# Woodroyd Medical Practice

## Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an unannounced focused inspection at Woodroyd Medical Practice on 6 April 2017. This inspection was carried out in response to some information of concern we had received from an anonymous source.

Following our initial inspection in September 2016, the practice was rated as good overall, requires improvement for providing safe services. We re-inspected the practice in January 2017 and the safe domain was rated as good.

The unannounced inspection was carried out to ensure that the specific risks identified were being addressed and to monitor the progress being made by the provider.

Our key findings across the areas we inspected were as follows:

# Summary of findings

- The practice actively reviewed their performance in the management of long term conditions, and was proactive in offering review and screening services, such as extra checks offered to people in pre-diabetic stages (247 patients seen by the practice in total in the last 12 months).
- People with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Outcomes were monitored through clinical audits. People with conditions such as diabetes attended regular clinics to ensure their conditions were monitored, and were given individualised management plans. Nurses and GPs worked collaboratively. Attempts were made to contact non-attenders to ensure they had appropriate routine health checks. The practice had developed a recall competence check and we reviewed the data for December 2016 to March 2017.
- Patients with pre-diabetes or who were identified as at risk of developing the condition were given early access to tests and GP appointments, and then referred if necessary into a preventative pathway incorporating diet and lifestyle changes.
- The practice offered in-house diagnostics and services to support patients with long-term conditions, such as blood pressure machines, electrocardiogram (ECG) tests, spirometry checks (Spirometry is used to diagnose asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing), blood taking, health screening, minor injuries and minor surgery.
- Incidents and significant events were recorded, processes were followed and outcomes and learning were shared with all clinical staff.
- The practice managed patients living with diabetes, chronic obstructive pulmonary disease (COPD) and Asthma by reviewing their medication.
- NICE (National Institute for Health and Care Excellence) guidelines were being followed.
- The practice used the Spirometry and interpretation of results to deliver effective care to patients.
- Patients with Long Term Conditions (LTCs) told us that they were able to speak with GPs, nurses and non-clinical staff, as and when required. These patients had longer 45 minute time slots for appointments.
- The clinical systems had up to date records of patients living with diabetes, COPD and Asthma.
- The practice continued to review the results of patient satisfaction surveys and ensured that it could meet the needs of the patient population in the future and improve access.

**Professor Steve Field (CBE FRCP FFPH FRCGP)**
Chief Inspector of General Practice

# Woodroyd Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

## Background to Woodroyd Medical Practice

Woodroyd Medical Practice provides services for 5,703 patients and is situated in the Woodroyd Centre, Woodroyd Road, Bradford, BD5 8EL.

Woodroyd Medical Practice is situated within the Bradford Districts clinical commissioning group (CCG) and provides primary medical services under the terms of a general medical services (GMS) contract. This is a contract between general practices and NHS England for delivering services to the local community.

They offer a range of enhanced services such as childhood immunisations, services for patients with a learning disability and facilitating timely diagnosis and support for people with dementia.

The National General Practice Profile shows that the age of the practice population is slightly different to the national average with lower numbers of patients aged over 40 and higher numbers of patients aged below 24. The profile shows that 47% of the practice population is from a south

Asian background with a further 12% of the population originating from black, mixed or non-white ethnic groups.

There is one GP partner (female). The practice currently uses a number of long term locum GPs (both male and female) to meet patient needs.

The practice has one permanent full-time female practice nurse and two locum nurses. They have recently recruited a female health care assistant (HCA) who works 30 hours per week. The practice is also supported by a pharmacist for two hours per day.

The clinical team was supported by a practice manager and a team of administrative staff.

The practice catchment area is classed as being within one of the most deprived areas in England. People living in more deprived areas tend to have a greater need for health services. Male life expectancy is 75 years compared to the national average of 79 years. Female life expectancy is one year below the national average at 82 years.

The surgery is situated within a large health centre which also hosts other GP surgeries and community facilities. Car parking is available. The surgery has level access and has disabled facilities.

The practice is open between 8.00am and 6.30pm Monday to Friday. Appointments are available from 8.00am to 11.30am and from 1.30pm to 5.30pm. The practice is closed on a Wednesday afternoon and patients are directed to the out-of-hours service. This service is provided by an external contractor, Local Care Direct at Hillside Bridge Health Centre. Patients are also advised of the NHS 111 service.

When we returned for this inspection, we checked and saw that the previously awarded ratings were displayed as required in the premises and on the practice's website.

## Why we carried out this inspection

We carried out an unannounced, focused inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions in response to

# Detailed findings

information of concern we had received from an anonymous source. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

## How we carried out this inspection

On 6 April 2017 we carried out an unannounced, focused inspection at Woodroyd Medical Practice, approximately 11 weeks after our last focussed inspection on 19 January 2017.

On the day of our unannounced inspection we focused only on the areas of risk we had received some information of concern about.

During our visit we:

- Spoke with a range of staff including a GP, a practice nurse, the practice manager, two receptionists and five patients.
- Reviewed a sample of the personal care or treatment records of patients.

# Are services safe?

## Our findings

**Overview of safety systems and processes**

There had been a concern raised to the Care Quality Commission (CQC) regarding the care and welfare of patients. Specifically the care and treatment of diabetic patients.

We looked at the records of three randomly chosen patients who had diabetes. We saw that all of these patients had had their blood sugars monitored regularly, and the results were recorded. The nurse prescriber and GP were starting medications appropriate to the ongoing diabetic monitoring or referring to the specialist community team.

We saw that patients were being seen and reviewed and that effective interventions were being made to try and modify dietary behaviour, compliance with therapy and new therapies commenced as appropriate. Referrals were made where necessary to the level II diabetes community team for insulin start-ups and close intensive monitoring. We saw evidence that patient notes were relevant and up to date with regards to these interventions.

All staff followed best practice when obtaining blood from patient's fingers, as we found that blood was taken from the side of the fingertip which in the long term reduces nerve damage.

Where the records showed that patients' had high blood glucose levels, there was a record of the actions the clinical staff took. We asked a member of staff what action they would take in the event that a patient had high blood glucose levels; they told us that there was clear guidance for staff to follow when a patient's blood sugar was too high.

There was no evidence that any of the patients had deteriorated due to the high blood glucose that had been recorded. This meant that there was a suitable protocol and system in place at the time of our visit to manage high blood sugars for patients with diabetes.

# Are services effective?

(for example, treatment is effective)

## Our findings

**Management, monitoring and improving outcomes for people**

Two patients we spoke with told us they received diabetes checks, one stated that the practice regularly called them at home, encouraging them to come to the practice. Other patients told us that they were able to discuss their care with the practice staff and they felt they received good explanations about their care.

People at high risk of developing Type II diabetes were identified and supported to manage their risks. The practice manager described ways of engaging with patients to encourage uptake of health checks and raise public awareness of diabetes.

There has been recent training in diabetes in October 2016 for practice staff to enable them to fully support and care for people with diabetes.

The templates used on the computer system for people with long term conditions supported staff in helping to involve people in their care, and staff updated these to reflect the latest guidance.

The practice nurses led in specialist clinical areas such as diabetes, heart disease and asthma and were supported by the GPs where required. This allowed the practice to focus on specific conditions. One of the practice nurses told us they were currently reviewing patients with asthma

and chronic obstructive pulmonary disease (COPD – a chronic lung disease). The practice was identifying patients who needed to be reviewed, so they could be invited to make an appointment.

We spoke with the respiratory nurse, who had a diploma in respiratory disease management from 2014/15 with several years' experience in the management of respiratory medicine. In discussion, they were aware of current COPD and asthma guidance as per the NICE and international obstructive airways disease management guidance. They attended updates whenever available and were able to demonstrate detailed knowledge of pulmonary medicine. They had specific training in spirometry.

The practice nurse had completed additional post qualification training to help meet the needs of patients with long-term conditions, such as diabetes. They were completing an MSc (Master of Science) in advanced nursing care.

We saw evidence of two audits were in progress (February 2017) relating to diabetes. One related to reducing average blood sugar levels (HbA1c) in poorly controlled patients. The second audit related to the review of patient referrals to specialised diabetic clinic teams, to help blood sugar control.

We checked treatments for several patients from the COPD register (153 patients) and also reviewed the Quality and Outcomes Framework (QOF) data (how am I driving current status). Of the 82 patients needing spirometry in the QOF period 2017 (which is yet to be verified or published) year 81 have had spirometry codes recorded and the one remaining patient was a house bound patient who would be visited shortly by the community matron to undertake limited spirometry if appropriate. All 82 patients had had oxygen saturations completed and all had been immunized against influenza. (QOF is a system intended to improve the quality of general practice and reward good practice).

A GP told us they would continually review and discuss new best practice guidelines for the management of all conditions. We reviewed some clinical meeting minutes and confirmed that this occurred. For example, the practice had recently implemented a new diabetic foot check process and the practice had identified where improvements could be made to their spirometry testing for patients.

The practice held chronic disease management clinics for asthma checks, dementia checks, follow up spirometry for chronic pulmonary heart disease and rheumatoid arthritis reviews.