their role.	P <sup>2</sup>
There was active and appropriate engagement in local safeguarding processes.	Y <sup>3</sup>
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.	P <sup>4</sup>
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
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. The practice had a policy that covered safeguarding of children and adults. Staff we spoke to knew who the safeguarding leads at the practice were. Staff knew where to find the practice safeguarding policies which contained information about when they should contact the local safeguarding team. The senior GP Partner was the safeguarding lead at the service. A review of patient records found the service had a system to highlight vulnerable adults and children on patient records and also a register. The practice included clear alerts on the records of patients who were known to be at risk. The team prioritised safeguarding concerns with regular meetings and review.</li> <li>2. The system to provide oversight of delivery of safeguarding training needed strengthening. The practice did not have evidence that all staff had completed training in safeguarding in line with practice policy and intercollegiate guidance. All members of the clinical team were trained to level 3 in adult and child safeguarding. However, of the five staff files we reviewed, two non-clinical members of staff did not have training in safeguarding (adults and children), at the appropriate level for their role. It was not clear that all practice staff were competent to recognise abuse and take effective action to keep people safe,</li> </ol>	

appropriate to their role. Following our inspection, the provider told us they had taken action to improve the system for monitoring mandatory training so that accurate records of staff information and training are maintained at the practice. This included implementation of a system to bring all staff training data on to one online elearning platform. The platform provided automated alerts for when training was becoming due. The provider told us they had put processes in place to improve oversight of mandatory training requirements.

3. The service followed up children of concern if they did not attend their appointment. The practice had carried out two 2-cycle audits in 2020 and 2023 to improve coding of children subject to a child protection plan (CPP). The practice appointed a safeguarding administrator to help scan case conference reports into the patient record and ensure the correct safeguarding codes are applied.
4. There was a system to check the DBS status of staff. Four out of five staff records we checked had an appropriate DBS check at the correct level. However, there was no record of a DBS check for one member of non-clinical staff prior to employment.

The practice had a policy regarding chaperoning, giving guidance on appropriate records coding. All staff undertaking chaperone duties had been suitably trained.

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	P <sup>1</sup>
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <p>1. Providers have a responsibility to ensure that all staff with whom patients interact as part of the delivery of care have received appropriate recruitment checks. During our inspection, we found there was insufficient recording of recruitment. The practice could not demonstrate the effectiveness of the system to ensure all staff have received appropriate recruitment checks. Recruitment checks were not always carried out according to Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reviewed six staff records and found that some did not contain the required pre-employment recruitment checks. We found that:</p> <p><b>Signed contract:</b> There was no record of signed contract in one non-clinical staff file.</p> <p><b>DBS:</b> Four out of five staff records we checked had an appropriate DBS check at the correct level. However, there was no record of a DBS check for one member of non-clinical staff prior to employment. There was no evidence of a risk assessment in place in the absence of a DBS check for this member of non-clinical staff.</p> <p><b>Professional registration check:</b> There was no evidence that the provider had checked the registrations status/qualifications for one professionally registered member of staff.</p>	

**Full employment history:** There was no record of a CV with employment history including written explanation for gaps in employment for one physician associate.

2. The practice had not ensured that staff had immunity to diseases in line with national guidance, or that immunity was checked in line with the practice's own infection prevention and control policy. The practice could not demonstrate that staff received the immunisations that were appropriate for their role. This meant that patient facing staff could potentially infect a patient or visitor should they have an illness or infection. Staff members were potentially at risk of contracting an illness or infection from a patient they came into contact with. There was no effective system of recording which staff were up to date with their routine immunisations, for example, tetanus, diphtheria, polio and MMR. For example, we reviewed five staff records (two clinical and three non-clinical) and found incomplete records of immunisation for four members of staff who's files we checked;

- The record of immunisation status for one member of the nursing team contained a partial record of immunisations; there was a record of Hepatitis B but no MMR 2 booster or dTipV.
- Two clinical staff records reflected that staff had received Hepatitis B but no other immunisations were documented. This was not in line with Green Book recommendations pre-employment health assessment which should include a review of immunisation needs. There was no evidence of a risk assessment of immunity done in the absence of information.
- For one member of non-clinical staff there were no immunisations recorded and no evidence of a risk assessment of immunity done in the absence of information.

When we discussed these concerns with managers, the provider told us they would ensure that a vaccination declaration form would be sent to existing staff and would be used for new staff joining the practice. Following our inspection, the provider told us they had taken action to improve the system for recording staff immunisation. The provider told us that staff immunisation would be recorded and managed using a secure cloud-based application which would be monitored by managers. The provider implemented a risk assessment template to use when staff declined or were unable to have certain immunisations. Leaders told us that following our inspection, they had completed antibody serology tests for those staff who required testing.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: 19/10/2023	Y
There was a fire procedure.	Y
Date of fire risk assessment: Novum Health Partnership Rushey Green Group 19/10/2023 Baring Road 13/07/2023	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence:	
There were premises risk assessments in place and generally we found actions were taken to mitigate risks identified.	

**Infection prevention and control****Appropriate standards of cleanliness and hygiene were met.**

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: 07/09/2022	Y
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y
Explanation of any answers and additional evidence:	

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

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	P <sup>1</sup>
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 were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence:	
1. We checked a sample of staff files and found not all staff were up to date with basic life support training. We spoke to managers who told us that in person CPR training was booked for all staff on 19 October 2023.	

**Information to deliver safe care and treatment****Staff did not always have the information they needed to deliver safe care and treatment.**

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	P <sup>1</sup>
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
Referrals to specialist services were documented, contained the required information 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 <sup>2</sup>
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. A review of patient records in relation to the clinical searches identified that care records were not consistently managed in a way to protect patients. For example, we found managers did not have an effective system to check that prescribers were following the policy to record they had reviewed monitoring when prescribing medicines. This meant care and treatment did not always reflect prescribing standards and best practice to keep patients safe.</li> <li>2. The practice had up-to-date governance policies relating to document handling and workflow.</li> </ol>	

### Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.55	0.69	0.91	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). (01/07/2022 to 30/06/2023) (NHSBSA)	5.0%	8.0%	7.8%	Tending towards variation (positive)
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 (01/01/2023 to 30/06/2023) (NHSBSA)	5.28	5.50	5.24	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	114.0‰	73.2‰	129.5‰	No statistical variation

Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.39	0.36	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	9.2‰	4.8‰	6.8‰	No statistical variation

Note: ‰ means *per 1,000* and it is **not** a percentage.

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 effective medicines reviews for patients on repeat medicines. 1	N <sup>1</sup>
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing. 2	N <sup>2</sup>
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 and Improvement 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.	Y
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 <sup>3</sup>
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. The records of patients prescribed certain high-risk medicines were checked to ensure the required monitoring was taking place. These searches were visible to the practice.</p> <p>Although the practice had a written protocol for repeat prescribing of medicines which needed monitoring, we found it had not been implemented effectively. For example, we found clinical staff had not followed protocols to ensure they are able to view monitoring information, and document that they have looked at those results and determined it was safe to prescribe.</p> <p><b>Medicine Reviews</b></p> <ol style="list-style-type: none"> <li>1. The practice had a written protocol for repeat prescribing of medicines which needed monitoring, however, managers did not have an effective system to check that prescribers were following the protocol. At this inspection, not all staff were properly checking that monitoring was up to date and that it was safe to issue a prescription. There was no indication in some patient's clinical records (which would be good practice) that the results of a test were considered when issuing a prescription and there was no explanation in the clinical record for departing from the current national prescribing guidance. This meant care and treatment did not always reflect prescribing standards and best practice to keep patients safe.</li> </ol> <p><b>High Risk Medicines</b></p> <ol style="list-style-type: none"> <li>2. Some patients on high-risk medicines whose records we looked at had not had appropriate monitoring completed.</li> </ol> <p><u>Lithium monitoring</u></p> <p>The clinical searches identified a total of 20 patients prescribed lithium. Of these we identified 6 patients who appeared to be overdue appropriate monitoring. We sampled 5 of these and found that there were problems with the care for 2 patients. One patient was overdue monitoring of lithium level and renal, thyroid and calcium level tests and a prescription was issued. We saw blood tests had been requested for this patient shortly before our inspection. For one of these patients there was no record of an up-to-date calcium blood test but a prescription had been issued. NICE recommended monitoring for practice prescribed lithium is that levels should usually be measured every 3 months. Recommended monitoring of renal, thyroid and calcium function tests is every 6 months. The provider was not able to demonstrate that it remained safe to prescribe medicines to patients where specific, frequent, monitoring was required.</p> <p><u>Disease-modifying antirheumatic drugs (DMARDs) Methotrexate</u></p> <p>Of 24 patients prescribed methotrexate (a medicine used to suppress the immune system), we identified 10 patients who did not have a record of the required monitoring. We reviewed a sample of 5 patient records and found there was no documentation in the local record that the required monitoring had been done, in the last 6 months. This was not in line with NICE recommended monitoring guidelines.</p> <p>There was evidence that four of these patients had been asked to make an appointment for blood tests but there was no record in the notes that these patients had the tests. There was no evidence in the records that prescriber checked monitoring was up to date prior to issuing prescription. There was no record in the</p>	



notes of any monitoring that was done in secondary care/outpatients department clinic. Although the practice had a recall system, there was no mechanism to capture monitoring if done elsewhere. This meant that care and treatment did not always reflect prescribing standards and best practice to keep patients safe. At the time of our remote records review, the senior GP partner reviewed two of these patient records and found that blood tests had been done in hospital and were available on the shared secondary care results portal (CERNER).

The dose of methotrexate medicine prescribed for the patients we identified, did not specify a day of the week to take the medicine, to reduce the risk of dosing errors and potentially fatal overdose. This was not in line with current national prescribing guidance.

### Antimicrobial prescribing

3. The service was aware of their overall antimicrobial prescribing. Staff followed prescribing guidelines and monitored antimicrobial prescribing practice. Indicators highlighted a positive variation in the practice's prescribing of antibacterial prescription items per STAR-PU and tended towards a positive statistical variation in the prescribing of broad-spectrum antimicrobials. These indicators demonstrated good antimicrobial stewardship. Antibiotics are used to treat infections caused by bacteria.

Following our inspection, we asked the practice to complete a review of all patients where concerns had been highlighted during the inspection. Where our searches had identified gaps in monitoring, the practice was able to provide evidence that patients had been recalled for monitoring and there was a clear plan in place to follow up those patients who had not attended.

Following our inspection, the provider took action and reviewed their prescribing policies and sent us their revised procedure for prescribing medicines that required monitoring. The provider also sent us evidence of their updated protocol for monitoring patients prescribed high risk medicines, for example, Methotrexate and Azathioprine. This included medicines prescribed under a shared care protocol where the provider had agreed to continue prescribing medicines initiated by secondary care. We saw that the updated repeat prescribing protocol included steps prescribers should take when monitoring was overdue, which included checks to do before prescribing, to see if the required monitoring had been done outside of primary care, for example, checking for blood test results on the CERNER hospital clinical report portal, and in clinical letters saved on the patient's file.

### 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:	11
Number of events that required action:	8
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> <li>There was an incident book kept in reception. All staff we spoke with were able to give us examples of significant events and subsequent learning. Staff documented action taken and learning points were logged and discussed at practice meetings. The practice had a system in place to review significant events monthly.</li> </ul>	

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

Event	Specific action taken
Patient contacted practice when staff had prescribed a medicine they were allergic to.	Notes were not coded correctly. Duty GP was asked to call and speak to patient. Patient given verbal apology. Allergy was coded in patient record. Reminder sent to all clinicians to check whether patient has any allergies and check it is safe to prescribe.
Patient did not receive test results following sample taken.	Patient contacted to tell them they had been told that they had a notifiable disease. Laboratory report went to the clinician but patient was not told by the practice about the result. Lead GP called patient to apologise and discuss the incident.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts. 1	P <sup>1</sup>
Staff understood how to deal with alerts.	Y
Explanation of any answers and additional evidence: <ol style="list-style-type: none"> <li>The practice had a safety alert policy. Staff showed us the tracker used to log MHRA/CAS safety alerts and log what action was taken. The clinical lead at the service was responsible for ensuring that any actions needed were completed within the required timeframe. However, the practice was unable to demonstrate that all relevant safety alerts had been responded to. For example, we saw that patients remained on combinations of medicines that increased their risk of health problems without anything in their records to indicate this had been identified and the risk discussed with the patient or alternative treatments considered. Our CQC clinical searches identified patients receiving treatment, which was the subject of a Medicines and Healthcare products Regulatory Agency (MHRA) safety alert issued more than three years ago. (MHRA alert published December 2016);</li> <li>Of 86 patients prescribed potassium sparing diuretics and ACEi/ARB medicines, the clinical searches identified 45 patients who had potentially not had U+Es blood monitoring in last six months. We reviewed 5 of these patients and found potential concerns for all 5 patients. All 5 patients were</li> </ol>	

prescribed a combination medicine (aldosterone antagonist and ACEi/ARB). Monitoring is essential for patients prescribed these medicines as there is a risk of developing renal failure that can cause cardiac arrhythmias. All 5 records showed required monitoring tests were overdue and there was no record in the notes of any monitoring that was done in secondary care. There was no discussion of risks documented. Not providing this information to patients could put them at risk of serious side effects of these medications as they may not seek help early enough. There was evidence that bloods had been requested but there were no follow up actions documented for the patients who had not engaged with the practice. . However, we found no evidence of patient harm.

- These findings were raised with the lead GP who informed us that they checked all five patients records and found that three patients had blood tests done in secondary care. Following our inspection, the lead GP told us that tests done in secondary care had been coded in the patient records. Bloods were requested for two patients who had not engaged with the practice and quantities of medicines prescribed had been reduced and a note added to the prescription.

Following this inspection, we asked the practice to complete a review of all patients where concerns had been highlighted. The practice confirmed an SMS text message with information of the risks of this combination medicine, was sent to all patients. Where our searches had identified gaps in monitoring, the practice was able to provide evidence that patients had been recalled for monitoring tests and there was a clear plan in place to follow up those patients who had not attended.

## Effective

## Rating: Requires improvement

*QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.*

**At this inspection, the practice is rated as requires improvement for providing effective services because;**

- We found that physical health monitoring was not effective. Records we reviewed showed some patients had not received appropriate monitoring and follow up, in line with current evidence-based guidance.
- The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles. The system to monitor staff mandatory training was not effective. We found gaps in records of staff training.

- The practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice.
- Childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were meeting the target in one area and below the target of 90% in five areas and below 80% in one area where childhood immunisations are measured. The practice was aware that performance needed to improve and had an action plan.
- The practice had not demonstrated it had an effective strategy to improve their performance for cervical screening which was lower than CCG and England averages.
- There was evidence of improvements made through quality improvement activities.

#### Effective needs assessment, care and treatment

**Patients' needs were not assessed, and care and treatment was not always 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.	N <sup>1</sup>
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	N <sup>2</sup>
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 had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
Explanation of any answers and additional evidence:	
<p>1. Patients presenting with symptoms that could indicate serious illness were not always followed up in a timely way. For example, the provider could not demonstrate that patients with abnormal HbA1c results received appropriate follow-up or were signposted to support for their condition. Our search identified 5 patients as having a potential missed diagnosis of diabetes. Four out of 5 patients had been appropriately coded as prediabetic. However, there was no recent HbA1c result recorded, and it was not known if these patients have diabetes. There were several requests for blood tests, but these had not</p>	

been acted upon by patients and not followed up by a clinician. We found that national guidelines were not always being followed in response to blood test results.

2. Patients' treatment was not always regularly reviewed and updated. Our clinical searches identified a small number of patients that were overdue monitoring for certain medicines, medication reviews and long-term condition reviews.

## Effective care for the practice population

### Findings

#### Medicines Usage – Gabapentin

- The service had a written protocol for repeat prescribing of medicines which needed monitoring, however, clinicians had not followed the protocol to ensure appropriate monitoring and prescribing has been carried out. For example, the clinical search identified a total of 156 patients prescribed gabapentin who have not had a review in last 12 months. From these we reviewed 5 records, of which 3 were not reviewed in line with national guidance, which would involve consideration of treatment options, referral for further management and regular monitoring of their condition to prevent long term harm. There was no record of attempts to contact these patients and no evidence of a follow up protocol. Therefore, they were not always reviewed in line with national guidance, which would involve regular monitoring and review, to prevent long term harm.  
This finding was raised with the lead GP who subsequently informed us that the 3 patients identified had been reviewed and monitoring for these patients was up to date. In addition, the provider told us they had blocked out the pharmacist's time for the remainder of the month to complete all medicine reviews.
- The practice routinely identified older patients who were living with or at risk of moderate or severe frailty. They worked with a multi-disciplinary team to undertake full assessment of their physical, mental, and social needs.
- Vulnerable patients could be referred to a social prescriber who worked closely with the service and provided support, guidance or help with issues including benefits, housing and social isolation.
- 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.
- 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.
- A pharmacist employed by the Primary Care Network (PCN) supported the management of patients with long term conditions and carried out medicine reviews and made referrals to preventative care.
- All patients with a learning disability were offered an annual health check. The practice kept a register of patients with a learning disability and there were alerts on medical records to help staff identify patients when they contacted the practice.
- 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 main site of the south-east London Special Allocation Service (SELSAS) was based at the Novum Rushey Green Group Practice. The SAS service was provided by Downham Health & Leisure Centre. SAS patients received care and treatment from clinical and non-clinical staff employed by the host NHS GP provider, Novum Health Partnership. We did not inspect the SAS service as part of this inspection.
- The practice had over 500 patients on the long-term Mental illness (LTMI) register. The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder.
- Patients with poor mental health, including dementia, were referred to appropriate services.

## Management of people with long term conditions

### Findings

In the absence of QOF data, the inspection team reviewed results from some additional searches of the clinical records to support the review of long-term condition management.

- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- The practice teams were supported by the PCN pharmacy hub. The pharmacy team supported the practices with repeat prescription queries and provided patients with chronic conditions with medication reviews.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- 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 COPD were offered rescue packs.

As part of our inspection a number of set clinical record searches were undertaken by a CQC GP specialist advisor. Records we reviewed showed some patients had not received monitoring or appropriate follow up, in line with current evidence-based guidance;

#### 1. Management of people with long term conditions

##### Chronic Kidney Disease Stages 4 or 5

The provider could not demonstrate that patients with Chronic Kidney Disease Stages 4 or 5 received the required monitoring. There were 58 patients in total with CKD 4 or 5. The clinical searches identified 28 patients who have not had U+E monitored in the last 9 months. We looked at a sample of 5 patient records. One patient was receiving care under the renal team. Three patients were receiving kidney dialysis. We found monitoring was overdue for 1 housebound patient. Patients were not always reviewed in line with national guidance, which would involve regular monitoring and review, to identify any deteriorating patients and prevent potential long term harm.

##### Hypothyroidism - levothyroxine monitoring



The provider could not demonstrate that patients prescribed levothyroxine received the appropriate monitoring. There were 400 patients in total with hypothyroidism prescribed levothyroxine in last 6 months and 23 were not monitored appropriately (within 18 months). We looked at a sample of 5 patients and found 4 patients had not had a medication review coded in the last 12 months and there was no evidence monitoring had been checked before issuing the last prescription. Patients prescribed levothyroxine must be monitored regularly to avoid under and over-treatment which can cause adverse effects.

Following our inspection, we asked the GP to check all these patients. The GP told us they had contacted all the patients for review and where appropriate, patients would be invited for tests and review. The GP Partner accepted that recording of blood tests needed to improve and also that recording of monitoring results done in secondary care, needed improvement. The provider also took action and reviewed their prescribing policies and sent us their revised procedure for prescribing medicines that required monitoring.

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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	232	270	85.9%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	229	282	81.2%	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) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	228	282	80.9%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	228	282	80.9%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	214	272	78.7%	Below 80% uptake

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**



- As shown in the table above, childhood immunisation uptake rates were still below the World Health Organisation (WHO) targets. Uptake rates for the vaccines given were below the target of 95% in all of the five areas where childhood immunisations are measured.
- A report published by the UK Health Security Agency (October 2021) showed that childhood immunisation uptake rates declined in England following the COVID-19 pandemic during 2020 and 2021 although practices continued to offer immunisations throughout the pandemic.
- We asked the service what they had done to improve uptake of childhood immunisations. The practice was aware of the low uptake and shared their action plan to improve uptake which included:
  - The service had put a call/recall protocol in place, for patients who were due childhood immunisations.
  - Allocated staff run regular searches and call parents / guardians to book appointments and send reminder letters to parents / guardians who were not contactable by phone.
  - Signed up to Accurx messenger app to promote call and recall to patients for immunisations.
  - Offered immunisation appointments with a nurse at GP Extended Access.
  - Parents who declined vaccinations were offered a consultation with the practice nurse to discuss their concerns.
  - The service 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 to follow up when necessary.

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	46.8%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	55.6%	N/A	70.3%	N/A
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (3/31/2023 to 3/31/2023) (UKHSA)	64.3%	N/A	80.0%	Below 70% uptake
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	56.3%	50.7%	54.9%	No statistical variation

#### Any additional evidence or comments

As shown above, in 2023 the practice was below the 80% coverage target for the national cervical screening programme (as measured by Public Health England). We asked the practice what they had done about low uptake to encourage greater coverage. The provider was aware of the lower achievement in cervical cancer screening.

The practice had discussed the low scores during their clinical team meetings and had taken action to follow up

all women who had not had cervical screening. Staff ran searches and contacted the patient and invited all those overdue cervical screening to make an appointment. All non-attenders were flagged on the medical records and staff called all patients who did not attend to have a further discussion. Screening was also offered opportunistically.

All staff eligible to perform cervical cytology screening had received up to date training and patients had access to female screening takers. Women were offered cervical screening appointments at different times during the week and outside of working hours. Patients were directed to the extended access service where they could have a nurse led screening appointment. Patients could self-book an appointment using Accurx.

The sample taker audited their inadequate cytology rates and had a system of follow up to recall patients for a second test.

### Monitoring care and treatment

**There was quality improvement activity and the practice routinely reviewed the effectiveness and appropriateness of the care provided.**

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice was conducting quality projects and audits. We saw examples of clinical audits that had been carried out in the last 2 years.</p> <p><b>Hypertension:</b> An audit to assess the quality of care and blood pressure control among persons with hypertension. The audit identified uncoded patients and increased numbers by 66 to the hypertension register. The register is a measure of the prevalence of hypertension in patients that has been recorded by the GP.</p> <p><b>CKD coding:</b> A coding issue was identified, and staff were tasked to contact patients with CKD 3 to discuss diagnosis, offer advice and review blood pressure.</p> <p><b>High dose morphine and Z drugs;</b> The provider had audited analgesic use particularly gabapentin and pregabalin. (Gabapentin and pregabalin are Schedule 3 controlled drugs and widely used to treat chronic pain). We looked at the minutes of three meetings with GPs and other clinical staff and saw examples of audits being discussed.</p>	
<b>Any additional evidence or comments</b>	

### Effective staffing

**The practice was unable 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.	N <sup>1</sup>
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
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.	N <sup>2</sup>
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
<p>Explanation of any answers and additional evidence:</p> <p>1. The practice was unable to demonstrate that staff had the skills, knowledge and experience to carry out their roles. We checked how managers identified the learning needs of staff, and whether staff had the appropriate training to meet these needs and cover the scope of their work. We looked at the training matrix tool used to monitor staff mandatory training but found it was not effective. The practice could not evidence staff completion of training at an appropriate level and did not have a system to flag in an effective way when training was coming due for renewal. We checked 5 staff files and found gaps in staff mandatory training. For example, of the 5 staff files we reviewed, Two did not have training in safeguarding (adult and children).</p> <p>Two out of 5 did not have training in Basic Life Support, infection control, information governance, and fire safety training.</p> <p>One member of clinical staff did not have Mental Capacity Act training.</p> <p>One member of non-clinical staff had not completed chaperone training.</p> <p>One member of non-clinical staff had not completed equality and diversity training.</p> <p>We discussed this with managers who explained that the current online training matrix only showed completed mandatory training from when the Primary Care Network (PCN) had paid for the practice to start using a new online eLearning platform. (We understood from staff that the PCN provided the funding in July 2023). Our understanding when we spoke with managers was that some mandatory training completed on the old eLearning platform may still have been relevant and within the required frequency. However, from the records we reviewed on the day, we were not able to tell whether staff were up to date or overdue with mandatory training. We were not assured that all staff had received appropriate training essential for their roles.</p> <p>Following our inspection, we asked managers to set out how leaders will manage and improve the system for monitoring mandatory training so that accurate records of staff information and training are maintained at the practice. The provider told us they had implemented a system to bring all staff training data on to one online elearning platform. The platform provided automated alerts for when training was becoming due.</p>	

2. The practice could not demonstrate how they assured the competence of staff employed in advanced clinical practice. For example, we looked at staff recruitment records but found no evidence of a check of the GP Performers List (the framework that assures GPs are qualified and competent to provide safe and effective primary medical care), for one salaried GP. We also found there was no check that registration was current for one practice nurse.

### Coordinating care and treatment

**Staff worked together and with other organisations to deliver effective care and treatment.**

	Y/N/Partial
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
Explanation of any answers and additional evidence:	

### 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 and tackling obesity.	Y
Explanation of any answers and additional evidence:	

### Consent to care and treatment

**The practice was unable to demonstrate that it always obtained consent to care and treatment in line with legislation and guidance.**

	Y/N/Partial
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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.	N <sup>1</sup>
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate. 1	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>1. There was no record of decision about Mental Capacity recorded in 5 patient records we looked at. It was not clear in the patient records that a mental capacity assessment had been undertaken where a patient is identified as lacking mental capacity. This meant that decision making processes were not in line with the Mental Capacity Act Code of Practice. The Mental Capacity Act 2005 requires everyone who cares for or treats people with capacity issues to respect their individual rights and to act in their best interests when making decisions on their behalf.</li> <li>2. We reviewed a sample of five individual care plans of patients who have had a Do not attempt cardiopulmonary resuscitation (DNACPR) decision coded in the patient record. Our clinical review of notes identified that four out of five patient records we looked at had a documented decision and reason for the decision recorded. Discussions with patients and their families about patient wishes had been documented. However, we found one patient had not had a DNAR decision coded in the patient record.</li> </ol> <p>We raised these findings with the provider and following our inspection, the provider updated their DNAR policy, which included a clinical template showing the steps to ensure information was recorded correctly and shared with appropriate organisations.</p>	

## Caring

## Rating: Good

**We rated the practice as Good for providing caring services because;**

- The practice's GP patient survey (GPPS) results for 2023 were above local and national averages for most questions relating to care and concern from clinicians. Scores were above the national average for three of the four indicators, with the fourth indicator, which measured patients' overall experience of their GP Practice, below the national average. The practice had carried out some analysis of the GP National Patient survey patient satisfaction results.

### Kindness, respect and compassion

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

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
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:	
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### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	89.6%	83.0%	85.0%	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 (01/01/2023 to 30/04/2023)	89.0%	81.3%	83.8%	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 (01/01/2023 to 30/04/2023)	97.4%	92.2%	93.0%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	62.5%	67.3%	71.3%	No statistical variation

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

### Any additional evidence

The practice were aware of the 2023 national GP patient survey results and described the steps they had taken to improve patient experience. For example, the provider had recruited additional staff.

We noted the practice had achieved good results in the National GP Patient Survey relating to its reception staff, with 79% of respondents finding the receptionists helpful (ICS average: 80% National average: 82%).

### 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
<p>Explanation of any answers and additional evidence:</p> <p>People were encouraged to be partners in their care and in making decisions. They were communicated with and receive information in a way they could understand. People's social needs were understood.</p> <p>Practice staff spoke a range of languages and were available to assist patients for whom English was an additional language.</p> <p>Easy read, pictorial and foreign language materials were available. The practice had easy read copies of a how to make a complaint leaflet which had information on how to escalate complaints to the Parliamentary &amp; Health Service Ombudsman (PHSO).</p> <p>The practice supported and signposted patients to the most appropriate service to meet their needs. Staff supported patients through referrals to the PCN social prescriber. This included giving patients details of services such as eye care, sexual health, urgent dental care and health and social care support services.</p>	

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	93.8%	89.0%	90.3%	No statistical variation

	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.	The practice had identified 754 carers which represented 3.59% of the practice list.



How the practice supported carers (including young carers).	Staff told us they made referrals to the PCN social prescriber who would contact a carer and advise about local carers services. Staff coded carers in the patient's record. The practice offered carers flexible appointment times and invited them for a carer's health check with the GP and annual flu vaccinations.
How the practice supported recently bereaved patients.	Staff told us they provided support and signposting to specialist bereavement services.

### Privacy and dignity

**The practice respected patients' privacy and dignity.**

	Y/N/Partial
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

**We have rated the practice as requires improvement for providing responsive care because;**

We found that the practice had been proactive and taken steps to improve responsive aspects of the service. However, improvements to the appointment system were not yet reflected in patient feedback and the practice's National GP Patient Survey results were below average in three of four areas surveyed.

We recognise the pressure that practices are currently working under and the efforts staff are making to maintain levels of access for their patients. At the same time, our strategy makes a commitment to deliver regulation driven by people's needs and experiences of care. Although we saw the practice was attempting to improve access, this was not yet reflected in the GP patient survey data or other sources of patient feedback. Therefore, the rating is requires improvement, as ratings depend on evidence of impact and must reflect the lived experience that people were reporting at the time of inspection.

### Responding to and meeting people's needs

**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	
Day	Time
<b>Rushey Green Group Practice opening times:</b>	
Monday	8.00am – 8.00pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm
Saturday	9.00am – 11.00am
Sunday	Closed
<b>Baring Road Surgery opening times:</b>	
Monday	8.00am – 8.00pm
Tuesday	8.00am – 6.30pm
Wednesday	8.00am – 6.30pm
Thursday	8.00am – 6.30pm
Friday	8.00am – 6.30pm
Saturday	Closed
Sunday	Closed
Appointments available within these times	

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> <li>Patients had a named GP who supported them in whatever setting they lived.</li> </ul>

- 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. Staff were able to refer to the Home Visiting Service run by the GP federation One Health Lewisham.
- The provider had introduced a digital access tool to improve the way patients could access services. Patients were able to contact their GP practice if they had a query without having to queue on the telephone. A team of clinicians were available to respond to patient queries over chat between 9.00am and 6.00pm Monday to Friday. Patients were advised that if they did not wish to use a messaging app on their mobiles to ask questions, they could still call the surgery or visit the reception desk in person.
- We saw evidence of a Digital Inclusion Policy which included information for practice staff about people becoming digitally excluded, when digital tools become the preferred or only way of accessing health services. (Digital exclusion refers to the lack of access, skills and capabilities needed to engage with devices or digital services that help people participate in society).
- Appointments with nursing staff were available outside of school-hours.
- There was a medicines delivery service for housebound patients.
- The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- The practice was open until 8.00pm on a Monday. Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a primary care network (PCN). Appointments were available 6.30pm to 7.30pm Monday to Friday and 9.00am to 11.00am. Appointments were available on Saturday at Novum Health Partnership (Rushey Green Group Practice) 9.00am until 11.00.
- The practice held a register of patients living in vulnerable circumstances including homeless people, Travellers and those with a learning disability.
- The practice provided access to healthcare services for asylum seekers and refugees living in temporary accommodation in Lewisham.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers. To make the service more inclusive, Novum Health Partnership had signed up to be a Safe Surgery through Doctors of the World UK, this means declaring your practice a 'Safe Surgery' for everyone and ensuring that lack of ID or proof of address, immigration status or language are not barriers to patient registration.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

## Access to the service

**People were not always able to access care and treatment in a timely way.**

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	P
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y

There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>Managers told us about the challenges the practice was experiencing regarding improving access for patients. The practice monitored appointments and were aware that the last six months data showed appointments offered fell below standard of &lt;70/1000/week. Leaders told us this was a recent problem because of staffing issues. Staff told us that at the time of the launch of the digital access tool, a number of staff including clinical staff, had left the practice which had led to pressure on the appointment system. Leaders told us that 3 salaried GPs had all taken maternity leave at the same time (12 sessions). Three other salaried GPs left the practice (20 sessions). One nurse practitioner retired and a senior Physician Associate also left. At the time of our inspection, the practice had lost 1 Health Care Assistant and another HCA was absent on long term absence.</p> <ul style="list-style-type: none"> <li>• The practice showed us their action plan following the GP survey results. In the 2023 National GP Patient survey, only 36.7% of patients responded positively to how easy it was to get through to someone at the practice by phone. Access issues were regularly reviewed as part of the provider's performance improvement plan. However, there was insufficient evidence available to demonstrate the actions being taken had had the required impact and that the access issues had been resolved. For example, results showed 40.5% of respondents to the 2023 GP patient survey responded positively to the overall experience of making an appointment. We felt the service required more time to embed and monitor the effectiveness of actions taken, in order to gain assurance that patient satisfaction had improved and access to the service was appropriate.</li> <li>• In response to the low GP Patient survey results, the practice increased the number of staff answering phones at peak times and introduced a digital access tool, with the aim of reducing the number of patients calling to book appointments. The practice had scored 75% for the percentage of respondents to the 2023 GP patient survey who were satisfied with the appointment (or appointments) they were offered, which was above the National and SICBL averages. (Sub-ICB Locations(SICBL) were previously known as CCGs or Clinical Commissioning Groups). However, indicators showed a downward trend for the percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times had decreased from 58.60% in 2021 to 43.6% in 2023.</li> <li>• Managers carried out an audit of receptionist call rates and offered support to those staff who were under-performing.</li> <li>• The practice increased the number of telephone appointments between Monday and Wednesday when demand was highest and increased the number of face-to-face appointments available.</li> <li>• The practice reviewed the information and improved the options people heard while waiting in the telephone queue.</li> <li>• The practice promoted the use of NHS AskFirst App which triaged patients and allowed direct self-booking of appointments.</li> <li>• In August 2023, the practice implemented a total digital triage model. This meant patients contacting the practice first provide some information on their reasons for contact and the information is triaged before making an appointment for the patient. The practice introduced a digital access tool for patients to contact the practice. Patients were able to send questions to the practice using a messaging app on their mobile phone. A team of clinicians were available to triage questions with a response or appointment being offered on the same working day of receipt of the query, meaning that any patient contacting the practice could be appropriately advised or offered an appointment to meet their needs. The digital triage was available Monday to Friday from 9.00am to 6.00pm. Staff reported that demand</li> </ul>	

on the phone lines had reduced. Patients who were unable to use a mobile phone could call reception for the query or appointment request to be submitted on their behalf.

- Staff told us that health queries that came through from patients on the digital access tool could be converted to a face-to-face appointment. During our inspection, we saw that there was a clinic room permanently available for the duty triage GP to see a patient face to face urgently. The practice had two dedicated receptionists booking appointments following triage of patient's messages by a duty GP.
- Staff told us they listened to their patients regarding the use of technology through existing feedback channels; for example, the complaints procedure, the Patient Participation Group (PPG), and through informal comments to receptionists and practitioners.

### National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	36.7%	N/A	49.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	40.5%	49.7%	54.4%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	43.6%	50.0%	52.8%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	75.2%	66.2%	72.0%	No statistical variation

### Any additional evidence or comments

- The practice had a digital inclusion policy and understood the need for adapting access to meet diverse needs. Staff were aware that some patients may suffer from 'absolute' digital exclusion. For example, a homeless patient who has had their mobile phone stolen, or a patient with dementia.
- Receptionists had been trained to show people how to use the online triage tool on their mobile phones. Staff told us that if a patient told the practice they do not use a mobile phone, a note to this effect would be placed on the patient's record.
- The practice had taken action to inform all patients about the change to appointment booking before implementing the online digital triage tool.

- We saw evidence of how the service communicated the ways people can access the service. For example, the practice arranged for a recorded message to play when a patient calls the practice which informs the patient about how to access the digital online triage tool. We saw notices at the entrance to the reception area, informing people about ways they can access appointments.
- There was information on the practice website about how to contact the practice.
- The PPG told us that patients had received information by text about the different ways people can access appointments. The PPG chairperson had met with the practice and given feedback about communicating in different ways with patients. The PPG told us the discussion was positive and the practice was planning to make a real-life video with southeast London ICB about using the new online triage tool.
- The GP Partner told us they were monitoring feedback from clinicians who triage queries that came through from patients on the digital access tool. The GP Partner told us they planned to do a survey of staff who were implementing the online triage tool.

Source	Feedback
NHS.uk website (formerly NHS Choices)	There were 21 comments in the last 12 months. Positive comments included feedback that staff were kind and helpful. There were 10 positive comments about the digital access tool and people said their queries were answered quickly. Negative comments included feedback about issues with speaking with receptionists over the phone and that some receptionists were rude and unhelpful.

## 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.	18
Number of complaints we examined.	18
Number of complaints we examined that were satisfactorily handled in a timely way.	18
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Example(s) of learning from complaints.

Complaint	Specific action taken
Prescription medicine was missing from repeat prescription request made by patient. Patient complained that staff had not apologised about delay.	Staff investigated complaint. Sent an apology to the patient. Staff checked prescriptions and found medicine had been requested on patient access but it was missed by GP. Staff directed patient to request script via prescription email via website.

# Well-led

# Rating: Requires improvement

We have rated Well Led as Requires improvement because some systems designed to keep people safe were not operating effectively in particular;

- There were systems in place for monitoring patients, but people did not always receive appropriate physical health monitoring and treatment in accordance with national guidance.
- Leaders could not show that they had the capacity and skills to deliver safe and effective care as they did not have adequate oversight of risks within the organisation.
- The overall governance arrangements were ineffective, especially the arrangements for overseeing the management of risk to ensure safety and for ensuring that policies were implemented effectively. For example, the provider did not have oversight that clinicians had checked that required monitoring had been done, before issuing prescriptions.
- Staff provided positive feedback about working at the practice which indicated that there was a good working culture. Learning was shared effectively and used to make improvements.
- Leaders responded promptly to concerns identified when we informed them of the areas where things could be improved.

## Leadership capacity and capability

There was compassionate and inclusive leadership at all levels. However, there were areas where leaders could not demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	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.	N <sup>1</sup>
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:  1. The provider demonstrated awareness of challenges to delivering care. For example, following an unexpected staffing crisis in February 2023, leaders developed a staffing and recruitment plan to address issues with capacity and prioritise patient care and protect the wellbeing of practice staff.	



Leaders told us that three salaried GPs had left the practice (20 sessions), and one senior Physician Associate had left, and one Practice Nurse had retired. At the time of our inspection, three salaried GPs were all on maternity leave (12 sessions).

Leaders told us they had successfully been able to appoint a new GP partner and one salaried GP returned as a locum. Leaders told us that they had engaged four regular bank GP locums, through a workforce management platform. The practice had also recruited a new Practice Nurse and five new full time physician associates to support the online digital triage hub. However, there were certain challenges associated with staff training and administration of staff recruitment records which leaders did not have oversight of.

## Vision and strategy

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

	Y/N/Partial
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y <sup>1</sup>
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	N <sup>2</sup>
<p>Explanation of any answers and additional evidence:</p> <ol style="list-style-type: none"> <li>Leaders had developed a core set of values with members of practice staff. The practice values were; <ul style="list-style-type: none"> <li>We care for the wider community, including people who might be excluded elsewhere.</li> <li>We don't discriminate.</li> <li>We are diverse.</li> <li>We respect people with diverse needs and backgrounds.</li> <li>We accommodate everyone and adapt to their needs.</li> </ul> </li> <li>There was a lack of understanding or oversight of key areas of risk, particularly related to clinical governance and oversight which compromised the quality of care provided by the organisation. The practice leaders had not established information systems that allowed them to oversee systems and processes intended to keep people safe and to ensure compliance with guidelines.</li> </ol>	

## Culture

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

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	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 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: <ul style="list-style-type: none"> <li>The practice was a Disability Confident Employer (Level 2). Disability Confident is a government initiative designed to encourage employers to recruit and retain disabled people and those with health conditions. (Under the Equality Act 2010, a disability is defined as a physical or mental condition which has a long-term and substantial effect on your daily life).</li> </ul>	

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

Source	Feedback
Staff feedback	<p>Staff we spoke to felt positive about working at the practice and felt supported. They told us:</p> <ul style="list-style-type: none"> <li>Staff told us they had access to training, development opportunities and effective managerial support at the practice.</li> <li>Policies and procedures were maintained in an organised way and easily accessible to staff.</li> <li>There was a whistleblowing policy and staff knew how to contact the practice's Freedom to Speak Up Guardian.</li> <li>Staff felt confident about giving feedback and that managers would act on feedback they received from staff.</li> <li>There was structure in place in terms of meetings and sharing of learning with staff.</li> <li>Practice partners promoted an Open-door policy to all staff.</li> <li>The leaders were described as approachable and responsive to ideas.</li> </ul>

	<ul style="list-style-type: none"> <li>Staff consistently told us that the practice ethos was to provide a caring service for patients.</li> </ul>
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## Governance arrangements

**The overall governance arrangements were ineffective.**

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N <sup>1</sup>
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence:  1. The overarching governance framework had not ensured that systems and processes were operating effectively. Risks that could threaten the delivery of safe and effective care were not always identified and managed. For example, it had not appropriately addressed concerns in relation to systems to review physical health monitoring with appropriate follow-up. The practice leaders had not identified all of the actions necessary to ensure that care would continue to be delivered safely to patients. The system to monitor staff mandatory training was not effective. Safety alerts were not always managed effectively to keep patients safe. Although there was a process for managing MHRA safety alerts, the provider lacked oversight of how actions were identified and followed up.	

## Managing risks, issues and performance

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

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N <sup>1</sup>
There were processes to manage performance.	Y
There was a quality improvement programme in place.	Y
There were effective arrangements for identifying, managing and mitigating risks.	N <sup>2</sup>
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:	

1. Assurance systems had not ensured that processes such as medication reviews and patient monitoring were being reviewed regularly and were operating as intended. For example, risks in relation to patients who required monitoring for their conditions had not been identified by the provider's own governance systems. Patients' treatment was not always regularly reviewed and updated which could put patients at risk of potential harm. The practice had a written protocol for repeat prescribing of medicines which needed monitoring, however, clinicians had not always followed the protocol to ensure appropriate monitoring and prescribing had been carried out. When we raised our concerns with leaders, they acknowledged that this needed improvement and following our remote records review on 10 October 2023, had sent us a written response of follow up actions taken for all the patients flagged in our findings.
2. Risks identified within the practice were not sufficiently well managed. For example, the practice could not demonstrate the effectiveness of the system to ensure all staff have received appropriate recruitment checks. There was insufficient recording of recruitment checks and information had not been sourced. It was not clear that managers had identified and addressed gaps in staff recruitment records.

Following our inspection, the provider reviewed their prescribing policies and sent us their revised procedure on prescribing medicines that require monitoring. The provider also sent us evidence of their updated protocol for monitoring patients prescribed high risk medicines, for example, Methotrexate and Azathioprine.

### Appropriate and accurate information

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

	Y/N/Partial
Staff used data to monitor and improve performance.	P <sup>1</sup>
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence:  1. There was a demonstrated commitment to using data and information proactively to drive and support decision making but the systems for managing patients taking medicines which required monitoring, needed improvement. For example, the practice did not have systems in place to ensure that prescribers had documented consideration of information prior to prescribing high risk medicines. Patients' treatment was not always regularly reviewed and updated in a timely way which could put patients at risk of potential harm.	

### Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y

Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence:	

### 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 <sup>1</sup>
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
<p>Explanation of any answers and additional evidence:</p> <p>1. The provider had reviewed the results of the national GP patient survey and feedback from their in house survey and had an action plan to improve patient experience. The provider informed us that they had also updated their appointments system following patient feedback. The provider had a dedicated team that focused on support for patients and linking patients up with local services to help manage their conditions.</p> <p>At the time of the inspection, the practice shared the feedback they had received from its patient participation group (PPG) and from formal complaints. We saw evidence that the practice responded to patient views. It had engaged with patients when the digital access tool went live. We saw complaints were responded to, and themes analysed to inform improvements.</p>	

Feedback from Patient Participation Group.

Feedback

The PPG chair person had met with the practice and given feedback about communicating in different ways with patients. The PPG told us the discussion was positive and the practice was planning to make a real life video about using the new online appointment access app.

- The practice shared and discussed the results of the GP Patient Survey with PPG members.
- The practice has supported people in how to use the online appointment access app.
- The practice GPs regularly attended the PPG meetings, and the provider kept the PPG informed about the changes at the practice.
- The practice had made information available on the practice website for people who wanted to join the PPG.
- The practice discussed any learning from complaints and incidents.

### Continuous improvement and innovation

**There was 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
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> <li>• The practice had a plan as to the areas where quality improvement was needed and how this would be achieved. However, leaders did not have full oversight of the areas of concern we identified. Some improvement actions were in progress and had not yet been completed. The practice had planned for recovery from the pandemic and was responding to patient feedback about accessing appointments.</li> <li>• There was an annual staff survey. The practice leaders reviewed this and used it to identify areas for improvement. There was evidence that leaders had listened to staff feedback and made changes although leaders acknowledged that there were still areas they need to improve on. For example, following staff survey feedback, leaders improved the training available for practice receptionists.</li> <li>• The practice was an accredited training practice and had two GP trainers.</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)	≤-3
Variation (positive)	>-3 and ≤-2
Tending towards variation (positive)	>-2 and ≤-1.5
No statistical variation	<1.5 and >-1.5
Tending towards variation (negative)	≥1.5 and <2
Variation (negative)	≥2 and <3
Significant variation (negative)	≥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 persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for those aged 25 to 49, and within 5.5 years for those 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.
- **UKHSA:** UK Health and Security Agency.
- **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.
- ‰ = per thousand.