

Care Quality Commission

Inspection Evidence Table

The Light (1-583552332)

Inspection date: 11 August 2022

Date of data download: 08 August 2022

Overall rating: Good

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.	Yes
Partners and staff were trained to appropriate levels for their role.	Yes
There was active and appropriate engagement in local safeguarding processes.	Yes
The Out of Hours service was informed of relevant safeguarding information.	Yes
There were systems to identify vulnerable patients on record.	Yes
Disclosure and Barring Service (DBS) checks were undertaken where required.	Yes
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.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• There were local and organisational safeguarding leads for adults and children.• There was a comprehensive safeguarding policy, which covered all aspects of safeguarding. Information was available with details of who to contact regarding any safeguarding concerns.• There was a chaperone policy which covered what was expected when undertaking the role.• We saw minutes from regular safeguarding meetings, where concerns were discussed.• In addition, the provider One Medicare Ltd operated a monthly forum at which safeguarding leads at the provider's other sites attended. This supported a consistent and informed approach across the organisation.• We were provided with several examples of safeguarding concerns, relating to both adults and children, that the practice had managed appropriately.	

Safeguarding	Y/N/Partial

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	Yes
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a recruitment policy which identified the necessary checks to be undertaken prior to the employment of new staff. • We reviewed three staff personnel files and found they included relevant information, such as evidence of qualifications, references, disclosure and barring service checks, photographic identification and interview notes. 	

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken. Date of last assessment: 17/02/2022	Yes
There was a fire procedure. Date of fire risk assessment: 17/02/2022	Yes
Actions from fire risk assessment were identified and completed.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Some risk assessments were undertaken by the landlord of the building where The Light was located, and information cascaded to the practice as appropriate. These included those relating to health and safety and fire. • The practice undertook monthly checks of firefighting equipment, fire doors and escape routes. • A planned fire evacuation drill had been carried out on 12/04/2022. The practice had appropriately trained fire wardens. • Electrical equipment and portable appliance testing were up to date. 	

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.	Yes
Infection prevention and control audits were carried out. Date of last infection prevention and control audit: 02/08/2022	Yes
The practice had acted on any issues identified in infection prevention and control audits.	Yes

The arrangements for managing waste and clinical specimens kept people safe.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a range of policies and procedures relating to infection prevention and control (IPC), which included safe management of waste. • There was a nominated IPC lead who had been appropriately trained and undertook quarterly IPC and hand hygiene audits. We saw that actions identified by the IPC audit had been completed. • Masks and hand gel were available for staff, patients and visitors to the practice. • Other personal protective equipment (PPE), such as gloves and plastic aprons, were also available. • Staff continued to wear masks on the premises, in line with COVID precautions. 	

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.	Yes
There was an effective induction system for temporary staff tailored to their role.	Yes
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Yes
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.	Yes
There were enough staff to provide appointments and prevent staff from working excessive hours	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • We were informed of the difficulties the practice had experienced in recruiting, which had impacted on the numbers of clinical staff. As a result, regular locums were used to support service delivery and prevent staff from working excessive hours. A recruitment campaign was ongoing, which had resulted in the recruitment of some new staff, which included two salaried GPs and nurses. • As a result of an incident, staff had been retrained regarding the awareness of “red flag” symptoms, such as those for sepsis, and what action to take in the event of a patient displaying them. 	

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.	Yes
There was a system for processing information relating to new patients including the summarising of new patient notes.	Yes

There were systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.	Yes
Referrals to specialist services were documented, contained the required information and there was a system to monitor delays in referrals.	Yes
There was a documented approach to the management of test results and this was managed in a timely manner.	Yes
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> At the time of our inspection, as a result of staffing shortages and a high turnover of patients, there was a backlog of some hard copy patient records waiting to be summarised. Action had been taken to ensure that any outstanding records did not relate to patients who were deemed to be at risk, vulnerable or had complex health needs. These included undertaking a risk assessment with regard to patient safety and the training of additional staff in summarising records. Clinical records for new patients to the practice were mostly received by electronic transfer (via a GP to GP system), whilst waiting for paper records to be sent by Primary Care Support England (PCSE). This ensured that for the majority of patients, information was recorded in their electronic records. Records of those patients whose records were unable to be transferred via GP to GP were prioritised for summarising. New patients registering with the practice were required to complete a registration form, where they were required to document any key information, such as allergies, medical history and prescribed medications. The pharmacist aligned to the practice reviewed the medications to ensure they were being prescribed safely and appropriately. 	

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) (01/04/2021 to 31/03/2022) (NHS Business Service Authority - NHSBSA)	0.33	0.82	0.79	Significant Variation (positive)
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). (01/04/2021 to 31/03/2022) (NHSBSA)	4.5%	6.7%	8.8%	Variation (positive)
Average daily quantity per item for Nitrofurantoin 50 mg tablets and capsules, Nitrofurantoin 100 mg m/r capsules, Pivmecillinam 200 mg tablets	5.37	4.70	5.29	No statistical variation

Indicator	Practice	CCG average	England average	England comparison
and Trimethoprim 200 mg tablets prescribed for uncomplicated urinary tract infection (01/10/2021 to 31/03/2022) (NHSBSA)				
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	16.2‰	111.8‰	128.2‰	Significant Variation (positive)
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/04/2021 to 31/03/2022) (NHSBSA)	0.10	0.48	0.60	Significant Variation (positive)
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/10/2021 to 31/03/2022) (NHSBSA)	2.0‰	4.9‰	6.8‰	Significant 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.	Yes
Blank prescriptions were kept securely, and their use monitored in line with national guidance.	Yes
Staff had the appropriate authorisations to administer medicines (including Patient Group Directions or Patient Specific Directions).	Yes
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.	Yes
There was a process for the safe handling of requests for repeat medicines and evidence of structured medicines reviews for patients on repeat medicines.	Yes
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.	Yes
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.	Yes
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	Yes
There were arrangements for raising concerns around controlled drugs with the NHS England and Improvement Area Team Controlled Drugs Accountable Officer.	Yes
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.	Yes

Medicines management	Y/N/Partial
For remote or online prescribing there were effective protocols for verifying patient identity.	Yes
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.	Yes
There was medical oxygen and a defibrillator on site and systems to ensure these were regularly checked and fit for use.	Yes
Vaccines were appropriately stored, monitored and transported in line with UKHSA guidance to ensure they remained safe and effective.	Yes
<p>Explanation of any answers and additional evidence:</p> <ul style="list-style-type: none"> • There was a repeat prescribing policy which described the process to follow. • There was a cold chain policy which identified what to do should the vaccine refrigerator temperatures be out of range. • The practice participated in prescribing initiatives to ensure safe and effective prescribing. They had the support of the primary care network (PCN) pharmacists to support safe medicines management. • Non-medical prescribers had regular clinical supervision and used a drug formulary to prescribe. They had daily access to a GP should they need to seek further advice or clarification. The non-medical prescribers adhered to a competency framework and completed an annual declaration of competency. 	
Any additional evidence or comments	
<p>As part of our inspection, on 11 August 2022 we conducted a series of clinical searches to assess the practice's procedures around medicines management and prescribing. The remote electronic review of the searches was undertaken by the CQC GP specialist advisor (SpA). The searches were visible to the practice. Searches were carried out on the following:</p> <ul style="list-style-type: none"> • Patients who were prescribed methotrexate, which is a disease-modifying antirheumatic drug (DMARD). The search showed that five out of six patients had received appropriate monitoring in line with guidance. Where the patient had not received monitoring, we saw that despite several attempts the patient had not attended for their appointment. • Patients who were prescribed azathioprine (a DMARD). The search showed that two patients were prescribed this medicine but neither had attended for monitoring, despite several requests by the practice. • Patients who were prescribed lithium, which is used to treat mood disorders. The search showed that three out of four patients had not received monitoring. <p>We discussed the findings of the searches with the practice. As a result, we found that monitoring had been completed elsewhere, such as in secondary care services. Records were updated to reflect this. We were assured that all necessary actions were being taken to ensure patient safety.</p>	

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
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The practice monitored and reviewed safety using information from a variety of sources.	Yes
Staff knew how to identify and report concerns, safety incidents and near misses.	Yes
There was a system for recording and acting on significant events.	Yes
Staff understood how to raise concerns and report incidents both internally and externally.	Yes
There was evidence of learning and dissemination of information.	Yes
Number of events recorded in last 12 months:	8
Number of events that required action:	8
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was an incident reporting policy, which informed staff how to report and action incidents. • Incidents were recorded internally and were collated according to the nature of the incident, such as medicines management and patient safety. Information regarding incidents was also cascaded to the provider who had oversight of all their services. This supported the practice and provider in identifying any themes or trends and action them accordingly. • Incidents were reported via an internal system and learning was shared across the organisation via monthly clinical governance meetings and locally, via huddles and team meetings. • Staff were aware of the incident reporting process and were encouraged to raise any concerns. They told us that incidents were discussed in meetings and any learning disseminated as necessary. 	

Example of significant events recorded and actions by the practice:

Event	Specific action taken
Staff unable to access the practice without having to go through the general telephone line.	A specific email address was given for staff to use and a media group organised, should staff need to let the practice know of any sickness absence, for example.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Yes
Staff understood how to deal with alerts.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • There was a policy for the management of patient safety alerts, which clearly identified the responsibilities of staff and actions required to be taken. • We saw that a matrix was maintained of safety alerts and what actions had been taken. Both the matrix and the clinical search showed the practice had a good process in place. For example, a Medicines and Healthcare products Regulatory Agency (MHRA) alert from April 2022 relating to women of childbearing age being prescribed teratogenic drugs (medicines which could cause birth defects), showed there were four patients identified. We reviewed these and found recorded evidence that all patients had been contacted and informed of any potential risks. 	

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 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.	Yes
Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.	Yes
Patients presenting with symptoms which could indicate serious illness were followed up in a timely and appropriate way.	Yes
We saw no evidence of discrimination when staff made care and treatment decisions.	Yes
Patients' treatment was regularly reviewed and updated.	Yes
There were appropriate referral pathways to make sure that patients' needs were addressed.	Yes
Patients were told when they needed to seek further help and what to do if their condition deteriorated.	Yes
The practice had prioritised care for their most clinically vulnerable patients during the pandemic	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• A clinical decision support tool was integrated into the clinical system, which allowed easy access to the latest evidence-based guidance. Locally used templates were also embedded into the system. These supported safety, consistency and clinical effectiveness.• Staff told us they were kept up to date with current evidence-based guidance through clinical meetings and in practice protected time.• Staff told us that case-based discussions were held in clinical meetings, and that this gave them an opportunity for retrospective evaluation of clinical decision-making in patient care.• We saw the practice monitored the use of evidence-based guidelines through consultation and prescribing audits.	

Effective care for the practice population

Findings

- The practice had access to midwifery and health visiting services to support families and children.
- The district nursing and neighbourhood teams supported patients who required home visits.
- New patient checks and appropriate health assessments were available, including NHS health checks for patients aged 40 to 74 years.
- Influenza, pneumonia and shingles vaccinations were available for patients who fit the criteria.
- Vaccinations were offered to those patients had an underlying medical condition.
- Patients with a learning disability were invited for an annual health check.
- There was a system in place to identify people who misused substances.
- Patients with poor mental health, including dementia, were assessed, monitored and referred to appropriate services.
- A clinical tool was used to identify older patients who were living with moderate or severe frailty. The patients received a full assessment of their physical, mental and social needs.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- Clinicians worked with other health and care professionals to deliver coordinated packages of care.
- Patients were signposted to other avenues of support as befit their health and social care needs, such as the wellbeing advisor.

Management of people with long-term conditions

Findings

As part of our inspection, on 11 August 2022, we conducted a series of remote clinical searches to assess the practice's procedures for the management of patients with long-term conditions. A review of the searches was undertaken by the CQC GP specialist advisor (SpA) without visiting the practice.

In general, our GP SpA found the management of patients with long-term conditions was satisfactory, particularly given the challenges of service provision during the pandemic and some patients not wishing to attend the surgery. The majority of patients we reviewed with a long-term condition, such as asthma or diabetes, had been followed-up appropriately. Some patients had not attended their appointments and were being followed-up by the practice.

We were informed that:

- Patients with a long-term condition were offered a structured review, in line with the relevant guidance, to check their health and medicines needs were being met.
- Patients were seen and reviewed as befit their ongoing needs, for example if they were experiencing an exacerbation of their illness.
- The practice used the local clinical commissioning group's template for recording long-term reviews and patient information.
- Adults with either newly diagnosed, or at risk of, cardiovascular disease were offered statins in line with local guidance.

- Patients with asthma and chronic obstructive pulmonary disease (COPD) were provided with management of care plans. Prescriptions for rescue medications was available for patients as necessary.
- Clinicians worked with other health and care professionals to deliver coordinated packages of care.
- Staff who were responsible for the care, treatment and reviews of patients with a long-term condition had received specific training.
- There was a process in place for following-up patients who did not attend their appointments.

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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	55	59	93.2%	Met 90% minimum
The percentage of children aged 2 who have received their booster immunisation for Pneumococcal infection (i.e. received Pneumococcal booster) (PCV booster) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	49	64	76.6%	Below 80% uptake
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) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	64	82.8%	Below 90% minimum
The percentage of children aged 2 who have received immunisation for measles, mumps and rubella (one dose of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	53	64	82.8%	Below 90% minimum
The percentage of children aged 5 who have received immunisation for measles, mumps and rubella (two doses of MMR) (01/04/2020 to 31/03/2021) (NHS England and Improvement)	38	71	53.5%	Below 80% uptake

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

Any additional evidence or comments

- The practice is located in Leeds city centre and has a high turnover of patients, including students and people from other countries. This had resulted in some patients no longer residing in the area

and the practice not being informed. We were told of the difficulty in obtaining and the recording of information when children had received immunisations elsewhere, such as their country of origin.

- Despite these figures, we saw evidence that the practice consistently worked to improve the uptake of childhood immunisations. A member of staff had been allocated time to contact patients and advise them of the importance of ensuring their child is immunised. Anyone who did not attend was then contacted and offered a new appointment.
- The practice had meetings with the health visitor to discuss strategies for increasing uptake, for example writing to the parent with an appointment rather than asking them to make an appointment. They were plans in place to trial a drop-in clinic to see if uptake rates improved.
- Two care coordinators had been recruited through the primary care network to support the practice with regards to childhood immunisations and non-responders.

Cancer Indicators	Practice	CCG average	England average	England comparison
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). (Snapshot date: 31/12/2021) (UK Health and Security Agency)	49.7%	N/A	80% Target	Below 70% uptake
Females, 50-70, screened for breast cancer in last 36 months (3-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	40.0%	64.0%	61.3%	N/A
Persons, 60-74, screened for bowel cancer in last 30 months (2.5-year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	46.2%	65.8%	66.8%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2020 to 31/03/2021) (UKHSA)	31.6%	52.2%	55.4%	No statistical variation

Any additional evidence or comments

- The practice was proactive in trying to improve their cancer screening uptake rates. They had engaged with stakeholders and the local cancer care coordinator to look at measures they could take. We saw minutes from meetings where the issues had been raised and discussed. For example, risk stratification of patients and commencement of targeted intervention, opportunistically managing patients and adding further information to the practice website. The practice had also identified some coding issues and was addressing these.
- The practice had organised cervical cancer specific clinics, which they reported to have had a good uptake. They were also in the process of training additional staff to support cervical cancer screening, which would increase availability.
- Two care coordinators had been recruited through the primary care network to support the practice with regards to cancer screening programmes and non-responders.

- We were informed of the numbers of registered patients who came from other countries, and the impact their non-attendance had on uptake rates. The practice liaised with Leeds Student Medical Practice (as part of the primary care network) to identify any actions they could take to address to improve uptake rates.

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.	Yes
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	Yes
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	Yes

Any additional evidence or comments

- The practice undertook clinical and non-clinical audits, which included those relating to medicines management, consultation and prescribing. Findings from these were used to improve patient care and service delivery.
- The practice had undertaken an audit regarding frequent attenders between 1 April 2021 and 31 March 2022 (at that time the registered patient list was approximately 14,869). The results were as follows:
 - 34,689 appointments were available during that time frame.
 - 6,152 (42%) of patients had an appointment. This had increased from 4,717 patients from the year previous.
 - 181 (1% of the patient population) had 21 or more appointments each; a total of 5,631 (16%). This had decreased from the previous year when 384 (3%) patients took 28% (8,821) appointments. This reduction had been attributed to the employment of mental health advisors who supported those patients.
- Case studies were also used to evaluate and improve patient care and treatment as necessary.
- The practice participated in the clinical commissioning group's quality improvement schemes.
- They engaged with the local primary care network to improve services for their patient population.

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.	Yes

The practice had a programme of learning and development.	Yes
Staff had protected time for learning and development.	Yes
There was an induction programme for new staff.	Yes
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.	Yes
The practice could demonstrate how they assured the competence of staff employed in advanced clinical practice, for example, nurses, paramedics, pharmacists and physician associates.	Yes
There was a clear and appropriate approach for supporting and managing staff when their performance was poor or variable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • There was a clinical supervision policy, which contained details of staff who were appropriately trained in providing clinical supervision. • Information was maintained regarding the professional registrations of staff to ensure they were up to date and appropriately registered. • There was an up to date appraisal policy which identified that staff received annual appraisals through a formalised process. • We saw that all staff received mandatory training and other training relevant to their role. A training matrix was maintained to ensure that staff were up to date. • Recruitment of staff remained an ongoing process. • The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high quality care. Staff were proactively supported to acquire new skills. For example, administration staff had been supported to train as healthcare assistants. 	

Coordinating care and treatment

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

Indicator	Y/N/Partial
Care was delivered and reviewed in a coordinated way when different teams, services or organisations were involved.	Yes
Patients received consistent, coordinated, person-centred care when they moved between services.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Staff told us they worked closely with other local organisations and healthcare providers to ensure patients received care in a coordinated manner. This included the establishment of close working relationship with health visiting teams and palliative care teams. We saw minutes from meetings to evidence this. 	

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.	Yes
Staff encouraged and supported patients to be involved in monitoring and managing their own health.	Yes
Patients had access to appropriate health assessments and checks.	Yes
Staff discussed changes to care or treatment with patients and their carers as necessary.	Yes
The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Palliative care and clinical meetings took place, which were minuted. We saw evidence where patients had been discussed regarding care and treatment needs.• The practice employed a wellbeing coordinator/social prescriber who supported patients, as befit their needs, to improve their health and wellbeing.• The practice encouraged a culture of self-help and self-management through health and promotional information on their website.	

Consent to care and treatment

The practice was able to demonstrate that it 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.	Yes
Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.	Yes
Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in line with relevant legislation and were appropriate.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none">• Clinicians we spoke with understood the requirements of legislation and guidance when considering consent and decision making.• Staff were aware of the need to request consent to share records in line with General Data Protection Regulation (GDPR) principles.• We saw that DNACPR decisions were discussed and recorded appropriately in patients' records.	

Caring

Rating: Good

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

	Y/N/Partial
Staff understood and respected the personal, cultural, social and religious needs of patients.	Yes
Staff displayed understanding and a non-judgemental attitude towards patients.	Yes
Patients were given appropriate and timely information to cope emotionally with their care, treatment or condition.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On the day of the inspection we observed that staff spoke with patients in a dignified and respectful manner. 	

National GP Patient Survey results

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 (01/01/2021 to 31/03/2021)	75.8%	90.4%	89.4%	Variation (negative)
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 (01/01/2021 to 31/03/2021)	75.1%	89.1%	88.4%	Variation (negative)
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 (01/01/2021 to 31/03/2021)	86.9%	96.2%	95.6%	Variation (negative)
The percentage of respondents to the GP patient survey who responded positively to the overall experience of their GP practice (01/01/2021 to 31/03/2021)	59.3%	84.6%	83.0%	Variation (negative)

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

Any additional evidence

The practice was addressing areas of patient dissatisfaction and were hoping the recruitment and retention of staff would have a positive impact.

They participated in the NHS Friends and Family Test. Between the period 27/09/2021 to 11/08/2022, they had received 1,124 responses, the results of which were:

- 782 responses rated them five stars
- 206 responses rated them four stars
- 59 responses rated them three stars
- 66 responses rated them one star
- 11 responses did not rate them
- 84% of responses said they would recommend the practice to their friends and family.

There was a plan to send out questionnaires via text messaging to patients, tailoring them to themes, to enable the practice to obtain additional patient feedback.

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.	Yes
Staff helped patients and their carers find further information and access community and advocacy services.	Yes

National GP Patient 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 much as they wanted to be in decisions about their care and treatment (01/01/2021 to 31/03/2021)	84.5%	93.4%	92.9%	Variation (negative)

	Y/N/Partial
Interpretation services were available for patients who did not have English as a first language.	Yes
Patient information leaflets and notices were available in the patient waiting area which told patients how to access support groups and organisations.	Yes
Information leaflets were available in other languages and in easy read format.	Yes
Information about support groups was available on the practice website.	Yes

Carers	Narrative
Percentage and number of carers identified.	39 registered carers Due to the patient demographic being a predominantly young population there are low numbers of patients who identify themselves as being a carer.
How the practice supported carers (including young carers).	When registering as a new patient with the practice they are asked if they are a carer. They were also identified during consultations. Carers were encouraged to register with the Leeds yellow card scheme and were referred to local carers' support organisations. Carers were invited for relevant vaccinations, such as those for protection against influenza and COVID viruses. Support was provided as befit the individual needs of the carer
How the practice supported recently bereaved patients.	Individual support was offered, as needed, to patients who experienced bereavement.

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.	Yes
There were arrangements to ensure confidentiality at the reception desk.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> On the day of the inspection we observed confidentiality at the reception desk. Staff we spoke with told us they followed the practice's confidentiality policy when discussing patients' treatments. We saw that staff had undertaken information governance training. 	

Responsive

Rating: Good

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.	Yes
The importance of flexibility, informed choice and continuity of care was reflected in the services provided.	Yes
The facilities and premises were appropriate for the services being delivered.	Yes
The practice made reasonable adjustments when patients found it hard to access services.	Yes
There were arrangements in place for people who need translation services.	Yes
The practice complied with the Accessible Information Standard.	Yes

Practice Opening Times	
Day	Time
Opening times:	
Monday	08:00 to 18:30
Tuesday	07:00 to 18:30
Wednesday	08:00 to 18:30
Thursday	07:00 to 18:30
Friday	08:00 to 18:30
Extended hours access based at Leeds Student Medical Practice.	
Saturday	09:00 to 12:00
Sunday	09:00 to 12:00

Further information about how the practice is responding to the needs of their population
<ul style="list-style-type: none"> • Patients had access to extended hours appointments at evenings and weekends at hubs based in Leeds, which were organised by the local confederation. • Out of hours cover was provided by Local Care Direct. Patients were directed to contact NHS 111 when the practice was closed. • The practice offered home visits and urgent appointments for those with enhanced needs and complex medical issues. • The practice liaised regularly with the community services to discuss and manage the needs of patients with complex medical issues. • The practice liaised with the district nursing team to support those patients who were housebound. • The practice attended bi-weekly extended access meetings with the primary care network to ensure services were suitable for their patient populations.

Access to the service

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

The COVID-19 pandemic has affected access to GP practices and presented many challenges. In order to keep both patients and staff safe early in the pandemic practices were asked by NHS England and Improvement to assess patients remotely (for example by telephone or video consultation) when contacting the practice and to only see patients in the practice when deemed to be clinically appropriate to do so. Following the changes in national guidance during the summer of 2021 there has been a more flexible approach to patients interacting with their practice. During the pandemic there was a significant increase in telephone and online consultations compared to patients being predominantly seen in a face to face setting.

	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	Yes
The practice offered a range of appointment types to suit different needs (e.g. face to face, telephone, online)	Yes
Patients were able to make appointments in a way which met their needs	Yes
There were systems in place to support patients who face communication barriers to access treatment	Yes
Patients with most urgent needs had their care and treatment prioritised	Yes
There was information available for patients to support them to understand how to access services (including on websites and telephone messages)	Yes
Explanation of any answers and additional evidence:	
<p>Due to high patient demand for appointments, the practice had developed a "e-hub". A named clinician was responsible for the management of the hub on a daily basis. Patients were encouraged to submit information and requests via the e-consult system. This was reviewed on the same day by the clinician, who arranged for triage of the patient (if necessary) and booked an appointment with an appropriate clinician as required.</p> <p>The hub was initially trialled to test the concept, gather feedback from staff and patients and make any identified changes to the model. Patient and staff feedback was positive. As a result, the practice was looking to increase clinical time allocated to the hub and trial a walk-in clinic for patients.</p>	

National GP Patient Survey results

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 (01/01/2021 to 31/03/2021)	41.3%	N/A	67.6%	Significant Variation (negative)

Indicator	Practice	CCG average	England average	England comparison
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2021 to 31/03/2021)	57.5%	71.0%	70.6%	No statistical variation
The percentage of respondents to the GP patient survey who were very satisfied or fairly satisfied with their GP practice appointment times (01/01/2021 to 31/03/2021)	56.4%	67.4%	67.0%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2021 to 31/03/2021)	73.8%	82.4%	81.7%	No statistical variation

Any additional evidence or comments

We were informed that access had been a recurring issue at The Light, mainly due to the staffing shortages, the volume of telephone calls and patient footfall into the practice. The practice had access to monthly call data, which showed the numbers of calls, abandon rates and average length of waiting time to be answered. As a result, they had increased the numbers of reception staff with a view to improving access for patients.

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.	9
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.	Yes
There was evidence that complaints were used to drive continuous improvement.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> There was a complaints policy which instructed staff on the process to follow. We saw that patients were given information for the Parliamentary and Health Service Ombudsman, should they not be happy with the outcome of their complaint. 	

- We reviewed some complaints and were assured by the action that had been taken. In one instance, specific arrangements had been put in place to enable the patient to be supported as befit their complex needs.

Well-led

Rating: Good

Leadership capacity and capability

There was compassionate, inclusive and effective leadership at all levels. Leaders could demonstrate that they had the capacity and skills to deliver high quality sustainable care.

	Y/N/Partial
Leaders demonstrated that they understood the challenges to quality and sustainability.	Yes
They had identified the actions necessary to address these challenges.	Yes
Staff reported that leaders were visible and approachable.	Yes
There was a leadership development programme, including a succession plan.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • The manager was open and transparent about the challenges the practice had faced regarding the recruitment of staff. • The practice was responsive and proactive to feedback during the inspection process and acted immediately upon findings. For example, issues relating to patients identified as part of our clinical searches were immediately actioned. • There was succession planning in place, regarding any changes in management or leadership. • The practice had access to a team of leaders and managers at an organisational level. 	

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.	Yes
Staff knew and understood the vision, values and strategy and their role in achieving them.	Yes
Progress against delivery of the strategy was monitored.	Yes
Explanation of any answers and additional evidence: <p>There was both a local and organisational vision, which staff were aware of:</p>	

Locally: “By understanding the communities we work within, we tackle challenges to health to improve the care we give. We want to continue offering better care for everyone which is delivered in the best possible way.”

Organisationally: “To provide the local community with prompt, evidence based, holistic and safe healthcare. In every encounter that a patient has with our team we will treat them with compassion, dignity and respect. We also want to provide flexible and responsive care to patients – getting the right service to patients, done by the right person at the right time.”

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.	Yes
Staff reported that they felt able to raise concerns without fear of retribution.	Yes
There was a strong emphasis on the safety and well-being of staff.	Yes
There were systems to ensure compliance with the requirements of the duty of candour.	Yes
When people were affected by things that went wrong, they were given an apology and informed of any resulting action.	Yes
The practice encouraged candour, openness and honesty.	Yes
The practice had access to a Freedom to Speak Up Guardian.	Yes
Staff had undertaken equality and diversity training.	Yes
Explanation of any answers and additional evidence:	
<ul style="list-style-type: none"> • Staff had access to both organisational and external Freedom to Speak Up Guardians. The whistleblowing policy informed staff of the process should they wish to raise a concern. • There was strong collaboration, team-working and support across all staff and a common focus on improving the quality and sustainability of care and people’s experiences. • Staff told us they felt supported by the GPs and the manager and were encouraged to raise any concerns as they arose. • There was an open-door policy for the manager and lead GP and a ‘no-blame’ culture in the practice. • A daily huddle took place, where information was cascaded and concerns could be raised. 	

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

Source	Feedback
Staff interviews and staff questionnaires	<p>We spoke with several members of staff during the inspection and received completed staff questionnaires. Staff informed us that:</p> <ul style="list-style-type: none"> • They felt supported professionally and personally.

	<ul style="list-style-type: none"> • They had access to the equipment and training necessary to enable them to perform their roles well. • The manager and lead GP were approachable and supportive. • They enjoyed working at the practice, worked well as a team and were supportive of one another. They were proud of how they had continued to deliver services to patients throughout the COVID pandemic.
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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.	Yes
Staff were clear about their roles and responsibilities.	Yes
There were appropriate governance arrangements with third parties.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • Communication with staff was through a variety of platforms, such as meetings, emails, text messaging and daily conversations in the practice. • There was a range of meetings and minutes of these were available for staff to read. This included the daily huddle which had standing agenda items, such as staffing, premises issues, outstanding work, incidents, checking of equipment and vaccine refrigerator temperatures. • There were systems in place to support the monitoring and tracking of staff training. • The practice had nominated clinical leads for key areas, such as the safeguarding of adults and children and infection prevention and control, whom staff could contact for specialist advice and support. • Staff we spoke with understood their individual roles and responsibilities and knew who to contact if further advice was required. • We saw new staff had received a role specific induction when they had commenced, and existing staff had annual appraisals. • Succession planning for the practice was discussed at board level. • As an organisation, the provider cascaded daily workflow information to each of their services. We saw evidence of these and that they contained items such as medicines management, referrals, reception tasks and any outstanding issues that needed actioning. This enabled the provider to identify any workflow issues, whereby support could be provided as needed. 	

Managing risks, issues and performance

The practice had clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	Yes
There were processes to manage performance.	Yes

There was a quality improvement programme in place.	Yes
There were effective arrangements for identifying, managing and mitigating risks.	Yes
A major incident plan was in place.	Yes
Staff were trained in preparation for major incidents.	Yes
When considering service developments or changes, the impact on quality and sustainability was assessed.	Yes

The practice had systems in place to continue to deliver services, respond to risk and meet patients' needs during the pandemic

	Y/N/Partial
The practice had adapted how it offered appointments to meet the needs of patients during the pandemic.	Yes
The needs of vulnerable people (including those who might be digitally excluded) had been considered in relation to access.	Yes
There were systems in place to identify and manage patients who needed a face-to-face appointment.	Yes
The practice actively monitored the quality of access and made improvements in response to findings.	Yes
There were recovery plans in place to manage backlogs of activity and delays to treatment.	Yes
Changes had been made to infection control arrangements to protect staff and patients using the service.	Yes
Staff were supported to work remotely where applicable.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> • All backlog of activity caused by the pandemic had been addressed. However, there were still some outstanding patient records which required summarising. We were informed the practice were in the process of taking steps to address this and an action plan was in place. • Personal protective equipment (PPE) was available for staff, patients and any visitors to the practice. Staff continued to wear masks and patients were asked to wear a mask when entering the premises. • Some staff were able to work remotely and had been provided with the necessary equipment, such as a laptop and mobile telephone. A remote working policy was in place. 	

Appropriate and accurate information

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

	Y/N/Partial
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Staff used data to monitor and improve performance.	Yes
Performance information was used to hold staff and management to account.	Yes
Staff whose responsibilities included making statutory notifications understood what this entailed.	Yes

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.	Yes
The provider was registered as a data controller with the Information Commissioner's Office.	Yes
Patient records were held in line with guidance and requirements.	Yes
Patients were informed and consent obtained if interactions were recorded.	Yes
The practice ensured patients were informed how their records were stored and managed.	Yes
Patients were made aware of the information sharing protocol before online services were delivered.	Yes
The practice had arrangements to make staff and patients aware of privacy settings on video and voice call services.	Yes
Online consultations took place in appropriate environments to ensure confidentiality.	Yes
The practice advised patients on how to protect their online information.	Yes

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.	Yes
The practice had an active Patient Participation Group.	No
Staff views were reflected in the planning and delivery of services.	Yes
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> We were informed the practice did not have an active patient participation group, despite attempts to develop one. They used information from patient feedback, compliments and complaints to improve services. A staff survey had been undertaken. The majority of staff said they felt able to make suggestions or improvements in their area of work and be involved in decisions that affected their team. 	

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	Yes
Learning was shared effectively and used to make improvements.	Yes
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> The practice engaged with their commissioners and neighbouring practices in local current and future initiatives which included the primary care network (PCN). The clinical searches undertaken as part of the inspection found effective systems and processes for monitoring care and treatment. 	

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

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

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

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

Note: The CQC GP Evidence Table uses the most recent validated and publicly available data. In some cases at the time of inspection this data may be relatively old. If during the inspection the practice has provided any more recent data, this can be considered by the inspector. However, it should be noted

that any data provided by the practice will be unvalidated and is not directly comparable to the published data. This has been taken into account during the inspection process.

Glossary of terms used in the data.

- **COPD:** Chronic Obstructive Pulmonary Disease.
- **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.