

Inspection Evidence Table

Spa Surgery

(1-542811575)

Inspection Date: 22 & 23 November 2023

Date of data download: 09/11/2023

Overall rating: Good

Context

The practice is situated within the NHS West Yorkshire Integrated Care Board and delivers General Medical Services (GMS) services to a patient population of 6,713. The practice is part of Wetherby Primary Care Network (PCN).

The clinical team consists of 4 GP partners, 3 salaried GPs (one currently on maternity leave), 2 nurses and 1 healthcare assistant. The team is supported by a practice manager and a team of reception and administrative staff.

The practice is a training practice and at the time of the inspection there were 3 GP registrars working at the practice.

Information published by the Office for Health Improvement and Disparities, rates the level of deprivation within the practice population group as 10, on a scale of 1 to 10. Level 1 represents the highest levels of deprivation and level 10 the lowest.

According to the latest available data, the ethnic make-up of the practice area is 97% white, 1% Asian, with a further 2% originating from mixed, or other non-white ethnic groups.

Safe

Rating: Good

Safety systems and processes

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

Safeguarding	Y/N/Partial
Safeguarding systems, processes and practices were developed, implemented and communicated to staff.	Y
Partners and staff were trained to appropriate levels for their role.	Y
There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	Y
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	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
<p>Explanation of any answers and additional evidence:</p> <p>There was a dedicated safeguarding lead and deputy for the practice. All of the staff we spoke with and received feedback from were aware of who the safeguarding lead was and how to identify and escalate any concerns.</p> <p>There was a safeguarding policy in place which clearly outlined the safeguarding leads for the practice and provided details of other organisations to support staff with any safeguarding concerns. For example, Leeds Domestic Violence Service, social services, NHS West Yorkshire Integrated Care Board Safeguarding Team and the police. We saw that details were also displayed throughout the practice.</p> <p>The practice held a register of patients at risk of, or suffering from, abuse and held regular meetings to discuss management and support for these patients. We saw that there was a system for identifying patients on the clinical system. However, at the time of our inspection, we were unable to see evidence of all family members associated with people on the safeguarding register having alerts on their records.</p>	

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 UK Health and Security Agency (UKHSA) guidance if relevant to role.	Partial

Explanation of any answers and additional evidence:

We reviewed 3 staff files and saw these contained evidence to demonstrate that appropriate checks had been undertaken during the recruitment process in the majority of cases. For example, we saw evidence of disclosure and barring checks (DBS), references and confirmation of professional registration. However, we were unable to locate references for one non-clinical staff member who had been recruited by the practice prior to registration with the Care Quality Commission.

The provider had a process in place to check immunisation status of clinical staff. However, non-clinical staff immunisation details were restricted to COVID-19 and influenza vaccinations. The provider advised us that this was due to non-clinical staff having no contact with urine or blood samples.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	Y
Date of last assessment: November 2022	Y
There was a fire procedure.	Y
Date of fire risk assessment: November 2023	Y
Actions from fire risk assessment were identified and completed.	Partial

Explanation of any answers and additional evidence:

The provider had systems in place to ensure health and safety risk assessments and checks were carried out at appropriate intervals. For example, fixed wire electrical testing, fire alarm testing and servicing, annual gas safety checks and portable appliance testing.

At the time of our inspection the provider was in the process of having building works done to improve the premises, we were advised that the updated health and safety risk assessment would be carried out upon completion.

The fire risk assessment had identified some actions for the practice to take. However, we were assured that this was something that would be addressed once the building works had been completed.

The practice carried out regular fire evacuation tests to ensure all staff were aware of their roles and responsibilities and could support patients to evacuate the building. We saw that the last test had been carried out in April 2023 and there had been issues with some staff members exiting the building and the length of time taken to exit. Therefore a further test was planned to take place in December 2023.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Y
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit:	December 2022
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: We found the premises to be clean and well maintained. We saw that sharps bins were available in the clinical rooms we reviewed. Sharps bins were signed and dated appropriately and not overfilled. We saw that information about steps to take in the event of a needlestick injury were displayed in the clinical rooms. The practice had an infection, prevention and control (IPC) policy in place. This included information such as the management of sharps injuries, waste management and handling of specimens. We saw that the policy required updating to reflect the current IPC lead, however all of the staff we spoke with and received feedback from knew who the current IPC lead for the practice was.	

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
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	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 were enough staff to provide appointments and prevent staff from working excessive hours.	Y
Explanation of any answers and additional evidence: The practice had a system in place to ensure there were enough staff to provide the service. The partners at the practice had some capacity to support sickness or absence of the salaried GPs. The practice also had a good relationship with The Medical Chambers who could arrange locum support when required.	

Many of the reception and administrative team worked part time hours, therefore they were able to provide cover for sickness and absence.

The practice was equipped to respond to medical emergencies. Staff were aware of the location of emergency medical equipment and medicines, for example oxygen and the automated external defibrillator (AED).

All of the staff we received feedback from were aware of how to respond to a medical emergency and what their role would be.

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
Referrals to specialist services were documented, contained the required information and 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
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Review of patient records in relation to the clinical searches identified that care records were managed in a way to protect patients. For example, history, examination, management plans, safety netting and follow up were adequately documented within the patient record.</p> <p>The practice had a process in place for the management of incoming test results. These were shared between the administrative team on a daily basis to code and, where necessary, assign to a clinician. During our clinical searches we saw that there were 20 results in the inbox, these had all been received within the last 24 hours.</p>	

Appropriate and safe use of medicines

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

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
Number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related	1.11	0.94	0.91	No statistical variation

Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)				
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). (01/07/2022 to 30/06/2023) (NHSBSA)	5.3%	6.2%	7.8%	No statistical variation
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 (01/01/2023 to 30/06/2023) (NHSBSA)	4.36	4.61	5.24	Tending towards variation (positive)
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	143.2‰	114.8‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/07/2022 to 30/06/2023) (NHSBSA)	0.39	0.43	0.54	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/01/2023 to 30/06/2023) (NHSBSA)	3.0‰	4.8‰	6.8‰	Variation (positive)

Note: ‰ means *per 1,000* and it is **not** a percentage.

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 effective 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
There was a process for monitoring patients' health in relation to the use of medicines including medicines that require monitoring (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 and Improvement 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
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 UKHSA guidance to ensure they remained safe and effective.	Y
<p>Explanation of any answers and additional evidence, including from clinical searches.</p> <p>During our records searches, we saw evidence of good quality, structured medication reviews being carried out by GPs and pharmacists within the practice. The reviews covered all medications and there was evidence that the review had included checking appropriate monitoring was up to date.</p> <p>We were informed that the majority of prescriptions were generated via the electronic prescribing service. However, the practice had a process in place to ensure blank paper prescriptions were stored securely and usage was monitored.</p> <p>As part of the inspection our CQC GP specialist advisor (SPA) conducted searches of the practice clinical records system, to assess the processes around medicines management and prescribing. The searches were undertaken remotely without visiting the practice.</p> <p>The searches performed, confirmed that processes were in place for monitoring disease modifying anti-rheumatic drugs (DMARDs) and other medications that required monitoring. The records reviewed showed that most patients were up to date with their monitoring checks with no significant patient safety risk identified. We found that:</p> <ul style="list-style-type: none"> - 230 patients were prescribed direct oral anticoagulation (a medicine used to prevent blood clots in patients with atrial fibrillation). We reviewed 5 patient records in detail and found that in all cases monitoring requirements for the practice had been completed, or the patient had an appointment booked to attend for monitoring. - 12 patients were prescribed azathioprine (a medicine used to treat conditions that affect the immune system). We found that monitoring requirements for all of these patients were up to date. 	

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:	38
Number of events that required action:	38
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process in place to identify and record significant events and incidents. Feedback we received from staff confirmed that they knew how to report a significant event and where appropriate, received feedback regarding any shared learning and changes to processes following investigation of incidents.</p> <p>The provider had carried out a review of significant event reporting and made changes to the process in order to improve reporting by all staff members. This included:</p> <ul style="list-style-type: none"> - Allowing dedicated administrative time for investigation and recording of significant events - Introduction of a protocol and procedure to support staff to submit a significant event - Delegation of significant events to the wider staff group for investigation. For example, the lead nurse, senior pharmacist and practice manager. - Discussing the changes with all staff and emphasising the process was intended to improve practice rather than apportion blame. <p>Many of the staff we spoke with and received feedback from were able to give examples of significant events and changes to processes within the practice as a result of these.</p> <p>Significant events were discussed monthly at the GP partners meeting.</p>	

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

Event	Specific action taken
Delayed urgent cancer referral	Change in protocol to ensure all requests for urgent referrals to the administrative team are clearly flagged to highlight the urgent nature.
Issue with task messages between clinicians and reception/administrative team being lost or delayed.	A review of the task process was undertaken and improved. All tasks from the reception and administrative team are now initialled by the staff member rather than the generic reception inbox.

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a process in place for managing safety alerts. Safety alerts were reviewed and cascaded to relevant staff. Searches were run to identify patients affected by any new safety alerts and the practice had systems in place to check for any patients affected by historical safety alerts. We saw there was a record of all safety alerts and actions taken as a result of searches. We reviewed this document as part of our inspection.</p> <p>We ran a search to review a safety alert relating to the use of medicines that were known or suspected to have the potential to increase the risk of birth defects and development disorders (teratogenic potential) when taken during pregnancy. We reviewed 5 patient records and saw all of these contained clearly documented evidence of risks having been discussed. Where appropriate, a pregnancy prevention programme (PPP) was in place. This is designed to make sure patients are fully aware of the risks, and contraception was prescribed.</p>	

Effective

Rating: Good

QOF requirements were modified by NHS England and Improvement for 2020/21 to recognise the need to reprioritise aspects of care which were not directly related to COVID-19. This meant that QOF payments were calculated differently. For inspections carried out from 1 October 2021, our reports will not include QOF indicators. In determining judgements in relation to effective care, we have considered other evidence as set out below.

Effective needs assessment, care and treatment

Patients' needs were assessed, and care and treatment was 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
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Y
We saw no evidence of discrimination when staff made care and treatment decisions.	Y
Patients' treatment was regularly reviewed and updated.	Y
There were appropriate referral pathways to make sure that patients' needs were addressed.	Y

Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Y
The practice had prioritised care for their most clinically vulnerable patients during the pandemic.	Y
The practice prioritised care for their most clinically vulnerable patients.	Y
<p>Explanation of any answers and additional evidence:</p> <p>The practice had processes in place to ensure those with the most urgent needs could access appointments. For example, there was a dedicated responsible GP from 4pm each day who reviewed and managed all requests for appointments dependent on clinical urgency. GPs at the practice had protected appointment slots each day which could be used to accommodate any urgent same day appointments required.</p> <p>The practice also held a register of patients whose circumstances may make them vulnerable, for example patients who may have a disability or those experiencing poor mental health. We saw that there was an alert on these patient records to ensure that any requests for appointments were accommodated.</p> <p>During consultations, patients were given advice and information regarding action to take should their condition deteriorate. The practice also used a text messaging service to share information with patients, for example links to other services and health information.</p>	

Effective care for the practice population

Findings

- Flu, shingles and pneumonia vaccinations were offered to relevant patients in this age group.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40 to 74. There was appropriate and timely follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified. The practice had undertaken 180 health checks in the previous 12 months.
- The practice held a register of patients with a learning disability. The practice had access to a dedicated learning disabilities care coordinator who worked across the Wetherby Primary Care Network. The role focused on engaging with this group of patients and their families, being a point of contact for support and advice and making the practice more accessible for patients. All patients with a learning disability were contacted and offered an annual health check. There were 33 patients on the learning disabilities register and at the time of our inspection, 22 had received a health check within the previous 12 months. The remaining 11 had been invited to attend for a health check.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.
- The practice demonstrated that they had a system to identify people who misused substances.
- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder
- Patients with poor mental health, including dementia, were referred to appropriate services.

Management of people with long term conditions

Findings

As part of the inspection, we conducted a series of remote clinical searches to assess the practice's procedures for the management of patients with long-term conditions. We found that generally patients were being monitored and managed appropriately. For example:

Chronic Kidney Disease (CKD) stage 4 and 5: We found that all patients had received appropriate monitoring by the practice. This included blood pressure and kidney function monitoring.

Hypothyroidism: Our searches identified only 1 patient as not having had thyroid function checks in the last 18 months. We looked at this record in detail and found that the patient was no longer under the care of the practice as they had relocated to another care setting.

Diabetes: 39 patients were identified as having a HbA1c of greater than 74mmol/l, and diabetic retinopathy. We reviewed 5 patient records and found that 3 patients had been followed up appropriately after having a raised HbA1c reading. However, 2 patients required follow up. We discussed this with the practice during our inspection and were advised that attempts would be made to contact the patients for review.

Asthma: Our searches showed that 50 patients had received 2 or more courses of rescue steroids in the last 12 months. We reviewed 5 patient records and found that in all cases there had been an adequate assessment undertaken at the time of prescribing. However, we noted 2 of these patients had not had an annual asthma review. We found issues with the process for following up patients within a week of an acute exacerbation in line with guidelines. We discussed this with the practice during our inspection and were advised this would be addressed.

Staff who were responsible for reviews of patients with long-term conditions had received specific training.

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 home blood pressure monitoring, the practice provided blood pressure monitors for use by patients.

Patients with COPD were offered rescue packs.

Child Immunisation	Numerator	Denominator	Practice	Comparison to WHO target of 95%
The percentage of children aged 1 who have completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib), Hepatitis B (Hep B) ((i.e. three doses of DTaP/IPV/Hib/HepB) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	55	57	96.5%	Met 95% WHO based target

The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	71	72	98.6%	Met 95% WHO based target
The percentage of children aged 2 who have received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	70	72	97.2%	Met 95% WHO based target
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	70	72	97.2%	Met 95% WHO based target
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2021 to 31/03/2022) (UKHSA COVER team)	60	68	88.2%	Below 90% minimum

Note: Please refer to the CQC guidance on Childhood Immunisation data for more information: <https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

Cancer Indicators	Practice	SICBL average	England	England comparison
Persons, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	69.5%	N/A	62.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2021 to 31/03/2022) (UKHSA)	81.2%	N/A	70.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (4/1/2021 to 3/31/2022) (UKHSA)	55.6%	48.8%	54.9%	No statistical variation
The percentage of persons eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (6/30/2023 to 6/30/2023) (UKHSA)	78.8%	N/A	80.0%	Below 80% target

Any additional evidence or comments

The practice had a system in place to encourage patients to attend for cervical screening. Searches were carried out to identify non-attenders and reminder letters were issued by the practice.

Similarly, there was a system in place to follow up and encourage parents of children who did not attend for measles, mumps and rubella vaccinations.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	Y
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Y
<p>Examples of improvements demonstrated because of clinical audits or other improvement activity in past two years:</p> <p>The practice had identified a gap in services around women's health and menopause. In response to this, two of the GPs within the practice had accessed additional training to enable the practice to offer in-house women's health clinics. The practice was able to offer in-house vaginal pessary insertion in some cases, resulting in a reduction in referrals to secondary care and a shorter waiting time for patients.</p> <p>The practice had carried out audit activity to review and improve the use of testosterone usage during menopause. As a result of the audit the practice had improved blood test timing to ensure a smoother process for women.</p>	

Effective staffing

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

	Y/N/Partial
Staff had the skills, knowledge and experience to deliver effective care, support and treatment.	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
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:

There was an induction process in place which all staff were required to complete when joining the practice. This included dedicated time to complete relevant training.

There was a schedule of statutory and mandatory training which included topics such as safeguarding, infection, prevention and control and fire safety. This was monitored by the management team to ensure training was completed at appropriate frequencies and we saw that staff were generally up to date with required training.

There was a system in place to ensure all staff had an annual appraisal. Feedback we received from staff confirmed that appraisals had taken place within the last 12 months and we saw evidence of this in some of the staff files we reviewed.

The practice had a system in place to ensure staff had appropriate support and worked within their competencies. For example:

- paramedics and advanced practitioners had agreements in place to outline specific conditions that they were able to manage.
- GP registrars working at the practice had a dedicated mentor and regular weekly supervision meetings.

Coordinating care and treatment

Staff worked together and with other organisations to deliver effective care and treatment.

	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Y
Patients received consistent, coordinated, person-centred care when they moved between services.	Y
Explanation of any answers and additional evidence:	
The practice utilised the clinical system to share information with other providers. For example, district nurses, hospitals and the out of hours service.	
The practice provided services for patients residing in a local care home. We received positive feedback from them regarding the processes which had been established with the practice for communication, access to services and continuity of care.	

Helping patients to live healthier lives

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

	Y/N/Partial
The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.	Y
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Y
Patients had access to appropriate health assessments and checks.	Y
Staff discussed changes to care or treatment with patients and their carers as necessary.	Y
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients wishing to stop smoking were referred to the Leeds Smoking Cessation service.</p> <p>The practice had dedicated care co-ordinators to support frail and vulnerable patients and patients with a learning disability. The care co-ordinators role included providing support and information to patients and their families and signposting to other services.</p> <p>The practice had identified an increase in women presenting with symptoms of perimenopause and menopause and had provided informal education evenings to improve knowledge, including lifestyle changes that could be of benefit.</p>	

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
Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Y
<p>Explanation of any answers and additional evidence:</p> <p>Clinical staff such as GPs and members of the nursing team demonstrated a good understanding of consent processes and when consent should be obtained.</p> <p>The practice utilised the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) forms to document patients views and wishes, including any decision regarding DNACPR (do not attempt cardiopulmonary resuscitation).</p> <p>Staff told us that they always sought consent from patients prior to referring them onto other services.</p>	

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
Staff displayed understanding and a non-judgemental attitude towards patients.	Y
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Y

Patient feedback	
Source	Feedback
NHS Choices Website	Words used to describe the service included efficient and friendly.
CQC Share Your Experience	We received feedback from 21 patients via the CQC share your experience forms. Of these, 18 contained positive feedback and used words such as compassionate, caring, friendly and kind, to describe the service. Staff at the practice were described as 'going above and beyond' by 7 patients we received feedback from.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	97.6%	87.2%	85.0%	Variation (positive)
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 (01/01/2023 to 30/04/2023)	97.5%	85.9%	83.8%	Variation (positive)
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 (01/01/2023 to 30/04/2023)	99.5%	93.8%	93.0%	Variation (positive)

The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2023 to 30/04/2023)	91.4%	73.4%	71.3%	Variation (positive)
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	Y/N
The practice carries out its own patient survey/patient feedback exercises.	Y

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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had introduced new easy read and pictorial information to support patients with a learning disability when accessing the service.</p> <p>The practice used a telephone interpretation service to support deaf, speech impaired and hearing people to communicate via the telephone.</p> <p>A care co-ordinator at the practice was trained in British Sign Language level 1 and was able to support patients who were deaf or hard of hearing.</p> <p>Information was available in large print as required.</p>	

Source	Feedback
CQC Share Your Experience	<p>We received feedback from patients via the CQC share your experience forms and patients told us how staff at the practice had:</p> <ul style="list-style-type: none"> - Made them feel part of the consultation - Explained each step really clearly - Clear and concise advice given at all times.

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	England comparison
The percentage of respondents to the GP patient survey who stated that during their last GP appointment they were involved as much as they wanted to be in decisions about their care and treatment (01/01/2023 to 30/04/2023)	98.9%	91.2%	90.3%	Variation (positive)

	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
<p>Explanation of any answers and additional evidence:</p> <p>Patients who did not have English as a first language had access to telephone translation services.</p> <p>The practice website was available to view in a range of languages.</p> <p>The practice had a link on the website requesting patients to provide details of any communication needs they required in order to access information. For example, braille, large print or advocate needed. Information received was documented on the patient record.</p>	

Carers	Narrative
Percentage and number of carers identified.	235 (3.5%)
How the practice supported carers (including young carers).	<p>The practice had a process of identifying patients who also acted in the role of a carer on the clinical system.</p> <p>Carers had access to services including influenza vaccination and health checks.</p> <p>The practice website contained a link to further information to support carers.</p>
How the practice supported recently bereaved patients.	<p>GPs at the practice made contact with recently bereaved families by telephone to offer support or a face to face appointment.</p> <p>All staff within the practice were notified when a patient passed away to enable them to provide support to any family member contacting the practice.</p>

Privacy and dignity**The practice respected patients' privacy and dignity.**

	Y/N/Partial
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
<p>Explanation of any answers and additional evidence:</p> <p>Incoming calls were answered away from the reception desk in order to reduce the risk of conversations being overheard.</p> <p>We were advised that a room would be made available should a patient wish to discuss a sensitive issue.</p>	

Responsive**Rating: Good**

At the last inspection in February 2017 the Responsive key question was rated good. The practice continues to be rated good for providing responsive services following this inspection.

Responding to and meeting people's needs**The practice organised and delivered services to meet patients' needs.**

	Y/N/Partial
The practice understood the needs of its local population and had developed services in response to those needs.	Y
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
There were arrangements in place for people who need translation services.	Y
The practice complied with the Accessible Information Standard.	Y

Practice Opening Times

Day	Time
Opening times:	
Monday	8am - 6pm
Tuesday	8am - 6pm

Wednesday	8am - 6pm
Thursday	8am - 6pm
Friday	8am - 6pm
Appointments available:	
Monday	8.30am - 6pm
Tuesday	8.30am – 5.30pm
Wednesday	8.30am – 5.30pm
Thursday	8.30am - 6pm
Friday	8.30am - 6pm

Further information about how the practice is responding to the needs of their population

- 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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when clinically necessary.
- Patients could access prebookable appointments outside of working and school hours via the enhanced access service. Appointments were available from 6pm until 8.30pm on weekdays and from 9am until 12pm on weekends.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode such as homeless people and Travellers.
- The practice adjusted the delivery of its services to meet the needs of patients with a learning disability. The practice had a dedicated care co-ordinator who focused on improving access to the service for patients with a learning disability and their families. The care co-ordinator carried out home visits to support patients and their families and to be a familiar face and point of contact.
- The practice had introduced a women's health clinic to support the increase in women presenting with symptoms of perimenopause and menopause. Appointments were prebookable up to 6 weeks in advance.
- In addition, one of the GP partners was involved with the Leeds Womens Health Network which reviewed womens health services across the city.
- The practice had undertaken work to support transgender and non-binary patients when navigating healthcare by ensuring correct names/pronouns are used.

Access to the service

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

	Y/N/Partial
Patients had timely access to appointments/treatment and action was taken to minimise the length of time people waited for care, treatment or advice.	Y

The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online).	Y
Patients were able to make appointments in a way which met their needs.	Y
There were systems in place to support patients who face communication barriers to access treatment (including those who might be digitally excluded).	Y
Patients with most urgent needs had their care and treatment prioritised.	Y
There was information available for patients to support them to understand how to access services (including on websites and telephone messages).	Y
<p>Explanation of any answers and additional evidence:</p> <p>Patients could access the appointment system via telephone, in person or via online access for pre-determined appointments. Patients could choose either a face to face or telephone appointment, unless it was clinically necessary for a face to face appointment to take place.</p> <p>The practice also offered an online consultation form which patients could complete. This would be reviewed by the relevant clinician and then an appropriate appointment offered.</p> <p>All requests for urgent appointments were reviewed by the responsible GP on a daily basis and requests were prioritised according to clinical necessity.</p>	

National GP Patient Survey results

Note: From July 2022, CCGs have been replaced with Sub Integrated Care Board Locations (SICBL) and CCG ODS codes have been retained as part of this.

Indicator	Practice	SICBL average	England	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 (01/01/2023 to 30/04/2023)	73.8%	N/A	49.6%	Variation (positive)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2023 to 30/04/2023)	79.3%	54.7%	54.4%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2023 to 30/04/2023)	75.1%	53.7%	52.8%	Tending towards variation (positive)
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2023 to 30/04/2023)	81.9%	74.3%	72.0%	No statistical variation

Source	Feedback
CQC Share your experience form	We received feedback from 21 patients via the CQC share your experience forms. Of these, 18 contained positive feedback regarding the service they received and access to appointments. We heard how 1 patient had contacted the practice at 4pm and had been offered an appointment. We received less positive feedback from 3 patients and noted that these made reference to individual complaints which did not relate to access and appointments at 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.	16
Number of complaints we examined.	2
Number of complaints we examined that were satisfactorily handled in a timely way.	2
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

Example(s) of learning from complaints.

Complaint	Specific action taken
Complaints regarding length of time to answer the telephone.	This was found to be due to reception staff dealing with patients arriving at the practice in person. In order to address this issue, the practice reconfigured the reception area to have a dedicated staff member at the front desk and additional staff dedicated to answering the incoming calls.

Well-led

Rating: Good

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: The provider had a good understanding of the challenges they faced and had taken steps to address these. This included: <ul style="list-style-type: none">- Accessibility for patients: undertaking work to ensure patients access an appointment with the most appropriate healthcare professional, resulting in GPs being available for those patients requiring a GP appointment. This included expanding the clinical team to include paramedics, pharmacists and advanced clinical practitioners.- Workforce: the practice had overcome a number of changes in the workforce including the practice manager, lead nurse and reception staff. In order to improve teamwork and staff morale the partners and management team introduced a wellbeing team which included a representative from each of the staff teams.- Succession planning: the GP partnership at the practice had expanded to include younger partners to address any potential future gaps in the GP workforce.	

Vision and strategy

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

	Y/N/Partial
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: The practice had a clear vision to provide high quality, safe, effective, timely and patient centered care for the local community. Their vision was supported by values which included having compassion and kindness at the core, valuing relationships, staff development and utilising diverse skills to the benefit of patients.	

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
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Y
The practice encouraged candour, openness and honesty.	Y
The practice had access to a Freedom to Speak Up Guardian.	Y
Staff had undertaken equality and diversity training.	Y
Explanation of any answers and additional evidence: Staff told us they felt able to raise concerns without fear of retribution and that their concerns would be listened to. They were aware of the Freedom to Speak Up Guardian and how to raise concerns via this route. The practice had a whistleblowing policy in place and this was accessible to all staff.	

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

Source	Feedback
Feedback from staff via interviews and questionnaires	All of the staff we spoke with and received feedback from were positive about Spa Surgery. Comments included: <ul style="list-style-type: none">- great place to work- we [practice] look after our patients- friendly and supportive place to work- one big team pulling in same direction- valued and respected as a team member

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
There are recovery plans in place to manage backlogs of activity and delays to treatment.	Y
Explanation of any answers and additional evidence: The practice had policies in place to support staff within their roles. This included safeguarding, infection, prevention and control and complaints. The policies were accessible to all staff via an electronic shared drive. We saw evidence of regular staff meetings in which there were standard agenda items. For example, safeguarding and significant events. Feedback we received from staff confirmed that they were clear about their roles and responsibilities.	

Managing risks, issues and performance

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

NHS	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 quality improvement programme in place.	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: There was a business continuity plan in place, and this outlined steps to take in the event of an unplanned incident such as loss of electricity and flooding of the premises. The plan clearly documented the business continuity leads for specific areas such as premises and information technology in order to support staff in the event of an incident.	

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 monitor and improve performance.	Y
Performance information was used to hold staff and management to account.	Y
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
Explanation of any answers and additional evidence: The practice proactively monitored performance and had a clear understanding of areas for improvement. The practice used information from a variety of sources to monitor performance.	

Governance and oversight of remote services

	Y/N/Partial
The practice used digital services securely and effectively and conformed to relevant digital and information security standards.	Y
The provider was registered as a data controller with the Information Commissioner's Office.	Y
Patient records were held in line with guidance and requirements.	Y
Patients were informed and consent obtained if interactions were recorded.	Y
The practice ensured patients were informed how their records were stored and managed.	Y
Patients were made aware of the information sharing protocol before online services were delivered.	Y
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Y
Online consultations took place in appropriate environments to ensure confidentiality.	N/A
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y

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
The practice had an active Patient Participation Group.	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
<p>Explanation of any answers and additional evidence:</p> <p>The practice had a well established patient participation group (PPG) which was represented by approximately 8 patients. The PPG met 3 times per year and representatives from the practice were always present. We reviewed minutes from meetings which had taken place in April and October 2023 and saw that topics such as recruitment campaigns, refurbishment of the premises and national vaccinations programmes had been discussed with the group.</p> <p>Feedback we received from staff confirmed that any changes to services were discussed and reviewed during practice meetings.</p>	

Continuous improvement and innovation

There were 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
<p>Explanation of any answers and additional evidence:</p> <p>The provider had a programme of quality improvement work which included reviews and learning from complaints and incidents, and a programme of clinical and non-clinical audits.</p> <p>The practice was a training practice and there were regular training sessions for GP Registrars. Two of the partners were responsible for the mentoring and supervision of the registrars. One of the GP partners also worked within Health Education England and had oversight of GP training for Yorkshire and the Humber. They told us how they were able to disseminate this information to support staff and trainees within the practice.</p> <p>The practice was committed to staff development. For example:</p> <ul style="list-style-type: none"> - at the time of our inspection one member of the nursing team was being supported to complete additional clinical courses to support them in their role. - we received positive feedback from a salaried GP who had previously been a GP Registrar at the practice. - One of the GP partners had completed the Primary Certificate in Menopause Care in order to support the Women's Health Clinics. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

Guidance and Frequently Asked Questions on GP Insight can be found on the following link:

<https://www.cqc.org.uk/guidance-providers/gps/how-we-monitor-gp-practices>

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

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **UKHSA:** UK Health and Security Agency.
- **QOF:** Quality and Outcomes Framework.
- **STAR-PU:** Specific Therapeutic Group Age-sex weightings Related Prescribing Units. These weighting allow more accurate and meaningful comparisons within a specific therapeutic group by taking into account the types of people who will be receiving that treatment.
- ‰ = per thousand.