

Care Quality Commission

Inspection Evidence Table

The Roehampton Surgery (1-543871326)

Inspection date: 11 September 2018

Date of data download: 15 August 2018

Please note: Any Quality Outcomes Framework (QOF) data relates to 2016/17.

Effective

Effective needs assessment, care and treatment

| Prescribing | | | | |
|--|----------------------|-------------|-----------------|----------------------------------|
| Indicator | Practice performance | CCG average | England average | England comparison |
| Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2017 to 31/03/2018) (NHSBSA) | 4.61 | 0.81 | 0.84 | Significant Variation (negative) |

Any additional evidence or comments

The practice were aware of the higher hypnotic prescribing rates. Their population included patients from three care homes and they were in the process of reviewing this with the Clinical Commissioning Group pharmacist to reduce prescribing of these medicines. As an initial step the practice were not prescribing these medicines new and those that had been prescribed it previously were given short period acute prescriptions where clinically indicated.

People with long-term conditions

| Diabetes Indicators | | | | |
|---|--|----------------------------|---------------------------------|---------------------------------|
| Indicator | Practice performance | CCG average | England average | England comparison |
| The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 68.7% | 72.9% | 79.5% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) 2.5% (9) | CCG Exception rate 7.9% | England Exception rate 12.4% | |

| Indicator | Practice performance | CCG average | England average | England comparison |
|--|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2016 to 31/03/2017) (QOF) | 66.4% | 72.5% | 78.1% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 3.3% (12) | 6.8% | 9.3% | |

| Indicator | Practice performance | CCG average | England average | England comparison |
|---|--|--------------------|------------------------|----------------------|
| The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2016 to 31/03/2017) (QOF) | 65.5% | 73.8% | 80.1% | Variation (negative) |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 5.8% (21) | 8.2% | 13.3% | |

| Other long term conditions | | | | |
|--|--|--------------------|------------------------|---------------------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2016 to 31/03/2017) (QOF) | 81.9% | 76.8% | 76.4% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 1.4% (3) | 2.6% | 7.7% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 90.5% | 91.9% | 90.4% | Comparable with other practices |

| | | | |
|-----------------------|---|---------------------------|-------------------------------|
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |
| | 8.7% (6) | 6.9% | 11.4% |

| Indicator | Practice | CCG average | England average | England comparison |
|---|-----------------|--------------------|------------------------|---------------------------------|
| The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2016 to 31/03/2017) (QoF) | 81.9% | 80.7% | 83.4% | Comparable with other practices |

| | | | |
|-----------------------|---|---------------------------|-------------------------------|
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |
| | 2.3% (14) | 2.8% | 4.0% |

| Indicator | Practice | CCG average | England average | England comparison |
|------------------|-----------------|--------------------|------------------------|---------------------------|
|------------------|-----------------|--------------------|------------------------|---------------------------|

| | | | | |
|---|-------|-------|-------|----------------------|
| In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2016 to 31/03/2017) (QoF) | 70.0% | 85.6% | 88.4% | Variation (negative) |
|---|-------|-------|-------|----------------------|

| | | | |
|-----------------------|---|---------------------------|-------------------------------|
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate |
| | 3.2% (3) | 7.5% | 8.2% |

Any additional evidence or comments

Unverified data on the day of the inspection showed that the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months was 71% so far in the first 6 months of the 2018/19 achievement year.

Unverified data for 2018/19 showed that the percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 65% which was on track for surpassing the achievement for current published data for 2016/17.

The practice were not able to provide unverified 2017/18 QoF data on the inspection day.

Families, children and young people

| Child Immunisation | | | | |
|---|------------------|--------------------|-------------------|---------------------------------|
| Indicator | Numerator | Denominator | Practice % | Comparison to WHO target |
| The percentage of children aged 1 who have completed a primary course of immunisation | 47 | 58 | 81.0% | Below 90% minimum |

| | | | | |
|---|----|----|-------|--|
| for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)(i.e. three doses of DTaP/IPV/Hib) (01/04/2016 to 31/03/2017)(NHS England) | | | | (variation negative) |
| The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2016 to 31/03/2017) (NHS England) | 36 | 53 | 67.9% | Below 80% (Significant variation negative) |
| The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2016 to 31/03/2017) (NHS England) | 37 | 53 | 69.8% | Below 80% (Significant variation negative) |
| The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2016 to 31/03/2017) (NHS England) | 37 | 53 | 69.8% | Below 80% (Significant variation negative) |

Any additional evidence or comments

Unverified data on the day showed that achievements submitted in April 2018 for 2017/18 showed an increase in all four indicators for childhood immunisations. Although the data was unverified, the practice had received payment for the targets they had reached.

Data showed:

The percentage of children aged 1 who have completed a primary course of immunisation had improved to 90%; the percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) had improved to 78% and the percentage of children aged 2 who have received immunisation for measles, mumps and rubella had improved to 74%.

Working age people (including those recently retired and students)

| Cancer Indicators | | | | |
|--|----------|-------------|-----------------|----------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2016 to 31/03/2017) (Public Health England) | 57.8% | 66.8% | 72.1% | Variation (negative) |
| Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (PHE) | 57.0% | 60.5% | 70.3% | N/A |
| Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(PHE) | 47.7% | 47.6% | 54.5% | N/A |

| | | | | |
|---|-------|-------|-------|---------------------------------|
| The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (PHE) | 83.3% | 79.9% | 71.2% | N/A |
| Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2016 to 31/03/2017) (PHE) | 26.3% | 51.5% | 51.6% | Comparable with other practices |
| Any additional evidence or comments | | | | |
| Unverified data submitted for 2017/18 showed that cervical screening uptake had increased to 65%. | | | | |

People experiencing poor mental health (including people with dementia)

| Mental Health Indicators | | | | |
|--|---|---------------------------|-------------------------------|---------------------------------|
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 75.9% | 89.8% | 90.3% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 2.5% (2) | 8.1% | 12.5% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 98.8% | 89.4% | 90.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 1.2% (1) | 6.4% | 10.3% | |
| Indicator | Practice | CCG average | England average | England comparison |
| The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 80.6% | 83.5% | 83.7% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 5.6% (4) | 4.9% | 6.8% | |

Monitoring care and treatment

| Indicator | Practice | CCG average | England average |
|---|----------|-------------|-----------------|
| Overall QOF score (out of maximum 559) | 508 | 535 | 539 |
| Overall QOF exception reporting (all domains) | 2.7% | 4.3% | 5.7% |

| Any additional evidence |
|---|
| <p>QoF data</p> <p>In 2015/16 the practice achieved 83% of the total number of points available. This was below the local clinical commissioning group (CCG) average of 94% and the national average of 95%.</p> <p>The practice overall exception reporting rate for 2015/16 was 3% which was in line with the CCG average of 4% and the national average of 6%.</p> <p>The practice had achieved 90.9% of the total number of points available in 2016/17 which was also below the local CCG average of 95.7% and national average of 96.6%.</p> |

Helping patients to live healthier lives

| Indicator | Practice | CCG average | England average | England comparison |
|--|--|--------------------|------------------------|---------------------------------|
| The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2016 to 31/03/2017) (QOF) | 91.7% | 94.6% | 95.3% | Comparable with other practices |
| QOF Exceptions | Practice Exception rate (number of exceptions) | CCG Exception rate | England Exception rate | |
| | 0.4% (5) | 0.6% | 0.8% | |

Well-led

Leadership capacity and capability

Examples of how leadership, capacity and capability were demonstrated by the practice

The partners and managers were knowledgeable about the challenges in relation to diabetes management, cervical screening and childhood immunisations uptake and hypnotic prescribing. They had prioritised these areas for improvement and implemented action plans.

The partners and two administrative managers worked cohesively to deliver and improve the service. Staff felt that all those in lead roles were approachable and supportive.

Vision and strategy

Practice Vision and values

There was no documented business plan but there was a vision to improve the quality of service in relation to performance data, enhancing the Patient Participation Group (PPG) and refining the governance structure. There were clear objectives documented in action plans seen on the inspection day.

Culture

Examples that demonstrate that the practice has a culture of high-quality sustainable care

Staff reported that the partners provide on-going day to day informal support. Staff reported that they could raise any issues and it was encouraged informally or in practice meetings.

Staff were actively encouraged to attend role-specific training. The office manager and operations manager were both in the process of applying for practice management training and were fully supported by the partners to undertake this.

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

| Source | Feedback |
|------------------|--|
| Staff interviews | <p>Since the previous inspection staff reported they had worked hard as a team to make improvements and they felt the improvements had been sustained.</p> <p>Staff reported they had all worked at the service for many years and were committed to making the improvements.</p> <p>Staff reported they felt respected and valued and there was an 'open-door' policy</p> |

Governance arrangements

Examples of structures, processes and systems in place to support the delivery of good quality and sustainable care.

| | |
|----------------------------|--|
| Practice specific policies | Policies contained in a physical folder for staff to refer to and hard copies were available electronically. |
|----------------------------|--|

| | |
|---|--|
| Other examples | Structured meeting arrangements including an all staff meeting and a clinical meeting. Management and governance discussions were included in the clinical meetings. |
| | Y/N |
| Staff were able to describe the governance arrangements | Y |
| Staff were clear on their roles and responsibilities | Y |

| |
|--|
| Any additional evidence |
| <p>There were clear lines of accountability in relation to administrative workflow processes, safeguarding, infection control, recall systems, performance data and clinical governance.</p> <p>Some aspects of practice management did not have clear governance arrangements, for example health and safety was monitored by one partner and the two administrative managers so it was not clear who would lead on ensuring actions were completed.</p> <p>However, staff felt that since the last inspection, there was more clarity around their roles and governance arrangements had improved.</p> |

Managing risks, issues and performance

Examples of actions taken to address risks identified within the practice

| Risk | Example of risk management activities |
|---|--|
| Carpets and sinks in clinical rooms need replacing | Identified from the infection control audit and health and safety risk assessments. Funding for replacement of both carpets and sinks has been approved in July 2018 and the practice are awaiting the refurbishments. |
| Staff vaccinations | Hepatitis B vaccinations were required for some staff. Both the first and second dose had been given by the practice nurse and the third dose was pending. |
| Fire blanket, smoke detectors and fire extinguisher maintenance | Fire risk assessment identified actions. A fire blanket and smoke detectors were purchased and installed in January 2018. Fire extinguishers were purchased in September 2017 and an annual service was booked. |

| |
|--|
| Any additional evidence |
| <p>A number of areas of risk were identified from performance data. Following this, audits were conducted. The practice monitored this via an audit log which included action plans and future audits.</p> <p>The practice had a robust process for dealing with safety and medicines alerts and managing patients on high risk medicines.</p> |

Engagement with patients, the public, staff and external partners

Feedback from Patient Participation Group;

| |
|------------------------------------|
| Feedback |
| We spoke with a member of the PPG: |

There are normally 12 members. Meetings are held every two months. The practice is very good at listening. Improvements made include putting more information on notice boards in the waiting area, the creation of PPG leaflets to promote the group and the PPG member survey which was currently being collected and analysed.

The PPG were keen to attend other PPGs to learn how they can make improvements and this action is in progress by the practice.

Any additional evidence

The practice gathered feedback from the NHS Friends and Family Test (FFT), NHS choices and a recent PPG survey.

Data from the NHS FFT from May 2018-August 2018 showed that from 208 text message and written responses, 93% of patients would recommend the practice.

Continuous improvement and innovation

Examples of improvements demonstrated as a result of clinical audits in past two years

| Audit area | Improvement |
|------------------------------------|---|
| Diabetes two-cycle audit July 2018 | <p>The practice nurse and a GP worked with a community specialist diabetic nurse and a consultant specialising in diabetes care, using a computer software programme, to identify and improve diabetic management of patients with uncontrolled diabetes. The joint working sessions with the diabetologist was a service commissioned by the Clinical Commissioning Group.</p> <p>The practice had undertaken a two-cycle audit that showed a number of patients with sustained weight loss and more than half of the patients (12 out of 21) had significant drops in their blood test result IFCC-HbA1c, indicating that their diabetes was better controlled.</p> |
| Sodium valproate audit July 2018 | One-cycle audit as a result of a medicines alert, demonstrating that of patients prescribed the medicine of a child-bearing age, it was clinically indicated and the patients remained under specialist care and were closely monitored. |
| Bisphosphonates July 2018 | To review in line with NICE guidance how many patients were taking bisphosphonates for longer than five years. The practice identified 15 out of 36 patients on these medicines where it was indicated in line with guidance. Letters were sent to these patients to explain why the medicine was no longer needed and we saw alerts were placed on records for the remaining 21 patients and the practice were in the process of carrying out 'bone health reviews'. |
| Under 5's childhood immunisations | Undertaken in January 2018. The practice nurse monitored uptake of childhood immunisations in November 2017 compared with the same period the previous year and found uptake had increased by 5.5%. The action plan was to continue to promote uptake using the current third reminder re-call system and in addition they had begun to send text message reminders to parents and guardians the day before the weekly baby clinic to encourage attendance. |

| | |
|--|--|
| Cervical cytology | The practice initiated this in response to low uptake despite a third reminder system. Those who do not attend were coded on the computer system and the practice had formal plans to commence an evening practice nurse surgery once a week to improve access and promote uptake. |
| Urinary tract infection (UTI) antibiotic prescribing February 2018 | To check how many patients suffering from UTI symptoms and receiving a specific named antibiotic return within two weeks with on-going symptoms. Two out of 75 patients returned and neither were resistant to the antibiotic indicating the usefulness of prescribing this as a first line antibiotic for UTIs for the practice population. |

| Any additional evidence | |
|--|--|
| DNA audit | |
| <p>The practice had audited those who 'did not attend' (DNA rate) since the introduction of the text message appointment reminder and cancellation system. Following a search, the practice found 933 DNAs were recorded between August 2016 - July 2017 prior to the text message system. For the same period the following year, August 2017 - July 2018, 858 DNA's were recorded. This showed an overall 9% decrease in DNA's since the text reminder system was introduced. Action points were to put up patient notices to inform patients to cancel if not required and to encourage online appointment booking.</p> | |

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 comparable, 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 comparable to other practices.

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

The following language is used for showing variation:

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

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

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

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

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

<http://www.cqc.org.uk/what-we-do/how-we-use-information/monitoring-gp-practices>

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease
- **PHE:** Public Health England
- **QOF:** Quality and Outcomes Framework (see <https://qof.digital.nhs.uk/>).
- **RCP:** Royal College of Physicians.
- **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. ([See NHS Choices for more details](#)).