

# Care Quality Commission

## Inspection Evidence Table

### Plumstead Health Centre PMS (1-541790426)

Inspection date: 14 August 2019

Date of data download: 13 August 2019

## Overall rating: Good

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

### Effective improvement

### Rating:

### Requires

- At the last inspection we rated the practice requires improvement for providing effective care because we found that the practice's Quality and Outcomes Framework (QOF) performance rates continued to be below the local and national average for several indicators; and the practice had not effectively monitor quality improvement.
- At this inspection we found that the practice has implemented two-cycle audits as part of their quality improvement activity, and additional quality improvement activity had demonstrated improvement for patients. However, the practice remains rated requires improvement for providing an effective service due to poor QOF performance in childhood immunisations and cervical screening.
- The practice provided their unverified 2018/19 QOF performance data for some indicators (outlined below). Although the data has not yet been verified by NHS Digital it demonstrates how the practice progressed towards target and shows a difference from the previous year due to improvements within the practice.

As these are non-verified results at this stage there are no comparators to national or local averages.

### Effective needs assessment, care and treatment

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

Prescribing	Practice performance	CCG average	England average	England comparison
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2018 to 31/03/2019) <small>(NHSBSA)</small>	1.06	0.91	0.77	No statistical variation

## Older people

## Population group rating: Good

Findings
<ul style="list-style-type: none"> <li>The practice used a clinical tool to identify older patients who were living with moderate or severe frailty. Those identified received a full assessment of their physical, mental and social needs.</li> <li>The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.</li> <li>Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.</li> <li>Health checks were offered to patients over 75 years of age.</li> </ul>

## People with long-term conditions

## Population group rating: Good

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c is 64 mmol/mol or less in the preceding 12 months (01/04/2017 to 31/03/2018) <small>(QOF)</small>	83.9%	73.3%	78.8%	No statistical variation
Exception rate (number of exceptions).	20.2% (176)	10.0%	13.2%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	67.0%	72.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	22.9% (200)	7.0%	9.8%	N/A

	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) <small>(QOF)</small>	87.7%	75.4%	80.1%	Tending towards variation (positive)
Exception rate (number of exceptions).	18.8% (164)	8.7%	13.5%	N/A

Other long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control using the 3 RCP questions, NICE 2011 menu ID: NM23 (01/04/2017 to 31/03/2018) (QOF)	76.5%	74.8%	76.0%	No statistical variation
Exception rate (number of exceptions).	8.2% (49)	2.9%	7.7%	N/A
The percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	80.5%	89.3%	89.7%	Tending towards variation (negative)
Exception rate (number of exceptions).	4.3% (10)	7.2%	11.5%	N/A

Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2017 to 31/03/2018) (QOF)	72.0%	79.3%	82.6%	Variation (negative)
Exception rate (number of exceptions).	1.5% (31)	3.3%	4.2%	N/A
In those patients with atrial fibrillation with a record of a CHA2DS2-VASc score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy (01/04/2017 to 31/03/2018) (QOF)	88.1%	85.0%	90.0%	No statistical variation
Exception rate (number of exceptions).	12.5% (12)	8.7%	6.7%	N/A

### Any additional evidence or comments

The practice's unverified 2018/19 QOF performance showed improvements made in most indicators.

- Percentage of patients with hypertension in whom the last blood-pressure reading measured in the preceding 12 months is 150/90mmHg or less – the practice achieved 86%, this was an improvement on the previous year.  
Exception rate: 1%
- 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 – the practice achieved 87% which was an improvement on the previous year when the practice achieved 67%.  
Exception rate: 2%
- The percentage of 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 – the practice achieved 91%, this was an improvement on the previous year when they achieved 88%.

Exception rate: 13%

- The percentage of patients with COPD who 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 – the practice achieved 91%, this was an improvement on the previous year when the practice achieved 81%.
- Exception rate: 2%.
- 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 – the practice achieved 74%, this was a decline on the previous year when they achieved 84%. Exception rate: 4%
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less (01/04/2017 to 31/03/2018) – the practice achieved 76% which was a decline on the previous year when the practice achieved 87.7%. Exception rate: 4%.

The provider informed us that their exception reporting rates in 2017/18 were high due to the merging of two practices in 2016, resulting in them taking on patients from another practice (approximately 1,500 patients); which gave them a high turnover of patients. Some of the patients had been exception reported prior to them joining the practice and were automatically included in the practice's exception reporting rate when their records were transferred.

Since 2017 the practice started daily dedicated QOF clinics for all GPs; a clinical governance lead took responsibility of all QOF work. The practice was able to reduce their exception reporting due to the majority of patients having a review; and the close monitoring of exception reporting figures. The practice also checked new patient's exception reporting to see whether any recording (by a previous practice) was required, if not they removed them from being exception reported and reviewed the patient.

## Families, children and young people improvement

Population group rating: Requires

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2018 to 31/03/2019) (NHS England)	151	173	87.3%	Below 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2018 to 31/03/2019) (NHS England)	141	165	85.5%	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	145	165	87.9%	Below 90% minimum

Hib/MenC booster) (01/04/2018 to 31/03/2019) (NHS England)				
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2018 to 31/03/2019) (NHS England)	145	165	87.9%	Below 90% minimum

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

### Any additional evidence or comments

The practice's childhood immunisation performance had declined since their last inspection on 22 August 2018. Previously the practice achieved a combined total of 89%. At this inspection the practice's combined total was 87%.

The practice was aware of this and stated that they had a GP and administrator leading on this area and that the HCA and nurses were more involved. In addition, they:

- Contacted the parents or guardians of children due to have childhood immunisations.
- Patients that refused child immunisations were referred to the practice nurse who would call the patient to discuss their concerns and provider guidance. The practice would also inform the community health visitor if a patient had refused.
- Had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation and would liaise with health visitors when necessary.

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

### Population group rating: Requires improvement

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64) (01/04/2017 to 31/03/2018) (Public Health England)	65.8%	N/A	N/A	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2017 to 31/03/2018) (PHE)	73.7%	66.1%	69.9%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2017 to 31/03/2018) (PHE)	52.8%	47.0%	54.4%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) (PHE)	69.7%	77.2%	70.2%	N/A

Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2017 to 31/03/2018) (PHE)	40.5%	53.1%	51.9%	No statistical variation
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#### Any additional evidence or comments

The practice was aware that improvements were required in encouraging women to attend cervical screening appointments and had taken steps to make improvements. We were informed that a member of the clinical team had plans to attend local community venues to educate women around the importance of cervical screening and to encourage uptake. One of the GPs at the practice recently ran a campaign at the practice to discuss cervical screening with Nepalese women.

We were also informed that the practice's 2017/18 cervical screening figures were not a true reflection of their performance. The practice discovered that several cervical screening results had not uploaded from the Open Exeter system (where the results were placed) to the practice. In response to this, a member of staff was tasked with the job of cross-referencing patients who had received a screening with the results on the Open Exeter system to ensure all patient data is captured.

#### People whose circumstances make them vulnerable

Population group rating: Good

#### Findings

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- 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.

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

Population group rating: Good

Mental Health Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	90.6%	86.0%	89.5%	No statistical variation
Exception rate (number of exceptions).	5.6% (5)	6.0%	12.7%	N/A
The percentage of patients with	89.8%	85.0%	90.0%	No statistical variation



schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)				
Exception rate (number of exceptions).	2.2% (2)	3.6%	10.5%	N/A
The percentage of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	83.6%	84.4%	83.0%	No statistical variation
Exception rate (number of exceptions).	5.2% (3)	4.7%	6.6%	N/A

#### Any additional evidence or comments

Below are the practice's 2018/19 unverified QOF performance data for the people experiencing poor mental health indicators:

- 93% 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. This was an improvement on the previous year.  
Exception rate: 2%.
- 95% of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months. This was an improvement on the previous year.  
Exception rate: 0%.
- 85% of patients diagnosed with dementia whose care plan has been reviewed in a face-to-face review in the preceding 12 months. This was an improvement on the previous year.
- Exception rate: 0%.

#### Monitoring care and treatment

**The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. There was limited monitoring of the outcomes of care and treatment.**

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	524.9	520.0	537.5
Overall QOF score (as a percentage of maximum)	93.9%	93.0%	96.2%
Overall QOF exception reporting (all domains)	7.8%	4.9%	5.8%

#### Any additional evidence or comments

The practice's unverified 2018/19 QOF performance data showed that the practice achieved 541.93 points out of a maximum of 559 point.

The practice had undertaken a range of audits and quality improvement within the last 12 months

including:

1. A pregabalin or gabapentin audit was carried out to ensure that all patients were only receiving one-month supply of either medication in accordance with current guidance. The aim of the audit was to switch any patient on a repeat prescription to an acute issue (one-month supply). The practice conducted searches for patients receiving repeat issues.
  - The baseline audit which was carried out between December 2018 and March 2019 showed that the practice had 110 patients prescribed pregabalin or gabapentin on a repeat prescription.
  - It was decided that eighteen patients were to remain on a repeat prescription due to clinical reasons.
  - Four patients had the quantity issued reduced to one month's supply.
  - The remaining 88-90% patients were taken off repeat prescription issue and switched to acute.
  - A second audit was carried out between May 2019 and June 2019. Forty-five patients prescribed Pregabalin or Gabapentin were on a repeat prescription.
  - Seventeen patients were to remain on a repeat prescription due to clinical reasons.
  - Three patients had the quantity issued reduced to one month's supply.
  - The remaining 25 (39.68%) patients were taken off repeat prescription issue and switched to acute.
2. The practice carried out a urinary tract infection (UTI) audit to evaluate prescribing for uncomplicated UTIs using the Health Protection Agency (HPA) guidance.
  - A search was carried out on female patients between the age of 16 and 65 with four specific read codes (a number code that uniquely identifies the clinical term) in their medical records.
  - After removing patients that fell within six exclusions (for example, male and pregnant patients) the results showed that 78.6% of patients were prescribed in compliance with HPA guidance. This was below the target of 90%.
  - A second cycle of the audit was undertaken between November 2018 and January 2019. The results showed that 88% of patients were prescribed in compliance with HPA guidance. Although there had been improvement the target was still not met. The practice identified two reasons for this: I) New clinical staff were not aware of the guidance and II) consideration for other collateral conditions requiring antibiotics at the time of diagnosis. In response to this, the practice took steps to make all clinical staff aware of the HPA guidance.
  - A third cycle of the audit was carried out between February 2019 and April 2019 which showed a 94% compliance with the HPA guidance.
3. Antibiotic Prescribing Habits by Advanced Nurse Practitioners audit was undertaken to see whether they are appropriately prescribing in accordance with NICE and local guidance.
  - A retrospective audit was carried out over a three-month period from December 2018 to March 2019.
  - The total number of patients seen were 207 with eight inappropriate antibiotics prescribed.
  - As a result, the antibiotic protocol was discussed in the practice clinical meeting on 24 June 2019 and information cascaded about the guidance to all clinicians and the administrative team.
  - A re-audit was carried out between April 2019 and 10 June 2019.



- The total number of patients seen were 253 with six inappropriate antibiotics prescribed. This was a 25%. The overall results showed a 50% improvement.
- 4. Audit of prescribing GLP1 Analogues (relating to diabetes) in accordance with NICE and Greenwich CCG guidance to monitor the rationale and evaluation of using newer therapies in treatment of type 2 diabetes at primary care level.
  - A baseline audit found 11 patients on GLP1 mimetic therapy. Four were on Exenatide and seven on Liraglutide.
  - All patients were prescribed in accordance with guidance.
  - Eight patients had been found to have lost more than 3% of weight and had their HbA1c down by more than 1%.
  - On re-audit the practice found 10 patients on GLP1 mimetic therapy. Three were on Exenatide and two on Liraglutide and two were started on Lixisenatide in secondary care and continued in primary care as per guidance.
  - All 10 patients showed a weight loss of more than 3% and or a 1% drop in their HbA1c, proving the rationale and efficacy of GLP1 medication in the management of type 2 diabetes at practice level.
- 5. Audit carried out to optimise docman workflow and 'free up' clinical time by checking that letters were filed according to practice protocol.
  - Initially a lead GP and two members of the administration team received training on docman and were familiar with the protocol.
  - Twenty-five letters were randomly selected and given to all GPs stating outcome of the letters.
  - GPs went through the letters and feedback on whether they were appropriately filed.
  - The results showed that 7% of letters were inappropriately filed.
  - The results were discussed at a clinical meeting with members of the administration team.
  - A second audit showed a decrease of 1% (6%) of letters had been inappropriately filed. The practice intends to carry out this audit on a monthly with a view to achieving 100%.
- 6. Audit on dermatology secondary care referrals because of discovering that the practice had the second highest referral rate for patients to see a specialist dermatologist in the CCG area.
  - The practice carried out a retrospective analysis of dermatological referrals. The first cycle showed that 22 patients were referred between October 2018 and January 2019.
  - As a result, the clinical team agreed that all dermatological referrals would be peer viewed; a training session was provided to clinicians on dermoscopy (examination of skin lesions). Subsequently, a salaried GP with a special interest in dermatology joined the practice.
  - A re-audit was undertaken between February 2019 and May 2019. The number of dermatology referrals had dropped by 25% (17 patients).

## Coordinating care and treatment

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

Indicator	Y/N/Partial
The contractor has regular (at least 3 monthly) multidisciplinary case review meetings where all patients on the palliative care register are discussed (01/04/2017 to 31/03/2018) (QOF)	Yes

## Helping patients to live healthier lives

**Staff were consistent and proactive in helping patients to live healthier lives.**

Smoking Indicator	Practice	CCG average	England average	England comparison
The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months (01/04/2017 to 31/03/2018) (QOF)	92.1%	93.7%	95.1%	No statistical variation
Exception rate (number of exceptions).	0.3% (10)	0.6%	0.8%	N/A

## Any additional evidence or comments

No additional evidence obtained.

## 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 practice's performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:  
<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

## Glossary of terms used in the data.

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