

Care Quality Commission

Inspection Evidence Table

Farmhouse Surgery (1-570101287)

Inspection Date: 20 – 22 March 2023

Date of data download: 27/02/2023

Overall rating: Inadequate

At this inspection, we found that those areas previously regarded as good had not been continued. We found systems and processes for keeping people safe were ineffective and placed patients at avoidable risk of harm. We therefore rated the practice as inadequate.

Safe

Rating: Inadequate

The practice did not have clear systems and processes to keep people safe and safeguarded from abuse.

Appropriate standards of cleanliness and hygiene were not met.

There were gaps in systems to assess, monitor and manage risks to patient safety. Staff did not consistently have all information they needed to deliver safe care and treatment.

More work was required to ensure all aspects of medicine management were safe. The practice learned and made improvements when things went wrong but did not always share learning and improvements with the staff.

There was limited monitoring of the outcomes of care and treatment.

Safety systems and processes

The practice did not have 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.	Partial
Partners and staff were trained to appropriate levels for their role.	N

There was active and appropriate engagement in local safeguarding processes.	Y
The Out of Hours service was informed of relevant safeguarding information.	N
There were systems to identify vulnerable patients on record.	Y
Disclosure and Barring Service (DBS) checks were undertaken where required.	Partial
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
<ul style="list-style-type: none"> The practice had a safeguarding lead GP who oversaw all concerns. Safeguarding concerns were discussed weekly as part of the clinical practice meetings and staff were aware of how to contact the local authority with any alerts or concerns. Safeguarding risk registers for adults and children were not used to enable an oversight of any risks and ensure ongoing monitoring of those risks. There were icons used on the electronic record system to alert staff to patients with a safeguarding risk. It was unclear what information was available to locum staff to ensure they had sufficient information when seeing patients. Safeguarding alerts were not audited to ensure what was being reported was appropriate and that follow up action was carried out. Child protection meetings were not held by the GPs at the practice and there were no audits of child protection to provide an oversight of risk. There was no system in place for safeguarding information if needed, to be provided to out of hours services. Adult safeguarding training was not in line with current national guidelines. The clinical staff at the practice were trained to safeguarding vulnerable adults' level 2. The Adult Safeguarding: Roles and Competencies for Health Care Staff August 2018, states that safeguarding vulnerable adults training level 3 should be undertaken by registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns (as appropriate to role). This includes general practitioners and registered nurses. The safeguarding lead for the practice should be trained to safeguarding level 4 in line with the national guidance but was only trained to level 2. This did not provide assurance they had the skills and competency required for the role. Children's safeguarding training was not in line with current national guidelines. The Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff, January 2019 states that safeguarding vulnerable children level 3 training is required for all clinical staff working with children, young people, parents and carers of children. This includes general practitioners and registered nurses. The practice had in place safeguarding Level 3 training for clinical staff. However, the safeguarding lead named clinician should be trained to level 4 in line with national guidance but was only trained to level 2. This did not provide assurance they had the skills and competency required for the role. 	

Recruitment systems	Y/N/Partial
Recruitment checks were carried out in accordance with regulations (including for agency staff and locums).	N
Staff vaccination was maintained in line with current UK Health and Security Agency (UKHSA) guidance if relevant to role.	N
<ul style="list-style-type: none"> The practice had not carried out Disclosure and Barring Service (DBS) checks for all staff prior to them commencing employment. The practice had a recruitment policy and procedure which stated criminal 	

record checks would be completed as part of the NHS employment check process. The DBS helps employers make safer recruitment decisions and prevent unsuitable people working with vulnerable people and children. We reviewed the recruitment records for 5 members of staff. We found there was no DBS check available for 3 non-clinical members of staff. The practice recruitment policy stated that all applicants would be risk assessed in relation to whether a DBS was required for the role. We were told the practice did not carry out DBS checks for non-clinicians. Recruitment records showed no risk assessments had been completed to ensure the suitability of these members of staff to work in the practice. This meant the practice management could not ensure that patients were safe.

- We reviewed the personnel folders for 4 members of staff. We saw all 4 staff had a contract which outlined their roles and responsibilities. One member of staff had not signed the contract. At the point of recruitment staff were asked to submit a Curriculum Vitae (CV). A CV is a short, written summary of their skills, achievements and experience which relate to a role. One personnel file did not evidence the CV and there was no information relating to their previous experience and/or skills for the role. This meant the practice were not able to review any gaps in employment and explore the reasons for this.
- The recruitment policy and procedure stated two written references would be obtained prior to appointment of new members of staff. Two personnel files showed only one reference. There was no evidence to demonstrate the persons proof of identify had been checked. For example, proof of address or photographic evidence.
- Locum staff such as nurses and GPs worked within the service. These staff were recruited through an agency. The practice did not have a written agreement on the checks undertaken by the agency to ensure the clinicians were suitable to work within a GP practice. The practice had retained some written evidence to demonstrate the assurances they had sought themselves. However, there were gaps in the evidence provided. For example, not all personnel files included evidence of DBS checks, references or training certificates.
- The staff files included a record of staff vaccinations. Nonclinical staff had a record of only influenza and Covid-19 vaccination. This meant it could not be identified if staff had appropriate vaccination protection.
- We raised the above issues during the inspection and were told the staff personnel files were being reviewed and developed. We were provided with assurances that this process would also consider additional information required to support the process.

Safety systems and records	Y/N/Partial
Health and safety risk assessments had been carried out and appropriate actions taken.	N
Date of last assessment:	N
There was a fire procedure.	Y
Date of fire risk assessment: 11 November 2022	Y
Actions from fire risk assessment were identified and completed.	N
<ul style="list-style-type: none"> • The fire risk assessment covered the 3 GP practices located at Christchurch Medical Centre. A smoke detection and emergency lighting system were installed throughout the building, along with fire extinguishers. The staff had received fire training and were aware of their responsibilities in the event of a fire or other emergency. However, a fire drill had been undertaken the week prior to inspection but drills for emergency evacuation had not been carried out and staff had therefore not practiced emergency procedures. 	

- A fire risk assessment had been completed in November 2022 which identified staircase enclosures should not contain obstructions and combustibles. At inspection we saw that staircase enclosures were still used for storage of unused equipment and combustible materials, and this created a risk to staff and patients.
- Risk assessments for the building, equipment, staff and patients were not completed. Therefore, the practice was not monitoring the risks or evidencing any actions to minimise those risks. For example, staff sometimes worked alone but there was a limited generic risk assessment to assess those risks and plan how to support staff safety.
- The security systems at the practice did not ensure the safety and security of the building. There were multiple sets of keys to the building which were provided to staff who took them home. However, there was no record of who held them and if they were held securely. Following the inspection, a keyholding policy was implemented with key logs to manage who held the building keys and who had access. The keyholder agreement advised staff that they must ensure the safekeeping of keys but did not outline any measures staff must take to ensure keys held at home were stored securely.
- There were external CCTV cameras monitoring the building and activity. There was no evident signage informing patients of the presence of CCTV and footage from the cameras did not belong to the practice. The practice leadership team did not know who monitored or managed the CCTV.
- All consultation and treatment rooms had been equipped with panic buttons for the use of staff members in the instance of an emergency or dangerous situation with a patient. The alarm would notify the reception desk and enable assistance to be called.

Infection prevention and control

Appropriate standards of cleanliness and hygiene were not met.

	Y/N/Partial
Staff had received effective training on infection prevention and control.	Partial
Infection prevention and control audits were carried out.	Y
Date of last infection prevention and control audit: March 2023	Y
The practice had acted on any issues identified in infection prevention and control audits.	Partial
The arrangements for managing waste and clinical specimens kept people safe.	Y
<ul style="list-style-type: none"> • The environment was a Grade 2 listed building. The building showed evidence of wear and tear associated with its use and as such maintaining a good level of hygiene was difficult. For example, we saw radiators which were rusty and ceilings which were water damaged. • The practice had an Infection Prevention and Control (IPC) policy for staff to follow. The practice manager had taken an interim IPC lead role but had not received any training for the role. A recent risk assessment for IPC for the building and the practice had been undertaken and an action plan developed to meet the areas of identified risk. Action to address these areas was underway but not yet completed. A hand hygiene audit had been completed in March 2023 which recorded 100% compliance. • Medical cleaning inspection audits showed an overall good standard of cleaning but identified some issues with the environment. 	

- Cleaning contracts were in place for cleaning both clinical and non-clinical areas. However, the practice had cluttered areas such as stair wells and unused treatment rooms which meant they were hard to keep clean and one GP's consultation room was untidy and all surfaces were covered with equipment, which meant they couldn't be used by other staff safely or be cleaned thoroughly.
- We observed staff took measures to reduce the risk of COVID-19 infection. For patients and staff, alcohol gel was located at the entrance and throughout the building. There was signage reminding people to use the hand gel and wear face masks if they were able to.
- Infection prevention and control training had not been completed by all staff including most clinical staff and so they could not be assured that all staff were aware of and followed IPC procedures.
- Clinical waste storage was available in clinical rooms. Sharps' boxes were dated and signed when first in use and again when ready for disposal, this enabled an audit trail of their use. Clinical waste was held securely until collected.

Risks to patients

There were gaps in 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.	N
The practice was equipped to respond to medical emergencies (including suspected sepsis) and staff were suitably trained in emergency procedures.	Partial
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.	N
<ul style="list-style-type: none"> • Staffing levels were planned to ensure there was enough cover for periods of leave such as annual leave or to cover sickness. However, there were not enough clinical staff to ensure reviews for all health conditions could be completed. There were shortages in nursing and medical staff which impacted on the services provided and the monitoring of the service. • Temporary staff were provided with induction training to support them to work safely. However, there were no consistent records to demonstrate that an induction had been provided and what the induction covered. This meant that there was no audit trail of training to support temporary staff. • Reception staff had access to a GP if they had concerns about the wellbeing of patients waiting in reception or on a telephone call. There were signage and flow charts to inform staff of actions to take in an emergency. Some staff had completed training in basic life support and how to deal with medical emergencies. However, 8 members of the medical and nursing staff had not completed this training or updated the training within the practice's training timescale and so may not be aware of current best practice in an emergency. 	

Information to deliver safe care and treatment

Staff did not have 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.	Partial
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.	Partial
There was a documented approach to the management of test results and this was managed in a timely manner.	Partial
There was appropriate clinical oversight of test results, including when reviewed by non-clinical staff.	Y
<ul style="list-style-type: none"> • All new patients who registered with the practice completed a detailed registration form and had a medicines and medical history review. Patients were booked to see a GP or practice nurse if necessary. For example, those patients with a long-term condition or those taking complex medicines. • There was a process used which required staff to update the electronic record system with the patient's historical records which were paper based. There were 67 records outstanding for this summarisation and a new member of staff had been allocated one day per week to start this task. There was no system to identify the earliest records requiring summarising. There was no clear system to prioritise the most at risk or vulnerable patients' notes, this meant those patients at higher risk may not have been recognised in a timely way. • The practice had a system to manage the receipt of test results to ensure clinical oversight of the tests. The process detailed that if the requesting clinician was not available to review the results, another GP would ensure results were seen and actioned. However, the systems used did not include transferring the results to a clinic record so that GPs could review this prior to prescribing medicines for the patient. This meant that the most recent results were not immediately available to inform any change of medicine doses and may mean the patients receive an incorrect dose. The GP's recognised this was an issue and planned to implement a system to transfer results, to ensure they were easily accessible and visible. • The practice policy for receiving test results had identified the need to audit pathology correspondence to ensure results were managed appropriately. However, this had not yet been completed. An action plan with timescales for completion had been provided. This meant there was no clinical oversight to ensure that the systems used were safe and effective. • Referrals for patients to see another clinician or specialist were requested by the GP and written by administrative staff. The information for these referrals was provided to administration staff from the patients notes. The referrals were not checked or signed by the GP and no audits were undertaken to ensure they were correct in their context and content. This may place patients at risk as any errors would go unchecked. 	

Appropriate and safe use of medicines

The practice did not have effective systems for the appropriate and safe use of all 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 Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.79	0.83	0.82	No statistical variation
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). (01/10/2021 to 30/09/2022) (NHSBSA)	5.7%	8.9%	8.5%	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 (01/04/2022 to 30/09/2022) (NHSBSA)	5.24	5.36	5.28	No statistical variation
Total items prescribed of Pregabalin or Gabapentin per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	164.6‰	104.2‰	129.6‰	No statistical variation
Average daily quantity of Hypnotics prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (01/10/2021 to 30/09/2022) (NHSBSA)	0.91	0.57	0.58	No statistical variation
Number of unique patients prescribed multiple psychotropics per 1,000 patients (01/04/2022 to 30/09/2022) (NHSBSA)	5.5‰	7.2‰	6.7‰	No statistical variation

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.	N/A
There was a process for the safe handling of requests for repeat medicines and evidence of effective medicines reviews for patients on repeat medicines.	Partial

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 high risk medicines (for example, warfarin, methotrexate and lithium) with appropriate monitoring and clinical review prior to prescribing.	N
The practice monitored the prescribing of controlled drugs. (For example, investigation of unusual prescribing, quantities, dose, formulations and strength).	N
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.	NA
The practice had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance.	N
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
<ul style="list-style-type: none"> There was no consistent process for monitoring patients' health in relation to the use of high-risk medicines. High risk medicines are those which require additional monitoring, such as blood tests, to ensure the patient is prescribed a safe dosage. There was no evidence that controlled drugs prescribing and ongoing use were routinely monitored. Our clinical searches identified a total of 22 patients taking a medicine called Spironolactone which was used to treat conditions such as heart and liver failure. We sampled 4 of these and found that there were problems with the monitoring for 3 of the 4 sampled patients. Post inspection the practice told us that all three have since had appointments booked for monitoring blood tests to be completed. One patient did not have a diagnosis recorded for the medicines prescribed and this has now been completed. There were no practice systems used to identify these shortfalls therefore could not guarantee that without the inspection team identifying these issues the monitoring would have been completed. Our clinical searches identified a total of 8 patients taking a medicine called Azathioprine which may be used to treat conditions which affect the immune system such as rheumatoid arthritis. Of these 8 patients, we identified one patient overdue appropriate monitoring. The medicine had been reviewed but there was no record to evidence what had been discussed with the patient or any actions taken. There was also a lack of review of blood results from the hospital to ensure accurate prescribing. This process was being reviewed to ensure that all test results were readily available and used when calculating doses for prescriptions. We looked at clinical records for patients who were prescribed methotrexate, a disease modifying anti-rheumatic medicine (DMARD). We identified that 23 patients took this medicine. Of the 3 patients we looked at who were prescribed this medicine 2 had received appropriate monitoring. One patient had their monitoring carried out in the local acute hospital. However, their results had not been reviewed to ensure they received the right dose of medicine. 	

- One patient had an antibiotic prescribed for 6 years without a defined diagnosis for this treatment or a record review of its prescribing. In response to our feedback this medicine has now been reviewed and diagnosis added.
- Medicine reviews were in the process of being completed by the Primary Care Network (PCN) pharmacist and GPs. The reviews were planned annually or in between times as needed. A procedure was in place for patients who chose not to engage with the review, which included a series of three communications such as letter or text message. Once the three communications were completed, if the patient did not respond, a remote review took place and a decision made about what further action to take. There were no other systems used to encourage the patient to participate in the review for their safety.
- We saw that medicine reviews were not always fully completed. We looked at the clinical records of 5 patients who had received a medicine review and 4 required action to ensure the medicines received were the correct dose. For example, not all medicines were reviewed as part of the process and the involvement of the patient was not always recorded. Following our inspection, the 4 patients were booked in for the appropriate monitoring. These systems were in the process of being reviewed by the practice.
- The Farmhouse Surgery did not employ non-medical prescribers. Patient Group Directions were used for nurses to administer some medicines. PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicines to a pre-defined group of patients, without them having to see a prescriber such as a GP or nurse prescriber.
- All medications were stored securely in either lockable refrigerators or a medicine safe. There were logbooks in place to monitor stock levels and usage of medicines.

Track record on safety and lessons learned and improvements made

The practice learned and made improvements when things went wrong but did not always share learning and improvements when things went wrong.

Significant events	Y/N/Partial
The practice monitored and reviewed safety using information from a variety of sources.	Partial
Staff knew how to identify and report concerns, safety incidents and near misses.	Partial
There was a system for recording and acting on significant events.	No
Staff understood how to raise concerns and report incidents both internally and externally.	Partial
There was evidence of learning and dissemination of information.	Partial
Number of events recorded in last 12 months:	11
Number of events that required action:	11
<ul style="list-style-type: none"> • The provider had a reporting system to capture incidents and errors that required investigation. However, staff told us they mostly told the practice and reception manager about any incidents and did not record them. This meant that the reporting of incidents was not always monitored or audited. • Management staff told us that they didn't receive any training in managing incidents and significant events. Staff did not receive any training in how to investigate and report any incidents. We were told 	

of an incident which had not been reported correctly. This meant there was a risk that the information was not available for future reference.

- We were told that feedback from incidents and any learning outcomes should be shared with staff through practice meetings, emails and discussion at one-to-one meetings. However, staff confirmed that learning was rarely shared and minutes from those meetings did not demonstrate that if something did go wrong, learning would be shared. Significant events were also reviewed at a weekly clinical meeting and the practice meetings, but minutes of these meetings were not shared with the wider staff team.

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

Event	Specific action taken
A booking error had meant mis information had been provided to the patient	The incident had been reviewed and the patient contacted to confirm discussions and actions taken
Patient information received from the hospital had not been updated on the patients record and medicines adjusted to an advised change of dose.	The practice manager reported as an adverse incident and the appropriate medicines prescribed.

Safety alerts	Y/N/Partial
There was a system for recording and acting on safety alerts.	Partial
Staff understood how to deal with alerts.	Y
<ul style="list-style-type: none"> • The practice had systems to receive and act on safety alerts, but this was not consistently reviewed to ensure all alerts were acted upon. Alerts and information were disseminated via clinical staff meetings, practice meetings, emails and by discussion. However, the systems used to monitor medicine alerts were not fully effective to ensure patient safety. • The provider was unable to demonstrate that all relevant safety alerts had been responded to. There had been guidance produced by the Medicines and Healthcare products Regulatory Agency (MHRA) regarding the combined prescribing of Simvastatin 40mg or above and Amlodipine. This was due to the potential risk that the combination with the dose of Simvastatin 40mg could impact on the blood levels of Simvastatin. Simvastatin is used to lower high blood cholesterol. During this inspection we undertook searches of the practice's clinical records system. We found that one patient in the search was at risk as they had not been contacted and the dose of Simvastatin 40mg reviewed. Since the inspection the patient was contacted to ensure a medicine review took place. • The MHRA had introduced safety measures, including the recommendation that Sodium Valproate must no longer be prescribed to women and girls of childbearing age, unless they were on a pregnancy prevention programme. Our searches showed that for 2 patients, records did not evidence the patients had been assessed as not at risk. Following our inspection, the practice contacted the 2 patients to confirm appropriate information had been provided. 	

**Effective
Improvement**

Rating: Requires

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.

We rated effective as requires improvement because patients’ needs were not all assessed, and care delivered in line with current legislation, standards and evidence-based guidance supported by clear pathways and tools. There was limited monitoring of the outcomes of care and treatment. The practice could not demonstrate that all staff had the skills, knowledge and experience to carry out

Effective needs assessment, care and treatment
Patients’ needs were not all assessed, and care and treatment was not 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.	Partial
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.	N
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
<ul style="list-style-type: none">• The practice used National Institute for Health and Care Excellence (NICE) compliance guidelines and any updates or changes in practice were reviewed. This meant that staff should be up to date with changes in good practice.• Audits were not consistently used to promote patient health and wellbeing. The week before inspection a GP had audited the follow up of patients who had experienced an exacerbation of their	

asthma condition which had required a prescription of steroids. The audit showed there was an inconsistent approach to follow up reviews for those patients prescribed emergency steroids and NICE guidance was not consistently followed. The audit also showed that assessment of patients with asthma was not consistent in how patients were assessed, and the tests used to monitor their condition. There was shared learning at the practice and a plan to re audit in 6 months to establish any improvement in practice.

- Patients' treatment for long term conditions and some high-risk medicines were not regularly reviewed and updated. Asthma, diabetes, chronic kidney disease and hypothyroidism reviews were not being consistently undertaken to ensure patients were fully assessed and reviewed. Due to a lack of staff with time capacity and specific review training to complete the reviews, not all patients were provided with relevant health assessments and their medicines reviewed as required. This could impact on patient's long-term health.

Effective care for the practice population

Findings

- Health checks, including frailty assessments, were offered to patients over 75 years of age. In some cases, the PCN Frailty nurse provided patients with support.
- The practice worked with homeless support services to provide ongoing support and could provide people registered at the practice, but without an address, a place for medical correspondence to be delivered.
- Patients with poor mental health, including dementia, were referred to appropriate services. The practice had had access to a mental health practitioner.
- The practice website provided information, advice and signposting for a range of health promotion including travel advice and immunisations
- All patients with a learning disability were offered an annual health check and support for vulnerable patients was maintained.
- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.
- The practice had access through the PCN to a social prescriber who visited the practice weekly. The social prescriber worked with the practice to identify and support patients to connect with the community services they needed.

Management of people with long term conditions

Findings

- Patients with long-term conditions were not consistently offered an effective review to check their health and medicines needs were being met. This was because the systems used to recall patients were not effective and there was a lack of staff to undertake the reviews. Advice and support had been sought from the primary care network (PCN) which Farmhouse belonged to, to address the systems used to recall patients for review. However, there had been no audits completed to assess if any improvements had occurred as a result of any changes to systems and processes. Staff who were responsible for reviews of patients with long-term conditions had received the specific training required.
- Patients who required high dose steroid treatment for severe asthma episodes were not always followed up in line with national guidance to ensure they received appropriate care. Systems were not in place to ensure patients were followed up post exacerbation of asthma to ensure review of their condition and medicines. Our remote searches identified 53 patients who had been prescribed rescue steroids. We looked at 5 patient records and saw that none of these 5 patients had been followed up by medical staff to ensure they had recovered or required further treatment or advice.
- Systems were not in place to monitor the prescribing of inhalers for patients who received repeat prescriptions for inhalers to treat asthma. We saw patients could telephone and request a replacement inhaler and the reception staff would arrange this with the duty GP. The prescribing was not reviewed to ensure that excessive prescribing did not take place. We reviewed the records of 5 patients and saw that all 5 patients had exceeded 12 inhalers per year. One patient had 16 inhalers prescribed in one year which exceeded their repeat prescription requirements and could have a negative impact on the patient's health.
- Patients with the long-term condition hypothyroidism were not always reviewed to ensure their treatment was optimised in line with national guidance. We saw there were 3 patients with hypothyroidism who had not had the appropriate monitoring for 18 months. Hypothyroidism is an underactive thyroid gland which can result in tiredness, weight gain and result in the patient feeling depressed. Monitoring of the thyroid blood levels enables the GP to monitor and establish the level of medicine the patient needs to feel well. Following the inspection, the patients were contacted to be reviewed and monitored.
- Patients with long term condition chronic kidney disease (CKD) stage 4 or 5 were not always reviewed to ensure their treatment was optimised in line with national guidance. We saw there were 8 patients with chronic kidney disease (CKD) stage 4 or 5. CKD is a long-term condition in which the kidneys do not work as well as they should. The searches identified that 1 patient may not have received the appropriate monitoring or review. Following the inspection, the patient was contacted to be reviewed and monitored.
- Patients with the long-term condition diabetic retinopathy were not always reviewed to ensure their treatment was optimised in line with national guidance. We saw there were 20 patients with diabetic retinopathy who had a blood level HbA1c more than 74 mmol/l. (A HbA1c reading is obtained through a blood test. A high reading means there is too much sugar in the blood and as such could lead to the development of diabetic complications if left untreated). Our searches identified that of the 5 patients we reviewed, 3 patients had not received the appropriate monitoring or review. Following the inspection, the patients were contacted to be reviewed and monitored.
- Our searches identified 2 patients whose records showed blood test results which indicated they may have a diagnosis of diabetes which had not been identified or recorded in their records. The systems used at the practice had not identified these 2 patients. The 2 patients have since been followed up by the practice.
- Patients with hypertension were supported to visit the surgery and take their blood pressure using a monitor in the waiting room. The patient was required to inform reception staff, who recorded the result in their clinical records and the results were tasked to the patient's GP for review.

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) (UKHSA COVER team)	44	44	100.0%	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) (01/04/2020 to 31/03/2021) (UKHSA COVER team)	45	48	93.8%	Met 90% minimum
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) (UKHSA COVER team)	45	48	93.8%	Met 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) (UKHSA COVER team)	45	48	93.8%	Met 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) (UKHSA COVER team)	48	51	94.1%	Met 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, 60-74, screened for bowel cancer in last 30 months (2.5 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.8%	72.3%	66.8%	N/A
Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %) (01/04/2020 to 31/03/2021) (UKHSA)	72.8%	61.5%	61.3%	N/A
Number of new cancer cases treated (Detection rate: % of which resulted from a two week wait (TWW) referral) (01/04/2021 to 31/03/2022) (UKHSA)	57.1%	58.5%	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)	76.9%	N/A	80.0%	Below 80% target

for persons aged 25 to 49, and within 5.5 years for persons aged 50 to 64). (30/06/2022 to 30/06/2022) (UKHSA)				
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Any additional evidence or comments

- The percentage of women eligible for cervical cancer screening who were screened adequately within a specified period was 76.9%, slightly below the 80% update level. The practice had evening screening clinics to meet the shortfall. The data could not be validated but the practice manager confirmed that the practice currently does not meet the 80% England average target. The practice told us this was because of the limited nursing staff available to undertake the screening tests.

Monitoring care and treatment

There was limited monitoring of the outcomes of care and treatment.

	Y/N/Partial
Clinicians took part in national and local quality improvement initiatives.	N
The practice had a programme of targeted quality improvement and used information about care and treatment to make improvements.	N
The practice regularly reviewed unplanned admissions and readmissions and took appropriate action.	N
<ul style="list-style-type: none"> The practice did not have a programme of clinical audits to monitor their service provision to inform and implement changes. They did not take part in any national or local audits which would be used to look at wider service provision. Clinical staff were informed of unplanned admissions and readmissions to secondary care, but this information was not audited or used to monitor patients and care provided. 	

Effective staffing

The practice could not demonstrate that all 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.	Partial
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.	Partial

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
<ul style="list-style-type: none"> The provider could not demonstrate that staff had the right qualifications, skills and knowledge to deliver good quality care and treatment. The training records provided showed that for some staff mandatory training in basic life support, safeguarding vulnerable adults and children, health and safety, moving and handling and infection prevention and control had not been completed or was out of date. Staff personal development was supported with staff able to complete online training during work hours. If not possible due to capacity of workload, staff could complete training at home and be paid for this. Induction training was provided for new staff but there was no clear record of the induction training provided for locum staff. This meant we could not be assured that they had the right information and support to ensure the safety of patients. Clinicians were required to maintain their professional registration and demonstrate their competencies when they revalidated with the relevant professional body. The practice monitored their up-to-date registrations to ensure they were registered to practice. 	

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
<ul style="list-style-type: none"> Clinicians were involved in multi-disciplinary discussion when needed. 	

Helping patients to live healthier lives

Staff were proactive in helping patients to live healthier lives.

	Y/N/Partial
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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
<ul style="list-style-type: none"> Information was available on the practice website and social media regarding action and support to live healthier lives. Patients with long-term conditions could also access information and support, for example, asthma and diabetes. Information regarding health and wellbeing was also provided to patients during health checks and appointments with clinicians. 	

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. 1	Y
<ul style="list-style-type: none"> The GP's used opportunities as they presented, to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) were completed. These agreements of care were reviewed as necessary to ensure that the correct legal pathways were created to support patient choice. Staff recorded all verbal consent agreed or denied in the patients record. If capacity to give consent was unclear, staff would seek advice and ensure that the appropriate legal route was used to ensure the patients best interest was served. 	

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.	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.	Partial
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
<ul style="list-style-type: none">• The provider had considered the needs of the local population and planned services to meet these. The practice provided a late evening surgery on Mondays to accommodate patients who worked or needed a later access. Cervical screening was offered out of working hours to enable a better uptake of the service.• The facilities and premises required maintenance to ensure that they were appropriate for use. There was a list of ongoing repairs for example, loose wall tiles and evidence of a water leak in the patient’s toilet and rust on radiators in treatment rooms.• A business continuity plan was reviewed and updated annually and when needed and enabled staff to understand actions needed if the business was interrupted.	

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Practice Opening Times

Day	Time
Opening times:	
Monday	8:30 am – 6:30pm
Tuesday	8:30am – 6:30pm
Wednesday	8:30am – 6:30pm
Thursday	8:30am – 6:30pm
Friday	8:30am – 6:30 pm
Appointments available:	
Monday	8:30am – 7:30 pm
Tuesday	8:30am – 6:30 pm
Wednesday	8:30am – 6:30 pm
Thursday	8:30am – 6:30 pm
Friday	8:30am – 6:30 pm

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.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.
- 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.
- Working aged people (including those recently retired and students) could access appointments early mornings and on a Monday evening to help those not able to attend during working hours.

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
<ul style="list-style-type: none"> The practice used a duty GP system. GPs working each day, when possible, took calls from their own patients but when not available a duty GP saw or spoke with those patients. The surgery was accessible to patients, with ground floor consulting and treatment rooms. The surgery had a website with a range of information for those patients with online access. Some areas of the website were out of date. The practice manager confirmed there was a plan to update the webpages. 	

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 (01/01/2022 to 30/04/2022)	59.4%	N/A	52.7%	No statistical variation
The percentage of respondents to the GP patient survey who responded positively to the overall experience of making an appointment (01/01/2022 to 30/04/2022)	56.7%	65.2%	56.2%	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 (01/01/2022 to 30/04/2022)	59.4%	61.8%	55.2%	No statistical variation
The percentage of respondents to the GP patient survey who were satisfied with the appointment (or appointments) they were offered (01/01/2022 to 30/04/2022)	73.2%	77.6%	71.9%	No statistical variation

Source	Feedback
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GP patients survey 2022	<ul style="list-style-type: none"> • The percentage responses to the GP patients survey 2022 showed that patients were enabled to access the practice when needed. • The NHS GP survey July 2021 showed that 34% of those surveyed were usually able to see or speak to their preferred GP when they would like to. This is below the national result of 38%. We were not aware of any action taken to address this shortfall. • The survey showed that 73% of patients consulted were satisfied with the appointment they were offered. This was compared to the national average of 72%.
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Listening and learning from concerns and complaints

Complaints were listened and responded to and used to improve the quality of care but it was not clear how learning from complaints was shared to improve the service

Complaints	
Number of complaints received in the last year.	8
Number of complaints we examined.	8
Number of complaints we examined that were satisfactorily handled in a timely way.	8
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
<ul style="list-style-type: none"> • There was limited evidence of how learning from complaints was shared with staff to improve patient care and experience. 	

Example(s) of learning from complaints.

Complaint	Specific action taken
We reviewed a complaint about a Do Not Attempt Resuscitation request.	<ul style="list-style-type: none"> • The practice manager arranged for a meeting with the community nursing team to review aspects of the complaint and create an improved line of communication and action to prevent reoccurrence of any areas of the complaint.

Well-led

Rating: Inadequate

We rated well-led as inadequate because the delivery of high quality care was not assured by the leadership, governance or culture.

Leadership capacity and capability
Leadership was not always effective.

	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.	Partial
Staff reported that leaders were visible and approachable.	Y
There was a leadership development programme, including a succession plan.	N
<ul style="list-style-type: none">Partners held managerial and financial responsibility for running the business. There was a business development plan for the ongoing running and development of the service. The leaders of the service were responsive and receptive to our feedback following the inspection and provided action plans with timescales to formalise how they planned to improve the areas identified as having shortfalls.The provider had clear management and staffing structures in place, so people understood their roles and responsibilities. Staff were allocated leadership roles which included infection prevention and control, safeguarding and clinical and non-clinical leaders. However, these roles were not reviewed to identify training needs or improve and develop the service.Staff spoke positively about the support they had from colleagues and told us they could speak to GP partners or the practice manager for support when necessary.Staff appointed into management or leadership roles had not completed appropriate management training and qualifications. This meant that they did not always have the insight or support to be effective.	

Vision and strategy

The practice did not have a clear vision and credible strategy to provide high quality sustainable care.

	Y/N/Partial
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The vision, values and strategy were developed in collaboration with staff, patients and external partners.	N
Staff knew and understood the vision, values and strategy and their role in achieving them.	N
Progress against delivery of the strategy was monitored.	N
<ul style="list-style-type: none"> The vision statement of the practice was “To be the leading practice for patient experience and clinical outcomes”. Staff were not aware of the provider’s vision and did not feel involved in the services vision, strategy and development. The ongoing practice development was not reviewed as part of operational meetings and staff appraisals. There was no recorded management of an ongoing strategy to meet the vision. 	

Culture

The practice culture did not effectively support high quality sustainable care.

	Y/N/Partial
There were arrangements to deal with any behaviour inconsistent with the vision and values.	N
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.	N
Staff had undertaken equality and diversity training.	Y
<ul style="list-style-type: none"> Staff told us there were no formal systems in place for them to give feedback to management. The practice manager operated an open-door policy and staff told us they felt able to raise any issues with the practice manager. Staff described how they could safely raise concerns and what action was taken. The practice did not have access to a Freedom to Speak Up Guardian. Not all leaders had the skills and training to manage inconsistent behaviour by staff. The management of staff performance was variable. We noted that management training and support had not been provided to leaders to ensure they all knew how to manage staff complaints and incidents and subsequently not all incidents had been managed consistently. We asked staff to complete a Care Quality Commission survey prior to our inspection and 5 staff completed and returned these. Staff spoke positively about working at the practice and most told us they felt listened to and supported and considered themselves to be a cohesive team. 	

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

Source	Feedback
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CQC Staff Surveys	<ul style="list-style-type: none"> We asked staff to complete a Care Quality Commission survey prior to our inspection and 5 staff completed and returned these. Staff mostly spoke positively about working at the practice. Some staff commented on the need for more clinical and non-clinical staff and the impact of pressures on the service. Some staff spoke about the need for staff pay to reflect their extended roles and commitment to the service.
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Governance arrangements

The overall governance arrangements were ineffective.

	Y/N/Partial
There were governance structures and systems which were regularly reviewed.	N
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.	N
<ul style="list-style-type: none"> The practice did not have any regular governance systems to monitor the quality of their service. There were no programmes of continuous clinical audit and internal auditing to monitor quality and to make improvements. There was a lack of systems and processes to ensure effective monitoring for patients taking high risk medicines and requiring reviews of long-term conditions. We were not assured that without the inspection process the lack of these systems would have been identified and addressed. Following the inspection, the leadership of the practice responded positively to our feedback and were keen to address the areas of concern. There was a plan for staff meetings which included, one clinical meeting every month, nursing staff meetings every 2 weeks, reception staff meetings monthly and a practice meeting every 6 months. Management meetings were held in between times if needed. We were told minutes were maintained for each meeting. We reviewed meeting minutes and saw that they were undertaken less frequently than planned. For example, reception staff had had three meetings in the previous 3 years and nursing staff met every three months when capacity allowed. Minutes of the meetings were accessible to relevant staff. The quality of the meeting minutes varied, and some lacked a clear agenda and structured recording of outcomes and actions. Clinical meetings also included complaints and significant events, these were also monitored at the time each complaint was received and actions taken as required. Incidents were monitored to identify any shortfalls in service provision but there were no systems to ensure feedback or learning to staff. The governance structure for the practice did not include changes being consistently communicated for example through operational meetings, emails and one to one discussions. Staff told us feedback was limited. 	

Managing risks, issues and performance

The practice did not have clear and effective processes for managing risks, issues and performance.

	Y/N/Partial
There were comprehensive assurance systems which were regularly reviewed and improved.	N
There were processes to manage performance.	N
There was a quality improvement programme in place.	N
There were effective arrangements for identifying, managing and mitigating risks.	N
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.	N
<ul style="list-style-type: none">• Risk assessments were not used to monitor and mitigate against any identified risks. Risks were not considered, and actions undertaken to reduce any risks to patients, staff and the environment.• There were no systems to identify or gather information/data about the performance of the practice and no processes to then address any identified issues.• Assurance systems did not monitor the services provided. For example, there was no auditing of the environment, of clinical practices or administrative services.• There was no monitoring of any improvement programmes to look at services provided and how the services could be improved, or the impact on the quality and sustainability of the practice. For example, a recent building survey had been undertaken to identify a plan of works but as yet this had not started.	

Appropriate and accurate information

The practice did not always act on appropriate and accurate information.

	Y/N/Partial
Staff used data to monitor and improve performance.	N
Performance information was used to hold staff and management to account.	N
Staff whose responsibilities included making statutory notifications understood what this entailed.	Y
<ul style="list-style-type: none">• Data was not gathered or used to consider or improve the service provided. For example, the practice did not monitor patient telephone calls for response and waiting times to establish if there were any delays. Incoming telephone calls from patients were not recorded for reference and/or training purposes.• Staff were observed to answer telephone calls promptly and the practice had not received any complaints about delays. The NHS patient survey for July 2021 showed that 59% of patients who responded found it easy to get through to the GP practice by telephone. This is above the national	

result of 53%. 78% of patients found the receptionists at this practice helpful, this is below the national result of 82%.

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.	Y
The practice advised patients on how to protect their online information.	Y
Staff are supported to work remotely where applicable.	Y
Explanation of any answers and additional evidence: <ul style="list-style-type: none"> Information was provided for patients on the practice website on how their personal details were stored securely and how their privacy was maintained. The website detailed how personal data was gathered and what that data would be used for. All electronic equipment was password protected and the reception area faced away from service users to protect confidentiality. Patient data was stored securely where it was on-site. 	

Engagement with patients, the public, staff and external partners

The practice involved the public, staff to a limited extent 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.	No
Staff views were reflected in the planning and delivery of services.	Partial
The practice worked with stakeholders to build a shared view of challenges and of the needs of the population.	Y
Explanation of any answers and additional evidence:	

- The practice told us that NHS friends and family surveys were primarily used as feedback. Feedback was not seen to relate to learning and to improve service quality.
- The Farmhouse Patient Participation Group (PPG) began in 2011 with a small number of patients joining the group and who met on a few occasions. This PPG was no longer operational, and the practice recognised that the PPG needed to restart. The practice website encouraged patients to sign up and share their views and be involved in surveys and events.
- Staff surveys were not used to gather staff views or suggestions. While the staff told us they felt able to raise any ideas they had for service improvement their views were not sought formally.

Continuous improvement and innovation

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

	Y/N/Partial
There was a strong focus on continuous learning and improvement.	N
Learning was shared effectively and used to make improvements.	N
<ul style="list-style-type: none"> • There was no programme of gathering information to identify issues or areas for improvement and subsequently create ongoing continuous improvement and innovation. Any learning from incidents and complaints was not systematically shared and so changes were not made as a result. 	

Examples of continuous learning and improvement

- We did not have any evidence of continuous learning and improvement.

Notes: CQC GP Insight

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

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

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

The following language is used for showing variation:

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

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

Child Immunisation indicators. These are scored against the World Health Organisation target of 95% rather than the England average. Note that practices that have “Met 90% minimum” have not met the WHO target of 95%.

- The percentage of respondents to the GP patient survey who responded positively to how easy it was to get through to someone at their GP practice on the phone uses a rules-based approach for scoring, due to the distribution of the data. This indicator does not have a CCG average.
- The percentage of women eligible for cervical cancer screening at a given point in time who were screened adequately within a specified period (within 3.5 years for women aged 25 to 49, and within 5.5 years for women aged 50 to 64). This indicator does not have a CCG average and is scored against the national target of 80%.

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

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

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

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

Glossary of terms used in the data.

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