

Care Quality Commission

Inspection Evidence Table

Tinkers Lane Surgery (1-587569635)

Inspection date: 08 January 2020

Date of data download: 27 December 2019

Overall rating: add overall rating here

Please note: Any Quality Outcomes Framework (QOF) data relates to 2018/19.

Effective

Rating: Good

We carried out an announced focused inspection on 8 January 2020 because our previous inspection of the practice (on 10 December 2018) rated effective services as requires improvement. This was due to the breach in Regulation 12 HSCA (RA) Regulations 2014: Safe care and treatment. Specifically:

- There was no evidence that a clinician had assessed some patients with increased risks prior to excepting them.

During this inspection we saw the concern had been addressed.

During this inspection we reviewed areas where the provider should make improvements identified at the previous inspection. We found these concerns had been resolved. Specifically:

- We spoke to staff and saw documentary evidence that learning points from significant events and complaints were shared with all staff, including those unable to attend meetings where they were discussed.
- Medicines (other than those stored in a fridge and emergency medicines), were kept in an orderly manner to ensure older medicines were used first.
- The practice policy on staff references met the standards set out in recognised guidance.
- There was a detailed, written succession plan for key staff.

Effective needs assessment, care and treatment

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

	Y/N/Partial
The practice had systems and processes to keep clinicians up to date with current evidence-based practice.	Y
Patients' immediate and ongoing needs were fully assessed. This included their clinical	Y

needs and their mental and physical wellbeing.	
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y

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) (01/10/2018 to 30/09/2019) (NHSBSA)	1.42 ¹	0.76	0.74	Tending towards variation (negative)

Any additional evidence or comments

- The practice prescribing of hypnotics medication showed a negative variation when compared with local and national prescribing. When we spoke with practice staff about this, they told us they were aware of this trend, and were taking steps to address it. The steps included:
 - Face-to-face medication reviews (including clinical assessments) for patients on high risk medications.
 - Monthly patient education sessions, run by a clinical pharmacist, aimed at increasing awareness of pain management and the long-term effects of medications. Practice staff told us they planned to audit the pain management sessions.
 - Reviewing the notes of all patients on hypnotic medication, inviting them in for a review, and discussing alternative treatment options.

The following initiative was available and benefitted all patient groups:

- An online digital service, enabling patients to check their symptoms, receive clinical advice, order repeat prescriptions and book GP appointments where appropriate.

Older people

Population group rating: Good

Findings

- 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.
- 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.

- The practice carried out structured annual medication reviews for older patients.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks, including frailty assessments, were offered to patients over 75 years of age.
- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- A named GP undertook weekly ward rounds at local residential and nursing homes. There was a dedicated telephone line for these homes and the community team.
- A care co-ordinator was based at the practice.
- A specialist practitioner undertook home visits for patients aged over 70 years.

People with long-term conditions

Population group rating: Good

Findings

- Patients with long-term conditions were offered a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long-term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice shared clear and accurate information with relevant professionals when deciding care delivery for patients with long-term conditions.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- Patients could access an in-house phlebotomy service and a machine used to detect and diagnose heart problems.
- Adults with newly diagnosed cardio-vascular disease were offered statins.
- Patients with suspected hypertension were offered ambulatory blood pressure monitoring.
- Patients with atrial fibrillation were assessed for stroke risk and treated appropriately
- Patients with COPD were offered rescue packs.
- Patients with asthma were offered an asthma management plan.

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 (01/04/2018 to 31/03/2019) (QOF)	89.7%	84.0%	79.3%	Variation (positive)
Exception rate (number of exceptions).	21.9% (125)	18.0%	12.8%	N/A
The percentage of patients with diabetes, on the register, in whom the last blood	82.4%	78.9%	78.1%	No statistical variation

pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less (01/04/2018 to 31/03/2019) ^(QOF)				
Exception rate (number of exceptions).	21.2% (121) ¹	13.3%	9.4%	N/A

Any additional evidence or comments

1. The practice exception rate for patients with diabetes and a recorded healthy blood pressure reading, exceeded local and national averages. Unverified data for 2019 (1 April to 31 December), supplied by the practice, showed this exception rate is now at 10.67%, which is in line with local and national averages. We looked at a selection of clinical records and saw that all patients had been appropriately excepted.

	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 (01/04/2018 to 31/03/2019) ^(QOF)	82.5%	83.6%	81.3%	No statistical variation
Exception rate (number of exceptions).	25.9% (148) ¹	16.6%	12.7%	N/A

Any additional evidence or comments

1. The practice exception rate for patients with diabetes and a healthy cholesterol level measurement exceeded local and national averages. When we spoke with practice staff they told us they were aware of this data, and explained that the high figure was due to a non-clinical member of staff exception reporting patients without first referring to a clinician. Since the last inspection, the practice had reviewed its systems and processes and all exception reporting is now done by a clinician. We looked at a selection of relevant clinical records and saw that all patients had been appropriately excepted.

The practice was unable to provide unverified or other data for 2019 that may show an improvement in exception reporting, because this QOF indicator has been retired from the scheme.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	87.6%	78.3%	75.9%	Variation (positive)
Exception rate (number of exceptions).	14.1% (89)	10.4%	7.4%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	94.9%	90.8%	89.6%	No statistical variation
Exception rate (number of exceptions).	17.9% (30) ¹	15.3%	11.2%	N/A

Any additional evidence or comments

1. The practice exception rate for patients with COPD and a review that included an assessment of breathlessness, exceeded local and national averages. At this inspection, unverified data for 2019 (1 April to 31 December), supplied by the practice, showed this figure is now at 11.48%, which is in line with local and national averages. We looked at a selection of clinical records and saw that all patients had been appropriately excepted.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	90.2%	83.4%	83.0%	Variation (positive)
Exception rate (number of exceptions).	9.1% (155)	4.9%	4.0%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.4%	92.7%	91.1%	No statistical variation
Exception rate (number of exceptions).	5.1% (12)	5.9%	5.9%	N/A

Families, children and young people

Population group rating: **Good**

Findings

- The practice has met the WHO based national target of 95% (the recommended standard for achieving herd immunity) for all of four childhood immunisation uptake indicators. The practice contacted the parents or guardians of children due to have childhood immunisations.
- The practice 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.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- Young people could access advice and support for sexual health and contraception, such as the Wiltshire-wide 'No Worries!' service.
- Staff had the appropriate skills and training to carry out reviews for this population group.
- The practice offered contraceptive advice and fitting for coils and implants.

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)	75	77	97.4%	Met 95% WHO based target
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)	79	83	95.2%	Met 95% WHO based target
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) (01/04/2018 to 31/03/2019) (NHS England)	79	83	95.2%	Met 95% WHO based target
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)	79	83	95.2%	Met 95% WHO based target

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>

Working age people (including those recently retired and students)

Population group rating: Good

Findings

- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Patients could book or cancel appointments online and order repeat medication without the need to attend the surgery.
- Patients could access extended hours appointments in the morning and evenings.
- Patients could access telephone appointments and book appointments online.
- The practice had a phlebotomy service.

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). (31/03/2019 to 30/06/2019) (Public Health England)	76.4% ¹	N/A	80% Target	Below 80% target
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2018 to 31/03/2019) (PHE)	77.7%	74.9%	71.6%	N/A
Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)(01/04/2018 to 31/03/2019) (PHE)	57.6%	63.9%	58.0%	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. (01/04/2018 to 31/03/2019) (PHE)	37.7%	62.1%	68.1%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2018 to 31/03/2019) (PHE)	47.0%	56.8%	53.8%	No statistical variation

Any additional evidence or comments

1. The practice's screening and diagnosis data for patients with cancer was comparable with local and national averages. However, cervical screening uptake was below the 80% coverage target for the national screening programme. The practice was aware of this and had taken action to improve cervical screening rates. Measures taken by the practice included ensuring patients were offered

appointments at different times throughout the week, including late appointments, and ensuring a female sample-taker was available. Staff also told us that plans to increase screening rates included arranging education evenings to raise awareness of the importance of screening, using social media offering longer appointment times.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- Same day appointments and longer appointments were offered when required.
- All patients with a learning disability were offered an annual health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice reviewed patients with learning disabilities and complex needs at two local residential homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Good

Findings

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services.
- Same day and longer appointments were offered when required.
- There was a system for following up patients who failed to attend for administration of long-term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- All staff had received dementia training in the last 12 months.
- Patients with poor mental health, including dementia, were referred to appropriate services.
- All practice staff had been trained as Dementia Friends, and learned about the condition to offer advice and support to affected patients and their families.

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	95.7%	92.5%	89.4%	No statistical variation
Exception rate (number of exceptions).	37.8% (14) ¹	16.0%	12.3%	N/A
The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months (01/04/2018 to 31/03/2019) <small>(QOF)</small>	100.0%	91.4%	90.2%	Variation (positive)
Exception rate (number of exceptions).	35.1% (13) ²	15.0%	10.1%	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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	88.5%	84.1%	83.6%	No statistical variation
Exception rate (number of exceptions).	24.3% (25) ³	9.7%	6.7%	N/A

Any additional evidence or comments

Practice exception rates for all three mental health indicators, exceeded local and national averages.

1. The practice was unable to provide unverified or other data for 2019 that may show improvement in exception reporting, because this QOF indicator has been retired from the scheme.
2. Unverified data for 2019 (1 April to 31 December), supplied by the practice, showed this figure is now at 10%, which is in line with local and national averages.
3. Unverified data for 2019 (1 April to 31 December), supplied by the practice, showed this figure is now at 10%, which is in line with local and national averages.

We looked at a selection of clinical records and saw that all patients had been appropriately excepted.

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.

Indicator	Practice	CCG average	England average
Overall QOF score (out of maximum 559)	559.0	552.4	539.2
Overall QOF score (as a percentage of maximum)	100.0%	98.8%	96.7%
Overall QOF exception reporting (all domains)	10.8%	6.2%	5.9%

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a comprehensive programme of quality improvement and used information about care and treatment to make improvements.	Y
Quality improvement activity was targeted at the areas where there were concerns.	Y
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Y

Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years

<p>An audit of smear samples in 2018 found that three of four tests were less than 97% 'adequate' (an adequate smear sample is required to more accurately determine the need for further treatment). A second cycle of the audit was undertaken in 2019, and this found there was a small improvement in adequacy rates.</p> <p>An audit in 2018 looked at the use of antibiotic medication for patients already on the blood thinning drug Warfarin, to see if it affected a patient's INR number (Warfarin is generally used to treat or prevent blood clots in veins or arteries, which can reduce the risk of stroke, heart attack, or other serious conditions. If a patients' INR number is in the normal range, then there are no concerns about blood clotting). The first cycle found that there was poor reasoning, documentation and follow up for antibiotic use. A second cycle in 2019 found that there was a clear rationale for using the antibiotic drug with warfarin, and that all audited patients had an International Normalised Ratio (INR) number in the normal range.</p>

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 the skills, knowledge and experience to deliver effective care, support and treatment. This included specific training for nurses on immunisation and on sample taking for the cervical screening programme.	Y
The learning and development needs of staff were assessed.	Y
The practice had a programme of learning and development.	Y
Staff had protected time for learning and development.	Y
There was an induction programme for new staff.	Y
Induction included completion of the Care Certificate for Health Care Assistants employed since April 2015.	Y
Staff had access to regular appraisals, one to ones, coaching and mentoring, clinical supervision and revalidation. They were supported to meet the requirements of professional revalidation.	Y
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Y
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Y
Explanation of any answers and additional evidence:	

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 (01/04/2018 to 31/03/2019) (QOF)	Y
We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.	Y
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
For patients who accessed the practice's digital service there were clear and effective processes to make referrals to other services.	Y

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.	Y

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 (01/04/2018 to 31/03/2019) <small>(QOF)</small>	91.8%	95.0%	95.0%	No statistical variation
Exception rate (number of exceptions).	0.6% (14)	0.9%	0.8%	N/A

Consent to care and treatment

The practice always obtained consent to care and treatment in line with legislation and guidance.

	Y/N/Partial
Clinicians understood the requirements of legislation and guidance when considering consent and decision making. We saw that consent was documented.	Y
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Y
The practice monitored the process for seeking consent appropriately.	Y
Policies for any online services offered were in line with national guidance.	Y

Notes: CQC GP Insight

GP Insight assesses a practice's data against all the other practices in England. We assess relative performance for the majority of indicators using a "z-score" (this tells us the number of standard deviations from the mean the data point is), giving us a statistical measurement of a practice's performance in relation to the England average. We highlight practices which significantly vary from the England average (in either a positive or negative direction). We consider that z-scores which are higher than +2 or lower than -2 are at significant levels, warranting further enquiry. Using this technique we can be 95% confident that the practices performance is genuinely different from the average. It is important to note that a number of factors can affect the Z score for a practice, for example a small denominator or the distribution of the data. This means that there will be cases where a practice's data looks quite different to the average, but still shows as no statistical variation, as we do not have enough confidence that the difference is genuine. There may also be cases where a practice's data looks similar across two indicators, but they are in different variation bands.

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

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

The following language is used for showing variation:

Variation Bands	Z-score threshold
Significant variation (positive)	≤ -3
Variation (positive)	> -3 and ≤ -2
Tending towards variation (positive)	> -2 and ≤ -1.5
No statistical variation	< 1.5 and > 1.5
Tending towards variation (negative)	≥ 1.5 and < 2
Variation (negative)	≥ 2 and < 3
Significant variation (negative)	≥ 3

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

- Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have "Met 90% minimum" have not met the WHO target of 95%.
- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of 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.