Care Quality Commission

Inspection Evidence Table

Woodhouse Hill Surgery (1-6453769443)

Inspection date: Tuesday 30 April 2019

Date of data download: 12 April 2019

The data included in this report relates to when the previously registered individual provider was operating the service. However, that GP is still the lead GP within this recently registered partnership, therefore there is a continuity of clinical care and service provision.

Overall rating: Requires Improvement

At the last comprehensive inspection, carried out in April & May 2018 we rated the practice as inadequate. The practice was placed in special measures because:

- The provider was not keeping an accurate record with respect to each patient. Not all patients were clinically coded correctly to support delivery of care and treatment.
- There was a significant backlog of patient records that required summarising.
- The practice did not have a system in place for carrying out a review of changes introduced following significant events.
- The provider did not have clear or effective systems in place for the planning and provision of staffing levels.
- National GP patient survey results with regards to access were lower than local and national averages.
- The recruitment process in place was not operating effectively. Some of the information required to be held to support the recruitment of staff was not available.

At this inspection, we found that the provider had satisfactorily addressed most of these areas and is now rated as requires improvement overall and for all of the population groups.

Safe Rating: Good

At the last comprehensive inspection, carried out in April & May 2018 we rated the practice as Inadequate for providing safe services because:

• A significant number of patients' records were not up to date and did not always include clinical information to support safe practice.

• We found leaders and managers were not always present, and the staff on duty did not have a good understanding of day to day activity at the practice.

• There was limited evidence that the practice was using up to date patient information (patient records were incomplete) to make clinical decisions. Locums (and other clinical staff) were viewing incomplete patient information in their records.

• The practice did not have a system in place for carrying out a planned review of changes introduced following significant events, to determine their effectiveness and to assure themselves that changes had been embedded into practice.

At this inspection, we found that the provider had satisfactorily addressed these areas and is now rated good for providing safe services.

Safety systems and processes

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

Safeguarding	Y/N/Partial
There was a lead member of staff for safeguarding processes and procedures.	Y
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
There were policies covering adult and child safeguarding.	Y
Policies took account of patients accessing any online services.	Y
Policies and procedures were monitored, reviewed and updated.	Y
Policies were accessible to all staff.	Y
Partners and staff were trained to appropriate levels for their role (for example, level three for GPs, including locum GPs).	Y
There was active and appropriate engagement in local safeguarding processes.	Y
There were systems to identify vulnerable patients on record.	Y
There was a risk register of specific patients.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Y
Staff who acted as chaperones were trained for their role.	Y
There were regular discussions between the practice and other health and social care professionals such as health visitors, school nurses, community midwives and social workers to support and protect adults and children at risk of significant harm.	Y
Explanation of any answers and additional evidence:	

Safeguarding	Y/N/Partial
The practice manager managed and maintained policies. They had developed a matrix of the practice's policies so that there was a schedule to help ensure they were up date and contained the correct information. The policies we saw were dated and had a review date. For example, we checked the safeguarding policy. It was up to date and included the correct information on whom to contact for safeguarding issues. On the back of all the clinical room doors there were updated safeguarding contact details. These had been updated two weeks prior to the inspection. The practice had identified patients where there had been safeguarding concerns, including victims of domestic abuse or those at risk of abuse. The practice had increased online patient registrations since the last inspection. We looked at the latest (April 2019) GP dashboard figures that showed Woodhouse Hill Surgery had 41.5% of patients registered with full access to their medical records. At the time of our inspection, this was the highest percentage in the CCG. We saw a copy of a report from 'MyHealthHuddersfied' dated April 2019 that confirmed this.	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Y
Staff vaccination was maintained in line with current Public Health England (PHE) guidance and if relevant to role.	Y
There were systems to ensure the registration of clinical staff (including nurses and pharmacists) was checked and regularly monitored.	Y
Staff had any necessary medical indemnity insurance.	Y
Explanation of any answers and additional evidence: We looked at the files of staff recruited since the last inspection. The files contained the necessary recruitment checks including, proof of identity and references. Hepatitis B forms were seen for all staff that required them. A staff matrix was seen with indemnity cover validation dates recorded for all clinical staff. We also saw copies of the indemnity certificates for the two lead GPs to corroborate this.	

Safety systems and records	Y/N/Partial
There was a record of portable appliance testing or visual inspection by a competent person. Date of last inspection/test: 13.02.2019	Y
There was a record of equipment calibration. Date of last calibration: 13.02.2019	Y
There were risk assessments for any storage of hazardous substances for example, liquid nitrogen, storage of chemicals.	Y
There was a fire procedure.	Y
There was a record of fire extinguisher checks. Date of last check: 15.10.2018	Y
There was a log of fire drills. Date of last drill: 06.02.2019 (every six months)	Y
There was a record of fire alarm checks. Date of last check: 24.04.2019 (Weekly)	Y
There was a record of fire training for staff. Date of last training: 28.01.2019	Y
There were fire marshals.	Y
A fire risk assessment had been completed. Date of completion: 03.04.2019	Y
Actions from fire risk assessment were identified and completed.	Y
Explanation of any answers and additional evidence: A digital record was in place to ensure that all environmental, health and safety and building maintenance checks were up to date and could be easily monitored. We saw that all issues relating to the day to day management of a general practice had been considered and were being closely monitored by the practice manager.	

Health and safety	Y/N/Partial
Premises/security risk assessment had been carried out. Date of last assessment: 11.2018	Y
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 11.2018	Y
Explanation of any answers and additional evidence: As a result of a recent health and safety assessment a chair had been removed from the reception area in order to enable easier access in case of an emergency. The practice was in the process of purchasing a fire blanket and installing security lighting outside the fire	

exit door.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
There was an infection risk assessment and policy.	Y
Staff had received effective training on infection prevention and control.	Y
Date of last infection prevention and control audit:	Jan 2019
The practice had acted on any issues identified in infection prevention and control audits.	Y
The arrangements for managing waste and clinical specimens kept people safe.	Y

Explanation of any answers and additional evidence:

The practice building had undergone some refurbishment since the last inspection. This had been completed in compliance with the most recent guidance on infection prevention and control. There were daily, weekly, monthly and annual cleaning schedules. We saw that these were routinely completed.

The practice held a service level agreement with an established clinical waste disposal service. Waste storage bins were locked and kept secure. Waste records were being maintained.

There was a procedure in place to safely handle patient specimens both on receipt at the surgery and at dispatch. Spillage kits were available and staff were confident in their usage. Recently the practice had moved to using disposable cleaning cloths and mop heads.

Infection prevention and control (IPC):

- The 2018 & 2019 external infection control audit found generally safe levels of compliance. The initial audit had resulted in a score of 65% for specific areas and activities. As a result of this, an action plan was developed and we saw that the majority of the actions had been completed. The practice was waiting for the re-audit which was due to commence in June 2019. This audit would be the first opportunity for the previously awarded score to be updated, in line with the external agencies' protocols, following the actions the provider had taken to improve the environment. The external audit was supported by an annual self-audit.
- We saw the site was visibly clean and there was effective monitoring of the cleaning contractors in place. The cleaner we spoke with confirmed this.

The COSHH 'Control of Substances Hazardous to Health' cupboard was kept locked. The practice was going to check with the IPC audit company whether they needed a sign on the door to alert staff as to where the chemicals are kept.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

	Y/N/Partial
There was an effective approach to managing staff absences and busy periods.	Y
There was an effective induction system for temporary staff tailored to their role.	Y
Comprehensive risk assessments were carried out for patients.	Y
Risk management plans for patients were developed in line with national guidance.	Y
Panic alarms were fitted and administrative staff understood how to respond to the alarm and the location of emergency equipment.	Y
Clinicians knew how to identify and manage patients with severe infections including sepsis.	Y
Receptionists were aware of actions to take if they encountered a deteriorating or acutely unwell patient and had been given guidance on identifying such patients.	Y
There was a process in the practice for urgent clinical review of such patients.	Y
There was equipment available to enable assessment of patients with presumed sepsis or other clinical emergency.	Y
There were systems to enable the assessment of patients with presumed sepsis in line with National Institute for Health and Care Excellence (NICE) guidance.	Y
When there were changes to services or staff the practice assessed and monitored the impact on safety.	Y

Explanation of any answers and additional evidence:

The practice had setup a 'WhatsApp' group (all clinical and management staff were included in this group). Recently this had been used to communicate the latest sepsis information and guidance, and delivery notification had been received. Follow up team meetings provided assurance that staff have read and understood it.

Information with regards to sepsis awareness was visible in the practice with posters displayed in waiting rooms and consultation rooms. Staff had received awareness training for sepsis.

At the time of our inspection, the fire exit door did not have a sign on it to clearly show that this was a fire door. The provider placed a sign on the door to that effect while we were on the premises. The practice manager was going to contact the CCG health and safety team to discuss this further.

Rotas were in place to effectively manage staff capacity and availability.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment.

	Y/N/Partial
Individual care records, including clinical data, were written and managed securely and in line with current guidance and relevant legislation.	Y
There was a system for processing information relating to new patients including the summarising of new patient notes.	Y
There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Y
Referral letters contained specific information to allow appropriate and timely referrals.	Y
Referrals to specialist services were documented.	Y
There was a system to monitor delays in referrals.	Y
There was a documented approach to the management of test results and this was managed in a timely manner.	Y
The practice demonstrated that when patients use multiple services, all the information needed for their ongoing care was shared appropriately and in line with relevant protocols.	Y

Explanation of any answers and additional evidence:

On the day of our inspection we saw that there were 116 outstanding patient records which required summarising (this had reduced from 638 at the previous inspection in May 2018.) However, out of the 116 records, the practice only had access to five (which required summarising). The remaining 111 records were awaiting to be received from Primary Care Support England (PCSE). Those patients had been invited into the practice for a review between August and December 2018 to reduce the risks associated with not having access to their records. The practice had followed up any patients who had not attended.

NHSE had audited a sample of clinical records in Aug 2018 and the findings showed the practice's record keeping quality was at 88% (above national average).

Appropriate and safe use of medicines

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

Indicator	Practice	CCG average	England average	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/01/2018 to 31/12/2018) (NHS Business Service Authority - NHSBSA)	1.75	1.03	0.91	Significant Variation (negative)
The number of prescription items for co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of prescription items for selected antibacterial drugs (BNF 5.1 sub-set). (01/01/2018 to 31/12/2018) (NHSBSA)	4.4%	7.1%	8.7%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/07/2018 to 31/12/2018) (NHSBSA)	6.17	5.76	5.60	No statistical variation
Average daily quantity of oral NSAIDs prescribed per Specific Therapeutic Group Age-sex Related Prescribing Unit (STAR-PU) (01/07/2018 to 31/12/2018) (NHSBSA)	1.85	2.78	2.13	No statistical variation

Medicines management	Y/N/Partial
The practice ensured medicines were stored safely and securely with access restricted to authorised staff.	Y
Blank prescriptions were kept securely and their use monitored in line with national guidance.	Y
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Y
The practice could demonstrate the prescribing competence of non-medical prescribers, and there was regular review of their prescribing practice supported by clinical supervision or peer review.	Y
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Y
The practice had a process and clear audit trail for the management of information about changes to a patient's medicines including changes made by other services.	Y

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.	Y
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Y
There were arrangements for raising concerns around controlled drugs with the NHS England Area Team Controlled Drugs Accountable Officer.	Y
If the practice had controlled drugs on the premises there were appropriate systems and written procedures for the safe ordering, receipt, storage, administration, balance checks and disposal of these medicines, which were in line with national guidance.	N/A
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	Y
For remote or online prescribing there were effective protocols for verifying patient identity.	Y
The practice held appropriate emergency medicines, risk assessments were in place to determine the range of medicines held, and a system was in place to monitor stock levels and expiry dates.	Y
The practice had arrangements to monitor the stock levels and expiry dates of emergency medicines/medical gases.	Y
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Y
Vaccines were appropriately stored, monitored and transported in line with PHE guidance to ensure they remained safe and effective.	Y

Explanation of any answers and additional evidence:

The practice had created a system to audit antibiotic prescribing such as the prescribing of quinolones, cephalosporins, co-amoxiclav and nitrofurantoin, to ensure these were only prescribed in line with guidelines. The lead GP sent email notification updates to all the prescribers within the service.

The most recent (2018/19, Quarter 2) CCG Prescribing Data showed year on year improvements ranging from 12.5% to 61% improvement in general prescribing performance.

The practice aimed to reduce antibiotic prescribing by working together with the CCG Medicines Management team. The practice had conducted a 'Patient Education Campaign' in the surgery. This included:

Displaying posters and notices in the waiting room to raise awareness of appropriate antibiotic prescribing.

GPs gave out "Treating your infection" information leaflets to patients to help to educate them further.

In-house meetings were held with the CCG to review progress and share best practice.

The practice, as a result of increasing online registration, had changed their policy which stated that patient identification must be verified before giving patients information about their care.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Y
Staff knew how to identify and report concerns, safety incidents and near misses.	Y
There was a system for recording and acting on significant events.	Y
Staff understood how to raise concerns and report incidents both internally and externally.	Y
There was evidence of learning and dissemination of information.	Y
Number of events recorded in last 12 months:	7
Number of events that required action:	7

Example(s) of significant events recorded and actions by the practice.

Event	Specific action taken
Fridge Temperatures.	Review and update of cold chain policy to ensure a single record and location of record is maintained. Now all cold chain recording is done using an electronic method.
Delay in sending PAL referral	Locum GP delayed a referral. The practice has created a clear flow chart. The referral form for PALS has been updated and this refined method implemented.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Y
Staff understood how to deal with alerts.	Y

Effective Rating: Requires Improvement

At the last comprehensive inspection, carried out in April & May 2018 we rated the practice as Requires Improvement for providing effective services because:

- Quality and Outcomes Framework (QOF) data, particularly for people with long-term conditions (Diabetes) was lower than local and national averages indicating that a large proportion of patients had not been monitored effectively.
- Due to data inputting issues and some inaccuracies in the performance data, the patient information and medical record system used was not able to assist the practice in monitoring patients effectively enough.
- There were examples where uptake for screening programmes were below local and national averages.
- Where older patients had complex needs, the practice shared summary care records with local care services. However, we noted a backlog in summarising of patient records. There were also clinical coding omissions on a selection of patient records that we reviewed. This meant there was a risk that the information shared with local care services may not have been comprehensive or accurate.

At this inspection, we found that the provider had addressed some of these areas, but is still rated as Requires Improvement for providing effective services due to the population groups of People with long-term conditions, Working age people and People experiencing poor mental health (including people with dementia) being rated as requires improvement.

We rated these three population groups as requires improvement because:

- Outcomes for patients living with diabetes, hypertension and mental health conditions were lower than local and national averages. This includes on areas as measured by the Quality and Outcomes Framework (QOF).
- The uptake of two of the four childhood immunisations for children under two years of age was below WHO target levels of coverage.
- The uptake of breast and bowel cancer screening was below local and national averages.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment were 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 needs and their mental and physical wellbeing.	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 were in place 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

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) (01/01/2018 to 31/12/2018) (NHSBSA)	0.77	0.79	0.79	No statistical variation

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 used a fragility register. Currently there were 60 patients on the practice register.
- The practice followed up on older patients discharged from hospital. Staff ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.
- Health checks were offered to patients over 75 years of age. There had been 154 patients identified by the practice. Seventeen of these patients were awaiting the offer of a health check. The practice was in process of writing to these patients.
- In 2017/18 the practice completed 60 home visits. In 2018/19 the practice completed 97 home visits. This is a 62% Year on Year increase in visits to housebound, elderly and vulnerable patients.

People with long-term conditions

Population group rating: Requires Improvement

Findings

- All of the Diabetes indicators were below the CCG & England average.

The percentage of patients with diabetes, with no average blood glucose (sugar) levels test in the past 12 months was 14%. The practice shared some data with us from 2018-19 that showed this had improved by 16% . Also 100% patients with no average blood glucose (sugar) levels in the past 12 months had been sent a letter invite with a blood form. This data has not yet been verified or published. The practice manager told us that these results have been achieved by clinician-led quality improvement activity, including 2-cycle audit, review and cascading of protocols and in-house training with the nursing team.

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) was 61%. The practice shared some data with us from 2018-19 that showed this had improved by 10% to 71%. This data has not yet been verified or published. This equates to 54 people who are “missing” the target. Of the 54, 42 people last had a blood test within the last 12 months. All 54 patients have been invited and provided with a blood form as part of the recall system. The practice continues to invite these patients monthly as part of the recall and anticipate this figure will continue to improve.

- We saw evidence that prior to the commencement of Ramadan, the practice contacted all their diabetic patients and those who wished to observe a period of fasting had their medications proactively reviewed with a GP.

- Patients with long-term conditions had 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. The practice nurse has attended training recently.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- The practice could demonstrate how they identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- 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.

Diabetes Indicators	Practice	CCG average	England average	England comparison
The percentage of patients with diabetes, on	70.7%	79.8%	78.8%	No statistical

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) (QOF)				variation
Exception rate (number of exceptions).	5.1% (10)	10.6%	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) (QOF)	65.9%	76.7%	77.7%	No statistical variation
Exception rate (number of exceptions).	6.6% (13)	7.8%	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) (QOF)	60.8%	75.1%	80.1%	Significant Variation (negative)
Exception rate (number of exceptions).	8.6% (17)	13.6%	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)	90.2%	77.7%	76.0%	Variation (positive)
Exception rate (number of exceptions).	3.8% (9)	3.8%	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)	81.3%	90.7%	89.7%	No statistical variation
Exception rate (number of exceptions).	2.6% (2)	9.5%	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)	68.1%	82.9%	82.6%	Significant Variation (negative)
Exception rate (number of exceptions).	5.5% (22)	3.4%	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)	76.2%	88.5%	90.0%	No statistical variation
Exception rate (number of exceptions).	25.0% (7)	7.7%	6.7%	N/A

Any additional evidence or comments

The practice manager told us that there had been a coding issue with some of their diabetes patients. When patients were on maximum tolerated therapies they should have been coded as such. Some of these medicines cannot be titrated further to achieve the cholesterol control required.

The practice actively invited patients to test their cholesterol. They had a register of the last time cholesterol was recorded and if it had been over three months ago, the patients were invited to the practice again. We saw that 42 patients out of 195 had not had their cholesterol tested in the last 12 months. We saw evidence that that these 42 had been invited for a cholesterol check.

The practice conducted an audit of the diabetic recall system. As a result, there was a review and refresher training of diabetic management protocols and in-house training sessions undertaken with the nursing team. The data above is over a year old and unverified data provides a more up to date picture.

We saw unverified practice data for February 2019, (year-end data was not available) which showed:
71.7% of diabetic patients with hba1c <64 (1% improvement)
66.4% of diabetic patients with cholesterol < 5. (5 % improvement)

Unverified data showed that blood pressure (BP) recording had been achieved for 80% of the practice patients who required it. We saw that 80 patients had been identified who were missing the target or it had been 12 months since their last BP check. It was noted that 32 out of 80 had not had a BP check. We looked at a sample of patients records which showed systematic recall of these patients had occurred.

Families, children and young people Population group rating: Good

Findings

- The practice prioritises young people with asthma for review. The practice achieved 86% of reviews for patients under 18 (QOF target for asthma review was 70%)
- The practice achieved updated smoking status for 92% of patients aged 14-19 with asthma. (QOF Target was 80%).
- The practice promoted online access to GP services. Patients could book appointments, order medication and view their record online. We were told that the practice was leading the way in the Primary Care Network with 39% of patients registered to use online services. (CCG/NHS target was 30%). The practice was sharing their learning with other practices. In the past three months the percentage of appointments booked online have ranged between 9% and 12% of all appointments in the calendar month.
- The practice offers a choice of eight “extended access” appointments per day available after 6.30pm, and on Saturday and Sunday. These are offered to working patients who report difficulties attending the surgery due to work commitments and/or child care issues.
- Childhood immunisation uptake rates were in line with the World Health Organisation (WHO) targets for two of the four indicators.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. It was noted that 32 pregnant patients had all been seen by midwife. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- 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 conducted an audit review of babies who had received their first, second but not third Meningitis B vaccination. The audit identified that 57% had been administered and the remainder were being invited on a regular basis. The audit was planned to be repeated in a month’s time.
- Young people could access services for sexual health and contraception.
- An effective process is in place to ensure post-natal reviews are carried out within eight weeks from birth. This is a multidisciplinary team (MDT) approach with health visitor staff and family support teams.

Child Immunisation	Numerator	Denominator	Practice %	Comparison to WHO target
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) (01/04/2017 to 31/03/2018) (NHS England)	64	70	91.4%	Met 90% minimum (no variation)
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2017 to 31/03/2018) (NHS England)	60	65	92.3%	Met 90% minimum (no variation)
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) (01/04/2017 to 31/03/2018) (NHS England)	58	65	89.2%	Below 90% minimum (variation negative)
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2017 to 31/03/2018) (NHS England)	56	65	86.2%	Below 90% minimum (variation negative)

Any additional evidence or comments

We discussed the mixed level of performance in relation to child immunisations with the provider. They told us that they had hoped to improve this through:

- Actively engaging with parents at every opportunity.
- When necessary repeatedly contacting parents, who had failed to have their child immunised, to persuade them to bring in their child.
- Arranging some additional immunisation clinics for children.

As a result of the above data the practice have created extra nurse appointments which are also available to book online in order to achieve the 90% target.

The practice have increased nursing team cover from 36 to 42 hours per week (17% increase) since the last inspection in 2018.

20-minute nurse appointments have been made available to book online for child immunisations. This has increased access for this particular cohort of patients.

Last quarter, the practice achieved 90% vaccination rates of eligible children. This data has not been verified or published.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

- The practice offered a choice of eight extended access appointments per day available after 6.30pm, and on Saturday and Sunday. These were offered to working patients who report difficulties attending the surgery due to work commitments or child care issues.
- In the last 6 months, the practice had invited 333 patients aged 40 – 74 for an NHS health check. 121 patients have attended these appointments so far. This had led to newly diagnosed hypertension in 10 patients who were now receiving appropriate care and treatment to help them to manage this condition. 34 patients had been given specific lifestyle advice to improve their health.
- The practice audited the number of patients aged 25-30 with no first cervical screening. These patients were contacted by the practice nurse to discuss and reassure. This resulted in increased uptake for patients aged 25-30 with no smear history.
- An audit of the cervical screening recall and follow up process showed a 92% improvement in administering a safety-net and follow up tasks to ensure smear results were back within two weeks of having a smear test. This was due to the implementation of a protocol which generated a task to admin for every smear done and read coded.
- Outcomes and Recommendations from Cycle 1 and 2 of the audit were:

  100% of smears had been read coded correctly.
  92% of smears had been tasked to Admin to check results were back within 2 weeks.
  100% of tasks had been actioned within 14-21 days to ensure results were back.
  2 out of 76 (2.6%) smears conducted this quarter had required intervention.
  1 of the 2 abnormal results was followed up as a result of the safety netting processes in place to ensure that patients who needed to be seen again were seen.

- The practice nurse reviewed smear history for all newly registered patients eligible for cervical screening and encouraged them to come for screening.
- 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. Available on line. 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.

Cancer Indicators	Practice	CCG average	England average	England comparison
The percentage of women eligible for cervical	69.7%	76.6%	71.7%	No statistical

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)				variation
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2017 to 31/03/2018) **(PHE)**	49.0%	66.1%	-	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)**	49.8%	58.6%	54.5%	N/A
The percentage of patients with cancer, diagnosed within the preceding 15 months, who have a patient review recorded as occurring within 6 months of the date of diagnosis. (01/04/2017 to 31/03/2018) **(PHE)**	55.6%	66.5%	-	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)	66.7%	53.0%	51.9%	No statistical variation

Any additional evidence or comments

The practice was aware that the uptake of cervical screening was just below the national average. The practice wrote to women who had not taken up the offer to remind them of its importance. The practice showed evidence that other nearby practices had had similar uptake rates.

The practice looked at cervical screening every three months. We noted that 763 out 886 eligible patients had received cervical screening (this was unverified data from the practices IT system). The practice had actively engaged with eligible patients who were under 30 years of age with no smear history; this was currently 40 patients.

In an attempt to increase uptake with national screening programmes, the practice had arranged for a training session with a breast screening team in November 2018. This led to promotional material being used on social media. As a result, patients were contacted and given details for breast screening. This was aimed at 50 to 70-year olds. A report was created and regular reminders were sent to this group of patients.

Other data that is unverified by the practice showed that cancer care review currently stands at 100% for patients as was the case at the previous inspection.

People whose circumstances make them vulnerable

Population group rating: Good

Findings

- 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 holds a register of those patients who require palliative care.

- The practice held a register of patients living in vulnerable circumstances, which included patients who have a learning disability, where of no fixed abode or a traveller.
- 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 young patients at local residential homes. There were a total of 20 patients across six homes.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings

- In 2018/19, 30 patients were invited in for an extended appointment with a GP. This gave these vulnerable/elderly patients adequate time (at least 20 minutes) to deal with complex needs. For example, elderly, learning disabilities, dementia and other mental health related problems.
- Care planning arrangements have been improved in the practice. This is demonstrated by an achievement of 91% (previously 71%, July 2018) of dementia patients having been reviewed within the past 12 months.
- The practice engages carers and involves support workers to improve engagement.
- The practice arranges home visits for people experiencing poor mental health who fail to attend, where appropriate.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder. They provided access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
- There was a system for following up patients who failed to attend for the 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.

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)	70.7%	92.1%	89.5%	Variation (negative)
Exception rate (number of exceptions).	2.4% (1)	9.4%	12.7%	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 (01/04/2017 to 31/03/2018) (QOF)	52.4%	89.8%	90.0%	Significant Variation (negative)
Exception rate (number of exceptions).	0 (0)	8.5%	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)	100.0%	85.7%	83.0%	Variation (positive)
Exception rate (number of exceptions).	0 (0)	5.0%	6.6%	N/A

Any additional evidence or comments
The practice manager told us that patients with schizophrenia, bipolar affective disorder did not always attend for their care plan reviews. There were currently As of April 2019, 49 patients, 73% of whom have had a care plan agreed. This data has not yet been verified or published. The outstanding patients had all been invited to attend for a review. The practice used a variety of recall methods including a texting service, letters for invite and telephoning patients to attend appointments. The practice informed us that recording the alcohol consumption of patients could be challenging, due to patients not providing appropriate information.

Monitoring care and treatment

The practice had a 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)	452.6	539.1	537.5
Overall QOF exception reporting (all domains)	3.9%	5.7%	5.8%

	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

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

We looked at three quality improvement initiatives. There was evidence that audits were used to drive improvement.
For example, an AF (atrial fibrillation) audit was completed to ensure all patients were appropriately risk assessed and anticoagulated where appropriate. Work carried out to increase the number of patients who had been risk assessed in the past 12 months resulted in an improvement from 88% to 100% of AF patients risk assessed and anticoagulated. This resulted in three patients being reviewed at face to face appointments and counselled and issued with anticoagulant medication.

Other examples include improvements in outcomes for Cervical Screening and Dementia reviews.

Any additional evidence or comments

The practice was running a pilot by providing a pulse oximeter for patients who regularly attended A&E. Patients reported anxiety over fast/slow pulse rates. The aim was to reduce A&E attendance and admission by patient self-help tools.

The practice had increased awareness of A&E attendance rates and the appropriate criteria for attending A&E. The practice provided an in-house newsletter to educate patients and displayed posters in waiting room. All administration staff had been trained in active signposting to direct patients to the appropriate service. The introduction of extended access appointments offered patients appointments for longer and discourages patients from going to A&E out of hours.

Comparing data from April to December 2016 with April to December 2017, the practice reported a cost change (cost per 1000 patients) which was 10% greater than the CCG average for attendances at A&E. April to December 2018 data showed that patients registered at the practice had a cost change which was 2% greater than the CCG average. This indicated how patients registered at the practice were using A&E closer to the average practice in the CCG in 2018 compared with 2017, and showed an improvement compared to 2017 and 2016 figures. This illustrates how the practice was outperforming the CCG average for emergency hospital admissions lasting over 1 day.

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: A computer based, comprehensive training matrix which also included the dates of appraisals was in place which alerted the practice manager when any training was due. All care certificate criteria were covered in the induction pack; this included equality & diversity training.	

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)	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	Y

organisations were involved.	
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
Explanation of any answers and additional evidence: The percentage of patients who had registered for online services was 42%. We were informed that one in ten appointments were being booked via the online practice portal.	

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
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
Explanation of any answers and additional evidence: Breast Screening training for all staff involved in the management of this activity was delivered by an external organisation, in November 2018.	

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)	91.2%	95.2%	95.1%	Tending towards variation (negative)
Exception rate (number of exceptions).	0.3% (2)	0.7%	0.8%	N/A

Any additional evidence or comments
The practice had achieved just below national average performance in relation to smoking indicator programmes. They told us that they actively engaged with patients to improve take-up. For example, for asthma the practice had: • Appointed an asthma champion to promote participation. • Sent patients a letter promoting the programme with the name of their GP. • Discussed with patients who did not participate and encouraged them to take part. The practice delivered: • Weight Management • Smoking Cessation • NHS Health Checks • Flu Campaigns

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
Explanation of any answers and additional evidence: Whilst most consent was seen within the practice as being implied, activities which were more intimate or invasive had consent noted in the patient record. The consent policy was dated Oct 2018 it was appropriate and used accordingly.	

Caring Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion. Feedback from patients was positive about the way staff treated people.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y
Explanation of any answers and additional evidence: Patients in the waiting area were treated in a friendly manner and with respect.	

CQC comments cards	
Total comments cards received.	15
Number of CQC comments received which were positive about the service.	12
Number of comments cards received which were mixed about the service.	3
Number of CQC comments received which were negative about the service.	0

Source	Feedback
CQC Patient Feedback cards	Patients said that the GPs were helpful and that staff were always very helpful, polite and happy. They also commented that staff were very caring and treated you with dignity, and they were always willing to held and advise.

National GP Survey results

Note: The questions in the 2018 GP Survey indicators have changed. Ipsos MORI have advised that the new survey data must not be directly compared to the past survey data, because the survey methodology changed in 2018.

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3653	411	105	25.5%	2.87%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at listening to them (01/01/2018 to 31/03/2018)	88.2%	91.0%	89.0%	No statistical variation
The percentage of respondents to the GP patient survey who stated that the last time they had a general practice appointment, the healthcare professional was good or very good at treating them with care and concern (01/01/2018 to 31/03/2018)	86.7%	89.4%	87.4%	No statistical variation
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they had confidence and trust in the healthcare professional they saw or spoke to (01/01/2018 to 31/03/2018)	94.2%	96.9%	95.6%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2018 to 31/03/2018)	74.2%	86.9%	83.8%	No statistical variation

Any additional evidence or comments
Both patient interviews and comment card responses showed that patients felt that all staff listened to them and discussed their concerns. They told us that the services were flexible to their needs and that they showed understanding and care.

Question	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

Any additional evidence
The practice has developed an on-line survey, of which 271 patients responded. The survey was sent out to all patients that booked an appointment. The following data was collected from patients this month. The practice manager told us that they discussed these results at practice meetings. Was the appointment you booked convenient – 72.2% Yes Was the receptionist polite – 81.9% Yes Was the receptionist caring – 67.6% Yes How helpful was the receptionist – 77.7% Very/fairly helpful

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment.

	Y/N/Partial
Staff communicated with patients in a way that helped them to understand their care, treatment and condition, and any advice given.	Y
Staff helped patients and their carers find further information and access community and advocacy services.	Y
Explanation of any answers and additional evidence: In response to the GP patient survey the practice: • Provided promotional material in reception to encourage patients to participate in subsequent surveys. • All staff completed customer care training and customer services courses. • Appointment times and availability were reviewed with the patient participation group. An action plan was going to be developed to try and improve appointment availability.	

Source	Feedback
NHS Choices	Patients said they love this surgery

National GP Survey results

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as	92.8%	94.5%	93.5%	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
much as they wanted to be in decisions about their care and treatment (01/01/2018 to 31/03/2018)				

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Y
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Y
Information leaflets were available in other languages and in easy read format.	Y
Information about support groups was available on the practice website.	Y
Explanation of any answers and additional evidence: We saw that a wide range of leaflets and information was available for patients.	

Carers	Narrative
Percentage and number of carers identified.	18. This represented less than 1% of the practice population.
How the practice supported carers.	There was a carers notice board in reception that included relevant information for carers. The practice used their social media page to support carers with information that may be useful.
How the practice supported recently bereaved patients.	GPs attend funerals of patients when possible.

Privacy and dignity

The practice respected always respect patients' privacy and dignity.

	Y/N/Partial
Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.	Y
Consultation and treatment room doors were closed during consultations.	Y
A private room was available if patients were distressed or wanted to discuss sensitive issues.	Y
There were arrangements to ensure confidentiality at the reception desk.	Y
Explanation of any answers and additional evidence: There was a poster in reception advertising the provision of a private area for mothers who wished to breastfeed on the premises.	

Responsive Rating: Requires Improvement

At the last inspection, carried out in April & May 2018, we rated the practice as Requires Improvement for providing responsive services because:

- Although the provider appeared to be responsive, the evidence we collected as part of the inspection did not always support this. We found that in some areas this service was not providing effective care in accordance with the relevant regulations.
- There were issues affecting the delivery of responsive services to patients. Some patient comments were negative toward the availability of care received. Significant concerns remained, the practice was below local and national average scores in GP survey results.

At this inspection, we found that the provider had addressed some of these areas however, there were still some concerns with regards to patient satisfaction with access to the service. The practice is still rated as requires improvement for providing responsive services and for all of the population groups as access to the service has the potential to impact on all patients.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs.

	Y/N/Partial
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Y
The facilities and premises were appropriate for the services being delivered.	Y
The practice made reasonable adjustments when patients found it hard to access services.	Y
The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.	Y
Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.	Y
Explanation of any answers and additional evidence: The practice had recently installed a new door that was wider and afforded improved access for people with disabilities and wheelchair users.	

Practice Opening Times	
Day	**Time**
Opening times:	
Monday	8:30AM to 6:30PM
Tuesday	8:30AM to 6:30PM
Wednesday	8:30AM to 6:30PM
Thursday	8:30AM to 12PM
Friday	8:30AM to 6:30PM

Appointments available:	
Monday	8:30AM to 6:30PM
Tuesday	8:30AM to 6PM
Wednesday	8:30AM to 6PM
Thursday	8:30AM to 12PM
Friday	8:30AM to 6PM

National GP Survey results

Practice population size	Surveys sent out	Surveys returned	Survey Response rate%	% of practice population
3653	411	105	25.5%	2.87%

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who stated that at their last general practice appointment, their needs were met (01/01/2018 to 31/03/2018)	93.3%	96.0%	94.8%	No statistical variation

Any additional evidence or comments

There was a strong ethos that the patients' needs came first. We saw information reminding staff that if they felt patients needed to be seen they should be booked in for an appointment. All the clinical staff accepted that meant, on occasion, that sessions would overrun but all supported this ethos.

The practice was part of a federation which offered a weekend service, 1pm to 4pm on both Saturday & Sunday which was operated and located at Huddersfield Royal Infirmary.

Older people

Population group rating: Requires Improvement

Findings

Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including:

- In 2018/19, 30 patients were invited in for an extended appointment with a GP. This gave these vulnerable/elderly patients adequate time (at least 20 minutes) to deal with complex needs for example, elderly, learning disabilities, dementia and other mental health related problems.
- In 2017/18 the practice completed 60 home visits. In 2018/19 the practice completed 97 home visits. This was a 62% year on year increase in visits to housebound, elderly and vulnerable patients.
- Care planning arrangements have been improved in the practice. This was demonstrated by an achievement of 91% of dementia patients having been reviewed within the past 12 months (same as July 2018.
- The practice has reported that 100% of patients with a new cancer diagnosis have been reviewed within six months of diagnosis. This data has not been published or verified.

- 100% of patients with palliative conditions have had advanced care planning discussed (CCG EPACCS template) to aid the delivery of Gold Standard Framework (GSF) care for those on end of life pathways.

- In the past month, the GP attended the funeral of a recently deceased patient. This was followed up with a home visit to the patient's wife to provide information about support and assistance in dealing with bereavement.
- A year on year (2017/18/2018/19) review of number of medication reviews carried out showed an increase of 136% which reflected the quality improvement activity over that period.
- All patients had a named GP who supported them in whatever setting they lived.
- The practice was responsive to the needs of older patients and offered home visits and urgent appointments for those with enhanced needs and complex medical issues.
- In recognition of the religious and cultural observances of some patients, the GP would respond quickly, often outside of normal working hours, to provide the necessary death certification to enable prompt burial in line with families' wishes when bereavement occurred.
- Patients were encouraged to sign up to the electronic prescribing service (EPS). At the time of our inspection, 96% of the practice's registered older people were signed up to EPS.

People with long-term conditions

Population group rating: Requires Improvement

Findings

Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including:

- Patients with multiple conditions had their needs reviewed in one appointment.
- The practice liaised regularly with the local district nursing team and community matrons to discuss and manage the needs of patients with complex medical issues.
- Care and treatment for people with long-term conditions approaching the end of life was coordinated with other services.

Families, children and young people

Population group rating: Requires Improvement

Findings

Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including:

- Additional nurse appointments were available until 6.30pm on a Monday and Friday for school-age children so that they did not need to miss school.
- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- Parents with concerns regarding children under the age of five could attend a drop-in clinic held at the same time as the twice weekly baby clinic.

- The practice distributed an easy read cervical screening guide to all relevant patients.

Working age people (including those recently retired and students)

Population group rating: Requires Improvement

Findings

Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including:

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Pre-bookable appointments were also available to all patients at additional locations within the area, as the practice was a member of a GP federation. Appointments were available Saturday and Sunday 10am until 1pm at a local extended access hub.
- The practice had increased online patient registrations since the last inspection. We looked at the latest (April 2019) GP dashboard figures that showed Woodhouse Hill Surgery had 41.5% of patients registered with full access to their medical records. At the time of our inspection, this was the highest percentage in the CCG. We saw a copy of a report from 'MyHealthHuddersfied' dated April 2019 that confirmed this.

People whose circumstances make them vulnerable

Population group rating: Requires Improvement

Findings

Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability.

People experiencing poor mental health (including people with dementia)

Population group rating: Requires Improvement

Findings
Patient satisfaction with access to aspects of the service was well below local and national averages. This impacts on all patients, including this population group. There were also examples of good responsive care being provided, including: • Priority appointments were allocated when necessary to those experiencing poor mental health. • Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. • The practice was aware of support groups within the area and signposted their patients to these accordingly.

Timely access to the service

People were able to access care and treatment in a timely way.

National GP Survey results

	Y/N/Partial
Patients with urgent needs had their care prioritised.	Y
The practice had a system to assess whether a home visit was clinically necessary and the urgency of the need for medical attention.	Y
Appointments, care and treatment were only cancelled or delayed when absolutely necessary.	Y

Explanation of any answers and additional evidence:

If a patient urgently needed to see a GP, the receptionist would send a notification to the GP to review the patient and the patient was seen when possible. We were informed that nobody who walked into the surgery would be turned away.

We noted that administration staffing cover had increased from 133.5 to 188.5 hours per week (41% increase in admin cover since the last inspection).

A document was created so that all staff were aware of who to go to for day-to-day operational issues.

The nursing team skills matrix was updated to ensure appropriate appointments were booked with each clinician.

The practice had increased its clinical GP sessions from 9 sessions (June 2018) to 14 sessions (March 2019) (55.5% increase). They had also increased nursing team cover from 36 to 42 hours per week (16.5% increase).

Indicator	Practice	CCG average	England average	England comparison
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 (01/01/2018 to 31/03/2018)	44.3%	N/A	70.3%	Significant Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2018 to 31/03/2018)	40.3%	69.6%	68.6%	Variation (negative)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2018 to 31/03/2018)	46.8%	66.3%	65.9%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the type of appointment (or appointments) they were offered (01/01/2018 to 31/03/2018)	48.5%	77.3%	74.4%	Variation (negative)

Any additional evidence or comments
The data that feeds into National GP Survey results above was collected when the previously registered individual provider was operating the service. However, that GP is still the lead GP within this recently registered partnership, therefore there is a continuity of service provision. The provider had made some changes to improve patient satisfaction levels with access to the service. However, at the time of the inspection, the impact of these changes had not been formally assessed. The practice had increased nurse appointments that were available online since June 2018. Patients now had the facility to send messages to the practice which were directed to the appropriate member of staff.

Source	Feedback
Interviews with patients.	We spoke with three patients. All said that they thought the practice was accessible when required. They said that both clinical and administrative staff were extremely helpful. They gave examples where staff had made extra efforts to make sure that they, the patients, received the care they needed to maintain and enhance their wellbeing. For example, patients had access to self-help aids like pulse monitors in order to lower anxiety levels.

	One patient told us that when they became aware that the practice was in special measures they were upset as this was quite contrary to their experiences of dealing with the practice.

Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care.

Complaints	
Number of complaints received in the last year.	4
Number of complaints we examined.	3
Number of complaints we examined that were satisfactorily handled in a timely way.	3
Number of complaints referred to the Parliamentary and Health Service Ombudsman.	0

	Y/N/Partial
Information about how to complain was readily available.	Y
There was evidence that complaints were used to drive continuous improvement.	Y

Explanation of any answers and additional evidence:

The practice was aware of compliments and complaints made on feedback platforms such as NHS choices.

The practice recorded verbal and written complaints and concerns. When a patient made a complaint, the lead GP spoke with them personally to try and allay any sense of grievance and to understand the complaint.

Example(s) of learning from complaints.

Complaint	Specific action taken
Urine Test	The wrong form was used by staff; staff have now been retrained. This was also discussed in the Nov 2018 team meeting.
DoLS	A patient had a delayed referral to Deprivation of Liberty Safeguards (DoLS). Staff were retrained in order to enable efficient referrals in the future.

Well-led Rating: Good

At the last inspection, carried out in April & May 2018 we rated the practice as Inadequate for providing well-led services because:

- There was a leadership structure in place. However, the lead GP was present in the practice for the latter half of the week only, and the practice managers were only present for half of the week. Long-term locums provided GP cover for the remainder of the week. However, we saw that due to the nature of the staffing structure, the capacity and capability to provide leadership was not always evident.
- We identified a number of summarising and coding omissions which meant that accurate information was not always available which could put patients at risk. The systems in place to support this activity were ineffective.

- The lead GP was currently receiving clinical supervision by another senior GP from another practice, reviews of his records and restrictions on some of his practice, such as telephone consultations.

- Implementation of the governance framework was not effective enough to always provide assurance that safe good quality care was being provided.
- A comprehensive understanding of the performance of the practice was not always maintained.
- The practice did not have a system in place for carrying out a planned review of changes introduced following significant events to determine their effectiveness and to assure themselves that changes had been embedded into practice.

At this inspection, we found that the provider had satisfactorily addressed these areas and is now rated good for providing well-led services.

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Y
They had identified the actions necessary to address these challenges.	Y
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	Y
Explanation of any answers and additional evidence: We saw evidence that assured us that the practice had a robust succession plan in the event that staff left the practice. The practice was also able to demonstrate how they had revised some of their roles and upskilled staff to improve cover in the event of staff absence.	

Vision and strategy

The practice had a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
The practice had a clear vision and set of values that prioritised quality and sustainability.	Y
There was a realistic strategy to achieve their priorities.	Y
The vision, values and strategy were developed in collaboration with staff, patients and external partners.	Y
Staff knew and understood the vision, values and strategy and their role in achieving them.	Y
Progress against delivery of the strategy was monitored.	Y

Explanation of any answers and additional evidence:

We saw the provider had updated their mission statement. The mission statement states that:-

We aim to provide the highest quality primary health care service to our patients by giving access to a team of professional health care specialists who work together to provide a service that fulfils our patient's needs'.

The provider's vision and vales were 'We put the patient first; we work as team and balance professionalism with our friendly approach whilst working hard in an open and honest manner'.

The practices vision was to maintain their values within the ever-changing face of the NHS and develop with those changes.

At Woodhouse Hill Surgery, they delivered their mission statement in line with the values by proactively reviewing the effectiveness and safety of the care provided by the practice. The leadership structure encouraged a caring, blame free culture.

Culture

The practice had a culture which drove high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	Y
Staff reported that they felt able to raise concerns without fear of retribution.	Y
There was a strong emphasis on the safety and well-being of staff.	Y
There were systems to ensure compliance with the requirements of the duty of candour.	Y
The practice's speaking up policies were in line with the NHS Improvement Raising Concerns (Whistleblowing) Policy.	Y
Explanation of any answers and additional evidence: All staff have a wellness card as part of the NHS employee assistance program.	

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

Source	Feedback
Staff interviews	On the day of inspection staff told us they were proud to work at the practice and felt supported by the management team who were visible and approachable. We were told of a supportive atmosphere. All mandatory staff training was up to date and we saw evidence that all staff appraisals had taken place for this year.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	Y
Staff were clear about their roles and responsibilities.	Y
There were appropriate governance arrangements with third parties.	Y
Explanation of any answers and additional evidence: The practice had the use of a neighbouring practice, in case of emergencies and this was detailed in the business continuity plan. The arrangements for leadership were now effective. We observed that there were adequate staff at the	

practice; there was a lead GP, another GP partner, a nurse and a practice manager present as well as admin staff. There was sufficient management and leadership at the practice. We corroborated this by viewing records of staffing from the last two weeks and sampled some records from the last 3 months.

A comprehensive understanding of the performance of the practice was now maintained. The practice manager could now provide assurance that as a result of concerns at another site operated (which has now been handed back to the CCG), they were working differently to make sure the concerns were not repeated at this site. SEA meetings and analysis was taking place monthly.

The practice had a system in place for carrying out a planned review of changes introduced following significant events to determine their effectiveness and to assure that changes had been embedded into the practice.

Changes to the significant events and complaints system were updated to include all possible and on-going significant events and complaints.

The recruitment process in place was now operating effectively. All the information required to be held to support the recruitment of staff was now available. We looked at staff files which detailed appropriate checks had been carried out.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Y
There were processes to manage performance.	Y
There was a systematic programme of clinical and internal audit.	Y
There were effective arrangements for identifying, managing and mitigating risks.	Y
A major incident plan was in place.	Y
Staff were trained in preparation for major incidents.	Y
When considering service developments or changes, the impact on quality and sustainability was assessed.	Y

Explanation of any answers and additional evidence:

Performance issues that still need to be addressed include:-

- Outcomes for patients living with diabetes, hypertension and mental health conditions were lower than local and national averages. This includes areas as measured by the Quality and Outcomes Framework (QOF).
- The uptake of breast and bowel cancer screening was below local and national averages.

- The uptake of two of the four childhood immunisations for children under two years of age was below WHO target levels of coverage.
- National GP patient survey results with regards to access were lower than local and national averages.

We saw evidence of clinical audit and its direct impact on patient safety. For example:-

An audit on antibiotics prescribing was carried out in July 2018. It showed the total number of co-amoxiclav (is used to treat common infections like chest infections, sinus infections, skin infections and urine infections UTIs) prescriptions issued in the last calendar month was six. The audit was repeated on 13.09.2018 and at that time, the total number of co-amoxiclav prescriptions issued last calendar month was zero. Ongoing quality improvement was demonstrated by reducing prescribing within four weeks from 6 to 0. Appropriate prescribing of antibiotics was discussed with clinicians and guidelines were refreshed from the South West Yorkshire Area Prescribing Committee (https://www.swyapc.org).

Some work was carried out on the management of respiratory tract infections in June 2018. The quality improvement activity involved the clinical team, and the practice refreshed the guidelines and printed charted of CRB65 (score is a mortality prediction tool for use by community clinicians making an initial assessment of people with suspected community-acquired pneumonia for clinicians to help to aid establish the severity of condition and management).

The provider had carried out some audits on dementia care. In November 2017 the percentage of patients who had been reviewed in previous 12 months was 36%. When the audit was repeated in September 2018, the percentage of patients reviewed in previous 12 months had increased to 93%.

We saw examples of numerous, managed systems which assured the practice that they were managing risk. For example, a system was in place to ensure that all health and safety and building maintenance checks were up to date and could be easily monitored.

We saw that policies and procedures were available to staff who were notified of any updates. Staff were aware of the incident plan.

We saw a copy of the business continuity plan which was last updated December 2018.

Appropriate and accurate information

There was a demonstrated commitment to using data and information proactively to drive and support decision making.

	Y/N/Partial
Staff used data to adjust and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Our inspection indicated that information was accurate, valid, reliable and timely.	Y

There were effective arrangements for identifying, managing and mitigating risks.	Y
Staff whose responsibilities included making statutory notifications understood what this entails.	Y

Explanation of any answers and additional evidence:

After the last inspection the practice leadership had talked with all the staff to find out how each staff member could contribute to addressing the issues the inspection had raised. The practice had considered the findings in our previous report and had taken actions to respond and deliver some improvements.

The whole practice team worked together. There were regular meetings, both whole practice meetings and smaller group meetings to monitor progress; this included work conducted at weekends. The practice was able to show how they had identified the root causes of the problems and worked to correct them.

We saw that the practice had introduced a number of templates and used the IT systems at the practice to ensure that patients received safe and effective care. At this inspection we saw additional work had been undertaken to review and improve the use of the computer systems in line with guidance and feedback. Staff training had taken place when new ways of working were introduced. This helped to ensure that consistent patient data was recorded and improved care could be delivered.

Staff reported that the use of the templates within the IT system reduced error, ensured timely referrals to the right clinician the first time and that necessary investigations were completed.

Engagement with patients, the public, staff and external partners

The practice involved the public, staff and external partners to sustain high quality and sustainable care.

	Y/N/Partial
Patient views were acted on to improve services and culture.	Y
Staff views were reflected in the planning and delivery of services.	Y
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence: Feedback from patients had resulted in a refurbishment programme. The entrance door had been replaced with a wider, more secure door.	

Feedback from Patient Participation Group (PPG).

Feedback
We spoke with one member of the PPG. They told us that the practice was open and transparent. They had frankly discussed the outcome of the last inspection.

Any additional evidence
The practice was a member of the local GP Federation. The practice had worked collaboratively within the federation. As part of this work, an extended hours service had been made available to their patients. The practice worked with neighbouring practices to make the best use of resources for the benefit of the most vulnerable patients or those with the greatest needs. The principal GP attended the local multidisciplinary team (MDT) meetings to direct resources to these patients. These meetings comprised representatives from the relevant services such as, mental health, social services, care navigation, ambulance and community services. We were informed that the practice was in the process of being highlighted as a case study by NHS England to educate and motivate other practices to improve. We saw a copy of an email from NHS England and NHS Improvement dated 5 April 2019 detailing developing a view to sharing more widely a case study/publication/presentation where the learning can be of help to performance teams and practitioners. This has the potential to help others with managing performance issues using a multi-disciplinary team approach with the practitioner at the centre.

Continuous improvement and innovation

There were evidence of systems and processes for learning, continuous improvement and innovation.

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Y
Learning was shared effectively and used to make improvements.	Y

Explanation of any answers and additional evidence:

An audit tracker covered all areas of deficiency, incidents, complaints, surveys and performance reports.

The practice looked at cervical screening every three months. We noted that 763 out 886 eligible patients had received cervical screening (this was unverified data from the practices IT system). The practice had actively engaged with eligible patients who were under 30 years of age with no smear history; this was currently 40 patients.

Examples of continuous learning and improvement
The practice was participating in and working with community partnerships to develop primary care networks which aimed to introduce new pharmacist roles, social prescriber roles and the delivery of effective extended access.

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.
- 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.