

# Care Quality Commission

## Inspection Evidence Table

### North Fulham Surgery (1-569641532)

Inspection date: 30 September 2022

Date of data download: 26 September 2022

## Overall rating: Good

### Effective

### Rating: Good

At our previous inspection on 3,10 and 22 June 2021, we rated this practice as good overall. We rated the safe, caring, responsive and well-led key questions. We rated the practice as requires improvement for the effective key question because:

- The percentage of patients with chronic obstructive pulmonary disease (COPD) that had a review with a healthcare professional within the last 12 months was significantly below the local and national averages. In addition, performance for two indicators relating to hypertension was below the local and national averages.
- The uptake for childhood immunisations was significantly below the local and national averages. The practice had not met the minimum 90% for all five childhood immunisation uptake indicators. The practice had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five of the childhood immunisation uptake indicators.
- The uptake for cervical screening was significantly below the national average.
- We saw that the practice had started to make improvements in the above areas.

At this inspection, which was carried out on 30 September 2022, we found that the practice had completed projects to review and act on the concerns identified in our previous inspection in June 2021. The projected figures for 2022 to 2023 demonstrated that the practice was on course for meeting targets. We have therefore rated the practice as good for providing effective services.

*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.*

## Management of people with long term conditions

### Findings

- At our previous inspection in June 2021, we identified that the percentage of patients with chronic obstructive pulmonary disease (COPD) that had a review with a healthcare professional within the last 12 months was significantly below the local and national average. The performance for two indicators relating to hypertension was below the local and national averages. The practice informed us that there had been a low response rate to recall as patients did not want to attend the practice during the Covid-19 pandemic. The practice told us that they had a quality lead who regularly reviewed performance for long-term conditions and that outcomes were discussed at clinical meetings. The practice had a recovery plan in place to improve outcomes for patients with COPD and hypertension, for example, the practice had increased the number of face to face appointments available to review patients with long-term conditions.
- At this inspection, we saw evidence that the practice had undertaken a COPD education and review quality improvement project from September 2021 to April 2022. The practice stated that it had resumed routine COPD review activities for all patients on the COPD register starting in September 2021 to coincide with the flu season and the most risky time for exacerbation of the condition. The clinical team decided to upskill the whole clinical team, including the clinical pharmacy team. Staff members completed a training session with a consultant respiratory physician due to their direct involvement in prescribing and monitoring of COPD and we saw evidence of the minutes from this training meeting. A repeat of this training was arranged for the whole clinical team. The practice arranged dedicated COPD clinics on a weekly basis and every patient was invited for a telephone review, with face to face appointments available if appropriate. The practice stated that it had found that a number of patients were incorrectly identified on the register and these patients were removed.

The practice provided us with QOF data which showed that in 2020 to 2021, 6.5% reviews were recorded. The practice stated that informal reviews were not coded during this period. In 2021 to 2022, the practice recorded 90.9% reviews and in 2022 to the date of inspection, the practice had recorded 81.6% reviews, with a rolling programme of reviews due to start in September 2022. The practice told us that it expected to meet its targets for reviews in 2022.

The practice told us that it had attempted to review whether the decrease in reviews coded during the Covid-19 pandemic had affected patient outcomes and had reviewed the admission rates to hospital with an exacerbation of respiratory disease. The practice reviewed records from September 2019 to September 2020, which indicated 24 admissions to hospital (for 14 individual patients, one admission related to Covid-19); September 2020 to September 2021, which indicated 16 admissions (for 12 individual patients, one admission related to Covid-19); and September 2021 to September 2022, which indicated 23 admissions (for 12 individual patients, four admissions related to Covid-19). The practice told us that it had concluded that the COPD review rate in 2021 did not correspond with a high rate of admission, however they were aware patients were shielding and socially distancing and the number of exacerbations may have been related to a decrease in infection rates generally.

The practice told us that it had conducted a separate audit into high dose inhaled corticosteroids (a type of anti-inflammatory medicine).

- We saw evidence that the practice had completed a hypertension post Covid-19 recovery project from March 2020 to April 2022. The practice stated that hypertension management during the Covid-19 pandemic was affected by the suspension of usual services and widespread lockdown, with patients reluctant to undertake routine monitoring and visits to the practice for blood pressure checking. The practice told us that a plan was made during the pandemic regarding the resumption of hypertension management. It told us that patients were advised to self-monitor blood pressures where possible and where patients did not have a blood pressure machine, they were invited into the practice for a blood pressure check and to consider whether to have a 24 hour monitor. The practice issued 40 blood pressure machines to patients, where they did not have machines and did not want to attend the practice, and had identified a cohort of patients who were at risk and who would benefit most from regular monitoring (patients with co-morbidities). The practice created a clinical list for the pharmacy team to follow up patients following guidelines. The senior pharmacist at the practice was able to prescribe medicines and the clinical pharmacists completed regular medication reviews with patients and were in contact with patients with hypertension regularly. The practice prioritised patients with co-morbidities (such as diabetes, heart disease or stroke).

The practice provided us with updated QOF data on the areas identified in the last inspection where indicators were below local and national averages:

- The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading was 140/80 mmHg or less:  
2020 to 2021 – 27%  
2021 to 2022 – 49.1%  
2022 to the date of inspection – 54.7%
- The percentage of patients aged 79 years or under with coronary heart disease in whom their last blood pressured reading was 140/90 mmHg or less:  
2020 to 2021 – 50%  
2021 to 2022 – 77.8%  
2022 to the date of inspection – 71.3%

The practice told us that whilst improvements had been made, further work was required to ensure that patients reached targets. The practice told us that where a patient with high blood pressure was detected, they would be passed to the pharmacy team for future management. The practice stated that it had created a diabetic clinic to target this cohort of patients, with all blood testing and blood pressure checks completed at this clinic. The results were passed onto the clinical lead to review. Patients were able to access the practice and attend for blood pressure checks and onward referral to the pharmacy team. The practice utilised remote systems for patients to share their blood pressure readings by using text responses.

- The practice told us that it planned to evaluate patients who were provided with home blood pressure monitors to review this intervention.
- The practice evidenced that it had started work to improve its performance in relation to hypertension management. We noted that the data provided for 2022 to the date of inspection demonstrated an improvement and that the practice told us that it expected to exceed the previous year's attainment.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	58	66	87.9%	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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	58	75	77.3%	Below 80% uptake
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	61	75	81.3%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	60	75	80.0%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	9	21	42.9%	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

- At our previous inspection in June 2021, we identified that the practice had not met the minimum 90% for all five childhood uptake indicators and had not met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all five of the indicators. We noted that the practice had put in place a recovery plan to improve the uptake of childhood immunisations.
- At this inspection, the practice told us that it had undertaken a childhood immunisations quality improvement project. The practice told us that it historically had lower rates than the national average and that its uptake was in line with local averages (although the locality performed below the London and national averages as a whole). The practice changed its processes for recall to

focus on patients becoming due for immunisations rather than waiting until they were overdue. The practice put in place a series of automated searches to identify patients based on age who were due for vaccination in the coming four weeks. The search was sent weekly to the assistant practice manager and healthcare assistant. The healthcare assistant called and sent text messages to parents and guardians during the four week period leading up to the date for immunisation. The practice contacted patients who were overdue by letter, text message and telephone call and parents and guardians who did not respond were escalated to the practice nurse or a GP for them to telephone directly to discuss immunisations to encourage attendance. The practice discussed non-attendance at weekly clinical meetings and with the safeguarding lead where appropriate. The practice liaised with the local safeguarding team and school nurses where required. The practice had a childhood vaccinations and immunisations policy.

- The practice monitored the rates of immunisation at its weekly management team meeting and recorded these discussions in the minutes. The practice noted that it had difficulty in recalling some cohorts of patients and shared this with the Primary Care Network (PCN). The practice recommended to the PCN that further IT support was needed and it was now able to view children on a single dashboard which was updated monthly.

- The practice provided us with updated QOF data which indicated the following:

#### First immunisation course

2020 to 2021 – 87.6% (Diphtheria, tetanus, pertussis, polio, hepatitis B vaccine completed by 12 months)

2021 to 2022 – 91.6% (Diphtheria, tetanus and pertussis vaccine completed by eight months)

2022 to the date of inspection – 60.4% (Diphtheria, tetanus and pertussis vaccine completed by eight months)

#### First year immunisations

2020 to 2021 – 71.4% (Measles, mumps and rubella completed by 24 months)

2021 to 2022 – 73.9% (Measles, mumps and rubella given by 18 months)

2022 to the date of inspection – 80.6% (Measles, mumps and rubella given by 18 months)

#### Immunisations completed by five years

2020 to 2021 – 42.9% (Measles, mumps and rubella given by five years)

2021 to 2022 – 74.1% (Diphtheria, tetanus, pertussis, polio booster and two measles, mumps and rubella vaccinations by five years)

2022 to the date of inspection – 70% (Diphtheria, tetanus, pertussis, polio booster and two measles, mumps and rubella vaccinations by five years)

- The practice told us that it had seen a steady improvement in relation to childhood immunisation rates. The practice stated that historical data was recorded slightly differently and direct comparisons were not completely accurate, although an upward trend was identified. The practice stated that improvements could be made by using a single immunisations dashboard, which had been procured by the PCN and would assist ease of identification of patients to reduce the number of searches and reports completed on a weekly basis.
- The practice told us that it had registered a large cohort of refugees from Afghanistan due to its proximity to a hotel being used to accommodate refugees. The practice informed us that a number

of children had needed extra immunisations or recording of previously administered immunisations which was challenging. The practice had provided and continued to provide extra polio vaccinations for preschool age groups.

- The practice informed us that it had open weekend clinics where the five practices in the PCN took it in turns to host the clinic which patients could attend for immunisations. The practice provided a WHO leaflet on childhood immunisations to patients which it sent by a text messaging service and had posters on its premises about childhood immunisation to raise awareness.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/03/2022) (UK Health and Security Agency)	66.6%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	48.5%	48.9%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	55.9%	57.1%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	42.3%	56.0%	55.4%	No statistical variation

Note: CCGs were replaced by integrated care systems in July 2022. The CCG averages will continue to be used until CQC's internal systems are updated and data for 2022/23 is released.

#### Any additional evidence or comments

- At our previous inspection in June 2021, we identified that the uptake for cervical screening was significantly below the national average (59.5%).
- At this inspection, we noted that uptake had increased to 66.6% but remained below the national average. We noted that the practice was working to improve cervical screening uptake and reduce barriers to screening. The practice had a cervical screening policy and had completed a cervical screening recovery plan and quality improvement project (August 2021 to April 2023). The practice told us that its cervical screening rates had declined in recent years, which was consistent with local borough averages (the local borough performed lower than the London average). The practice prioritised the uptake of cervical screening following the Covid-19 pandemic and aimed to



achieve the London average of 70% and the national average of 80%. The practice identified that proactive recall letters had not resulted in a good response rate. The practice altered its approach and sent text messages and contacted patients by telephone. The practice developed a new protocol where automated searches of patients due and overdue for screening were generated, which were sent on a weekly basis to the assistant practice manager. The lists were reviewed and text messages were sent on a monthly basis, with patients who did not respond contacted by telephone. The practice discussed the screening programme at its weekly management meeting, where monitoring of live numbers of screening was undertaken. The clinical team were kept informed of progress in weekly clinical team meetings and administrative staff were updated in administrative team meetings and using the practice email bulletins.

- The practice invited external facilitators from the West London Cancer Alliance and Jo's Cervical Cancer Trust and a meeting was held in July 2022. The two organisations identified that the measures put in place by the practice were robust and that uptake had improved since the original data collection. Further actions were identified, which the practice were in the process of implementing. We saw evidence of minutes from this meeting. The practice liaised with and shared good practice amongst other practices in the PCN.

- The practice provided us with updated QOF data which indicated the following:

2019 to 2020 – 60% (QOF data) and 58.2% (Public Health England data)

2020 to 2021 – 59% (QOF data) and 56.8% (Public Health England data)

2021 to 2022 – 66% (QOF data)

2022 to the date of inspection – 64.2%

The practice told us that it was projected to meet the 80% national target (based on the assumption of 12 cervical screening appointments per week until the end of financial year, which were currently being completed on a regular basis).

- The practice told us that it had experienced some challenges due to staff sickness and the reduction of available screening appointments during this time. The practice had redirected patients to alternative screening centres or reinvited patients when appointments became available.
- The practice conducted a questionnaire audit of patient experience and asked patients attending for cervical screening to provide their views. The audit concluded that patients were happy with their overall experience of cervical screening at the practice.
- The practice told us that a cohort of patients from the Somali community had historically not engaged with cervical screening, however, uptake rates were increasing amongst this cohort.

#### 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. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

#### Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.
- $\text{‰}$  = per thousand.