

Care Quality Commission

Inspection Evidence Table

Wimbledon Medical Practice (1-6989164183)

Inspection date: 27 May 2021

Date of data download: 26 April 2021

Overall rating: Good

We inspected Wimbledon Medical Practice on 29 October 2019 and rated it as good overall (good for all key questions apart from Effective).

We rated the practice as requires improvement for effectiveness because many of the indicators on the Quality and Outcomes Framework (QOF) were statistically significantly below average. The practice was registered with CQC in June 2019, after the end of the previous QOF year. The results for the practice at the time of the inspection were carried over from the predecessor practice. Practice staff told us about the action the practice was taking to improve and we saw evidence that results had improved, although results were generally not, so far, in line with average.

We found some other areas in 2019 that we recommended that the practice look at, to:

- improve record-keeping on recruitment, prescribing of high risk medicines, and on safety alerts
- upgrade staff training on safeguarding to in line with latest guidance
- consider introducing appraisals for salaried GPs
- improve uptake of for cancer screening
- improve the identification of carers to enable this group of patients to access the care and support they need.

This review followed up on these areas and we found that the practice had made all of the improvements.

Please note: Any Quality Outcomes Framework (QOF) data relates to 2019/20.

Safe

Rating: Good

Following the inspection in 2019, we rated the practice as good for safety, but we recommended the practice consider how to improve record-keeping on recruitment, the prescribing of high risk medicines, and on safety alerts.

Safety systems and processes

The practice had clear systems, practices and processes to keep people safe and safeguarded from abuse.

Safeguarding	Y/N/Partial
Partners and staff were trained to appropriate levels for their role.	Y

Safeguarding	Y/N/Partial
<p>Explanation of any answers and additional evidence:</p> <p>In 2019 we checked a sample of 5 training records during the inspection. Not all staff had completed the training recommended by intercollegiate guidance for their roles.</p> <ul style="list-style-type: none"> Two GPs had not completed level three training in safeguarding vulnerable adults, in line with recently updated guidance. The GPs completed the training during the inspection. The guidance on training for staff in keeping children safe from abuse was revised in January 2019, increasing the levels recommended for all non-clinical staff to level 2. The practice told us that it would increase the levels of staff when training was next renewed. <p>For this review the practice sent us evidence that GPs had completed level three training in safeguarding vulnerable adults and non-clinical staff had completed training to level two.</p>	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
<p>Explanation of any answers and additional evidence:</p> <p>In 2019, we saw evidence that identity documents had been checked (because staff had NHS ID cards). However, the practice had not kept copies of the documents and recorded the date of check, as required by the Immigration, Asylum and Nationality Act 2006.</p> <p>For this review the practice sent us evidence that identity documents had been checked and copies retained for two staff who started work at the practice since 2019.</p>	

Appropriate and safe use of medicines

The practice had systems for the appropriate and safe use of medicines, including medicines optimisation

Medicines management	Y/N/Partial
There was a process for monitoring patients' health in relation to the use of medicines including high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	Partial
<p>Explanation of any answers and additional evidence:</p> <p>In 2019, we checked a sample of high risk medicine prescribing. Most records showed appropriate monitoring had been completed. There were two instances where a high risk medicine had been prescribed without blood monitoring results being available. We heard that risk assessments had been completed, including of factors surrounding each person's care, the length of time that they had been stable on the medicine and the risk of not prescribing, but this risk assessment was not recorded.</p> <p>As part of this review we discussed with practice staff the process for prescribing high risk medicines. We asked for evidence that the practice used to monitor high risk medicines prescribing and for evidence that showed that risk assessments were documented if clinical judgment had been applied.</p> <p>The practice had updated their prescribing policy since the last inspection and we saw evidence of the process used to identify and recall patients who needed checks, such as blood tests, to keep them safe. The practice did not have an automated oversight system that would identify instances of patients on particular medicines who had not had checks completed within the recommended time periods. We saw evidence that practice staff were checking individual patients as part of the routine recall systems, and identifying those who needed checks, and heard from practice staff how this information was provided to the GPs to support prescribing decisions.</p> <p>The practice sent us some anonymised parts of patient records. These did not raise any concerns, but did not (from the limited information in a small sample of patient records) show examples of full risk assessment.</p>	

Track record on safety and lessons learned and improvements made

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
<p>Explanation of any answers and additional evidence:</p> <p>In 2019, there was no log of safety alerts reviewed and actions taken. We saw examples of actions taken on recent alerts for example, regarding sodium valproate, but the actions were not very well recorded. The practice told us that they would review the system for future alerts.</p> <p>For this review the practice sent us evidence of a new system, in which actions were recorded. Practice staff told us that a different system had been in operation during the pandemic, and that they were in the process of deciding what system should be used going forwards.</p>	

Effective

Rating: Good

In 2019, we rated the practice as requires improvement for effectiveness because many of the indicators on the Quality and Outcomes Framework (QOF) were statistically significantly below average. The practice was registered with CQC in June 2019, after the end of the previous QOF year. The results for the practice at the time of the inspection were those that had been carried over from the predecessor practice. Practice staff told us about the action the practice was taking to improve and we saw evidence that results had improved, although results were generally not, so far, in line with average.

For this review we looked at the latest published performance data. We found that the practice had improved significantly in all of the areas that were previously below average, and for several indicators had performed above the national average.

People with long-term conditions

Population group rating: Good

Findings

- For this review we looked at the latest published data (01/04/2019 to 31/03/2020). This showed significant improvement on the data we saw in 2019.
- The indicators for diabetes changed for the Quality and Outcomes Framework 2019/2020 so it is not possible to make a direct comparison between the current data and that we looked at in 2019. In 2019 the practice performance in diabetes care was significantly below average. This has changed in the latest published data. The practice was in line with the national average for management of blood pressure in patients with diabetes and performed above average for the management of blood sugar (measured by HbA1c) in patients with diabetes without moderate or severe frailty.
- In 2019 the practice performance on the indicators for asthma and COPD were both statistically significantly below average (significant variation negative). In the latest published data both were improved to in line with average performance for asthma and the COPD indicator was tending towards positive variation.
- In 2019, the practice performance on the indicators for blood pressure in patients with hypertension and for treatment of patients with atrial fibrillation were both statistically significantly below average (negative variation). The indicator for blood pressure in patients with hypertension changed in 2019/20 so it is not possible to compare directly. The practice performance but is in line with national average. Performance on the treatment for atrial fibrillation remained below average, but was now only slightly below.

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. (01/04/2019 to 31/03/2020) (QOF)	80.0%	75.3%	76.6%	No statistical variation

PCA* rate (number of PCAs).	3.4% (12)	9.0%	12.3%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	97.4%	90.2%	89.4%	Tending towards variation (positive)
PCA rate (number of PCAs).	10.6% (9)	8.6%	12.7%	N/A

Long-term conditions	Practice	CCG average	England average	England comparison
The percentage of patients aged 79 years or under with coronary heart disease in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	86.9%	82.2%	82.0%	No statistical variation
PCA rate (number of PCAs).	1.2% (1)	3.4%	5.2%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last IFCC-HbA1c is 58 mmol/mol or less in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>	78.0%	64.7%	66.9%	Tending towards variation (positive)
PCA rate (number of PCAs).	12.3% (21)	10.7%	15.3%	N/A
The percentage of patients aged 79 years or under with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 140/90 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	75.3%	71.0%	72.4%	No statistical variation
PCA rate (number of PCAs).	3.5% (22)	4.9%	7.1%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	82.1%	90.6%	91.8%	Tending towards variation (negative)
PCA rate (number of PCAs).	8.2% (6)	4.8%	4.9%	N/A
The percentage of patients with diabetes, on the register, without moderate or severe frailty in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2019 to 31/03/2020) <small>(QOF)</small>	82.6%	74.9%	75.9%	No statistical variation
PCA rate (number of PCAs).	9.4% (16)	8.6%	10.4%	N/A

Families, children and young people

Population group rating: **Good**

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) (01/04/2019 to 31/03/2020) (NHS England)	93	98	94.9%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2019 to 31/03/2020) (NHS England)	122	133	91.7%	Met 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) (01/04/2019 to 31/03/2020) (NHS England)	125	133	94.0%	Met 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2019 to 31/03/2020) (NHS England)	124	133	93.2%	Met 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2019 to 31/03/2020) (NHS England)	96	135	71.1%	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

In 2019 we found that the practice had met the minimum 90% target for the four childhood immunisation uptake indicators that CQC used at that time, and met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for one childhood immunisation uptake indicator. Since that inspection CQC has added immunisation for measles, mumps and rubella (two doses of MMR by age 5) to our standard set of evidence.

The latest annual data published (above) showed that between 01/04/2019 and 31/03/2020 the practice met the 90% target for four childhood immunisation uptake indicators, but not for two doses of MMR by age 5, where the uptake was reported as 71.1%.

In response to the draft report, the practice queried the data for two doses of MMR by age 5 and sent us searches on 3 dates from the practice information system which showed an uptake of 82% - 85%. This data cannot be compared directly with the nationally validated data.

We looked at published quarterly data for 01/04/2020 to 31/12/2021. Although this data has not been validated, it showed that (averaged over the 3 quarters) the practice uptake was 90% for four childhood immunisation uptake indicators, and over 80% for two doses of MMR by age 5 (82.6%).

Working age people (including those recently retired and students)

Population group rating: Requires improvement

Findings

In 2019, the practice had not met the 80% target for cervical cancer screening. Staff members had been given specific responsibility to invite patients for screening and the practice was using new text messaging software to send invitations. For this review, the practice sent us (unvalidated) data which showed an increase in uptake. The practice hoped that the next validated data would show that the practice had met the 80% target, however this may not be the same data as is used for the national target as published information for the first 3 quarters of 2020/21 showed the practice had achieved a take up of just over 61%.

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). (Snapshot date: 30/09/2020) (Public Health England)	63.7%	N/A	80% Target	Below 70% uptake

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

The practice was registered with CQC in June 2019, after the end of the 2018/19 QOF year, but the results were carried over from the predecessor practice. These were statistically significantly below the national and local averages (ranging from 19.6% to 34.4%). When we inspected in 2019, practice staff told us about the action the practice was taking to improve and we saw evidence that results had improved considerably in the six months of the current QOF year, although results were not all, so far, in line with average.

The latest published data (01/04/2019 to 31/03/2020) showed that the practice performance had improved considerably, from being statistically significantly below average to being above average.

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,	100.0%	88.1%	85.4%	Variation (positive)

in the preceding 12 months (01/04/2019 to 31/03/2020) <small>(QOF)</small>				
PCA rate (number of PCAs).	13.8% (9)	11.2%	16.6%	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 (01/04/2019 to 31/03/2020) <small>(QOF)</small>	98.0%	82.2%	81.4%	Variation (positive)
PCA rate (number of PCAs).	2.0% (1)	5.6%	8.0%	N/A

Effective staffing

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

	Y/N/Partial
Staff had 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
<p>Explanation of any answers and additional evidence:</p> <p>In 2019, the practice did not carry out appraisals for salaried GPs, and relied on the national system of GP appraisal.</p> <p>For this review we saw evidence that the practice had now introduced a system of appraisal for all staff, including salaried GPs.</p>	

Caring

Rating: Good

Carers	Narrative
Percentage and number of carers identified.	<p>When we inspected in 2019, the practice had identified 49 patients as carers. We said that the practice should improve the identification of carers to enable this group of patients to access the care and support they need.</p> <p>For this review the practice sent us evidence that showed that 82 patients had been identified as carers. As the practice list size had grown, this increased number still represented slightly less than 1% of the practice's list size (10,112 patients, as of 1 May 2021). The practice sent us a copy of their carer's identification and support policy, which had been reviewed recently. The practice told us that identification and support of carers had been a focus during the pandemic, and the carers list had been reviewed and patients removed as well as deleted, as their circumstances changed.</p> <p>In response to the draft report, the practice told us that the efforts to ensure that the register was accurate, by removing patients who were no longer carers as well as adding newly identified carers, meant that this increase represented a greater than 40% increase in carers identified since the last inspection.</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 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)	≤ -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 women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

Glossary of terms used in the data.

- COPD:** Chronic Obstructive Pulmonary Disease.
- PHE:** Public Health England.
- QOF:** Quality and Outcomes Framework.
- STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- *PCA:** Personalised Care Adjustment. This replaces the QOF Exceptions previously used in the Evidence Table (see [GMS QOF Framework](#)).
- %** = per thousand.