First Practice Management

CQC Inspection Reports Profile Over Last 4 Weeks

Key Reasons Given for Overall "Requires Improvement" and "Inadequate" CQC Ratings for GP Surgeries

Note: *that the many positive and commended comments which may also have been given at the same time by the CQC are not included in this section; this is simply a list of the sorts of things that other practices can work to improve to avoid getting RI or Inadequate ratings themselves. These comments are not exhaustive. Many of these actions have since been rectified according to the CQC.*

	INSPECTION COMMENTS (*all scored 1 or 2 by CQC*)
SAFE	
Learning culture	• "When we requested evidence about how they record, respond, share and analyse complaints or significant events, managers **could not provide us with documentation such as their complaints register**. Leaders told us that during staff meetings, the whole team discussed and learnt from clinical issues but could not provide us with any recent examples from the last 11 months since their previous assessment. • Nine significant events had been recorded in the last 12 months. A significant event log was shared with us during our site visit. However, it was difficult to cross reference the log with the records kept on file as they were not easily identifiable and some of the **significant event records were missing from the file**. The forms had not always been signed and dated and lacked detail including learning and quality improvement. We found that 1 of the events had

	not been discussed during the practice's monthly meeting and had not been shared with the wider team for learning to help prevent it happening again.
Safe systems, pathways and transitions	• Our clinical searches found 1 patient with a potentially fatal heart condition whose consultant had written to the practice asking them to change their medication in April 2025. This **letter had not been scanned onto the clinical system** until 13 working days later and had not been actioned. When we raised this example with the provider, they realised the letter had been missed and actioned it that day, 3 months after the letter had been sent. • Our clinical searches found 4 patients who had been prescribed disease modifying anti-rheumatic drugs **(DMARDs)** for rheumatoid arthritis by the hospital. These DMARDs had not been added to the patients' list of medicines by the practice, making it unclear that the patient was taking them. • We asked about how the practice followed up patients who are seen by out-of-hours services. We were shown an example of a patient with a history of cardiovascular disease who called an ambulance for a suspected stroke but refused to attend hospital. The practice was informed by the ambulance service and the GP said they had followed this patient up. However, the next entry in the medical record 14 working days later was for a different condition and **did not reference the possible stroke symptoms**.
Safeguarding	• During our previous assessment we found that **safeguarding registers were incomplete and not correctly coded**. The practice had improved these aspects of its safeguarding processes. The practice leaders told us that they held monthly in-house safeguarding meetings and tried to include health visitors and/or social workers in a multidisciplinary team meeting every 3 months. However, when we asked to see the minutes and action plans from these meetings the practice could not produce them.
Involving people to manage risks	• **Emergency equipment** was stored in a clinic room that may be occupied during a medical emergency or could be locked when not in use. The equipment was not kept together in one box, bag or trolley. Emergency medications were not stored in tamper-evident containers but were stored in a locked cupboard. Water for injections, syringes, hypodermic needles and a sharps box were available but not stored with the other emergency equipment. There was no signage on the clinic room door to make it clear where the emergency equipment was kept. Medicines were checked regularly but the records were of poor quality and appeared to check the number of boxes of each medicine rather than the number of vials or tablets. We found a box marked "anaphylaxis" which contained a variety of oropharyngeal airways. This was misleading if a staff member was looking for adrenaline to treat anaphylaxis. Not only this, but none of the oropharyngeal airways had expiry dates on them and some were not in any packaging at all. • Checks were carried out on the emergency medicines and equipment held but not at the required frequency, as recommended by the Resuscitation Council UK (RCUK)
Safe environments	• Fire evacuation routes during the building work had not been properly risk assessed and on the day of inspection we found **one route blocked by a locked door**. The other route (which could have been used by wheelchair users) was paved except for the last 2 feet which was gravelled and led to an unlocked door. However, a parked car **blocked wheelchair access** from this door to the fire assembly point. We also found cardboard boxes blocking one of the fire evacuation routes. We found 3 fire **extinguishers which were overdue servicing**.

	• At the time of our assessment, the practice was still undergoing building works to extend and upgrade the premises. Issues identified in our previous inspection 11 months previously such as automatic front door access, widened corridors at the front of the building and **severely restricted parking** had yet to be addressed by the renovations. • Some of the furniture in rooms such as the treatment couches did not meet infection control standards in that they had **wooden frames** and one had a **tear in the couch cover**. • There was **no hot water in the ground floor accessible toilet**. The practice manager was aware that the hot water had been turned off due to the building work. The second time we visited the water felt warm but not hot and did not appear to reach safe temperatures to prevent the growth of **legionella bacteria**. When we asked to see the practice records for water temperature testing, flushing records (all taps must be flushed weekly to ensure water is not stagnant in the pipes) and their **legionella risk assessment** the practice was not able to provide these documents. • The practice was not working in line with their health and safety policy in pro-actively **identifying slip and trip risks** in the workplace and eliminating these risks where possible. We found not all environment risks had been identified or actioned, for example trip hazards in the staff offices due to the **worn and uneven carpets.** • The practice manager confirmed there was no established schedule for renewal or refurbishment in place for the replacement for floor coverings, the redecoration of the premise and replacement of furniture and furnishings. They were not working in line with their policies, which stated items must be renewed or replaced if they are damaged, broken, or unsafe or creating potential trip, slip, or electrical hazards. • Patient paper **records were not stored securely** to prevent unauthorised access as they were stored on open shelving in the reception office, which led up to staff offices on the first floor. • The room was cleaned by an external cleaner when the practice was closed. We were told a risk assessment had not been completed to mitigate the risk of **breaches to patient confidentiality**. • **Legionella monitoring** records had not been maintained, and the last documented test was completed in 2022. There was no evidence to demonstrate that regular flushing of infrequently used water outlets had been carried out or recorded. • A fire risk assessment was completed in October 2024, with several actions identified and due for completion by December 2024. At the time of inspection, not all actions had been completed. There were no records to show that in-house fire drills had taken place, and the service was unable to demonstrate that its evacuation policy was fully embedded. It was noted that a recent **TARGET Day focusing on fire safety was cancelled** by the external provider, and the service was still trying to organise a new date. • The service had CCTV operating in public areas. However, there was no signage to inform people of this. • On the first floor, there was **no routine staff presence in the waiting area** unless a GP left their consultation room to call the next person. This meant that deterioration in a person's condition might only be identified between consultations.

Safe and effective staffing	• The practice had a practice manager, 1 part-time medical secretary and 4 part-time receptionists. The practice showed us an analysis they had done in July 2024 of their staffing requirements based on the number of patients registered with them. This showed that in order to be able to service the needs of their population they should have 2.5-3 whole time equivalent (WTE) GPs and 3-4 WTE administrative staff. WTE is a standardised measure of the workload of an employed person working a full week of 37.5 hours, 0.5 of a WTE would be someone who works 18.75 hours a week. This analysis suggested that the practice **required at least 18.75 extra GP hours and at least 75 extra administrative hours per week.** • At our first visit we were told that the practice was planning to recruit a pharmacist. A pharmacist had been recruited 7 days later when we attended for our second visit. Leaders told us that this pharmacist had been recruited urgently to improve the management of patients diagnosed with diabetes and that they had specialist diabetes training. However, when we spoke with the pharmacist, they **did not have specialist training** and though they were planning to undertake that training, they were **not confident** to carry out all aspects of diabetes management. We reviewed the personal file of the pharmacist and did not find evidence that they had completed any specialist training in diabetes, this meant they were unable to fulfil specific areas of the role for which they had been recruited. • Staff records we sampled showed their **induction** was not always appropriate to their role. For example, a non-clinician had completed an induction not relevant to their work. No evidence of completed induction was available on file for the regular locum GP. • We saw a risk assessment had been completed for 1 staff member in the absence of a disclosure and barring service (DBS) check; however, records showed it took **14 months to obtain a DBS check**. A DBS check for another staff member had been completed post their start date and no risk assessment had been completed. One reference had been obtained for the regular locum GP; however, this was dated 14 months post their start date and their contract was dated 18 months post their start date. The recruitment records for a locum GP who was due to commence working at the practice a couple of days after our site visit were not available for inspection. • Not all staff members were up to date with their mandatory training. The roles with **overdue training** included both clinical and non-clinical staff and covered 19 different training subjects. • Whilst we were informed several informal supervision methods were in place, including case-based discussions, group reflections, lunch-and-learn sessions, and educational talks delivered by external speakers, the service was **unable to provide evidence of formal supervision, monitoring, or appraisal arrangements** for clinical staff and non-medical prescribers. The service did not have a supervision policy in place, and no formal records were available for staff involved in the training practice accreditation, such as medical students and Foundation Year 2 (FY2) doctors.
Infection prevention and control	• The internal audit did not identify staff offices on the first floor were carpeted and stated bins were emptied daily. During a tour of the practice, we saw **bins in public areas were full** and cleaning mops, although colour coded, were not stored appropriately and posed the risk of cross infection. An external company was employed and

	provided **just 6 hours of cleaning a week** over 2 days. Staff were responsible for cleaning their own rooms and felt the practice would benefit from additional cleaning hours provided externally.
Medicines optimisation	• We found there were issues with overuse of asthma rescue inhalers and 1 patient was prescribed a specific medicine which was **contraindicated**. This was not identified at the patient's annual asthma or medication reviews. • Out of 60 people with chronic kidney disease (CKD) stages 4 or 5, 18 patients were ov**erdue for the required blood test monitoring.** We then reviewed 5 of these 18 patient records. All 5 required blood test monitoring, and 3 also required up-to-date blood pressure monitoring, in line with National Institute for Health and Care Excellence (NICE) guidelines. Out of 585 people identified as requiring monitoring for hypothyroidism, 31 were overdue for blood test monitoring. We then reviewed 5 of these 31 patient records, and all 5 required blood test monitoring. • Out of 64 people prescribed Disease-Modifying Anti-Rheumatic Drugs (**DMARDs**), such as Methotrexate, 5 patients were overdue for blood test monitoring. • Out of 2,091 people prescribed **ACE inhibitors**, which help manage blood pressure and protect kidney and heart function, 138 patients were identified as not having received the required monitoring. • The service had a process in which specific teams were assigned responsibility for recalling people requiring condition-related monitoring, based on their birthday month. But the remote clinical searches demonstrated that the process had not been working effectively, and feedback was provided to the service leads to improve its implementation. • Prescription pads were returned to storage without serial numbers being recorded, meaning the service could not maintain an **accurate audit trail**. The emergency medicines bag was tagged with numbered seals, but there was no record of the tag numbers or evidence of regular checks or audits. As a result, the service could not demonstrate when the bag had last been opened or re-sealed. • **Medication reviews were not effective**; not all medicines the patient was taking had been discussed with the patient to identify if they were experiencing any side effects or whether the medicine was effective. Medicines that had been discontinued had not been removed from the prescribing list and **medicine quantities were not aligned**. Aligning medicines means ensuring that with each prescription, all medicines are provided in a quantity that will last for example, 2 months, so that the patient will run out of all medicines at the same time. • Our clinical records searches found 2 patients with poorly controlled asthma who had been prescribed a medication for anxiety which would make their asthma inhaler ineffective. • Patients prescribed **methotrexate** by a hospital consultant had not had this medicine added to their prescribing records. We also saw that a letter from a consultant requesting the practice to change a patient's medicines had **not been acted on** for over 3 months. • The repeat prescription system involved reception staff **writing paper notes for the GPs** in a notebook which was not audited by the practice. This system was unreliable and risked information being inaccurate, lost or delayed. The practice continued with this paper-based system despite the fact there were **readily available electronic methods** for managing repeat prescriptions on the practice's existing clinical software

EFFECTIVE	
Assessing needs	• Leaders told us that they **did not refer many patients to the social prescriber** because they felt the social prescriber could only have a limited effect on the endemic socioeconomic problems faced by their patients. Leaders described these problems such as a lack of council housing as national problems which could not be solved locally and whilst this may be the case, this approach denied patients the opportunity to benefit from other support a social prescriber could provide. • Our review of clinical records found multiple records with inaccurate or incomplete information which could not be explained by the practice. Leaders highlighted one elderly patient with diabetes and dementia who had consistently failed to attend appointments in December 2024. The provider told us they were concerned by this non-attendance and contacted the patient to find out what had happened and to book a review with them. However, the medical record showed that the provider did not contact this patient until July 2025 when they arranged a home visit, which did not demonstrate a high level of care and **concern for the wellbeing of vulnerable patients.** • In our clinical searches, we found 17 patients whose records and prescribed medicines indicated they may have asthma, high blood pressure, diabetes or pre-diabetes but they **did not have a clinical diagnosis code** in their patient record.
Delivering evidence-based care and treatment	• We saw that **409 out of 410 diabetic foot checks had been coded as low-risk**, this meant there was a low-risk of developing complications. However, we found a proportion of the patients coded as low-risk had been diagnosed with other conditions which made it very unlikely that their risk of foot complications was low, such as pre-existing amputations or ulcers. The records did not contain enough detail to explain how this conclusion had been reached. When we asked the GPs about this, they agreed the information was incorrect and voluntarily suggested that they may need further training in carrying out foot checks. During our second visit to the practice 6 working days later, we saw that some of the patients we had highlighted had had their foot checks repeated, the risk level had changed to moderate or high and the records contained detailed information as to how this conclusion had been reached. This would suggest that the original foot checks were **not carried out with sufficient skill and care.**
How staff, teams and services work together	• Some information was not readily available to staff. For example, the practice register of high-risk vulnerable patients, such as those at the end of life was **stored on the desktop of the clinical lead GP's computer**. This meant it was only available when they were at the practice to login to their computer. • An elderly patient had called an ambulance with symptoms that could indicate a serious neurological condition. The patient did not want to attend hospital and required GP follow up. However, the patient was **not followed up** for 21 days at which time a telephone consultation was made for a different condition.
Monitoring and improving outcomes	• Staff were **unable to describe a clear process** that was followed when patients did not attend and the practice could not provide a written policy about this. A lot of the administrative tasks associated with managing long-term condition reviews were performed by the GPs, which took time away from their clinical duties.

	• The latest published data for 2023/4 indicated the practice's performance for **childhood immunisations** was significantly **below national targets**. For the range of childhood immunisations for which statistics are gathered the practice was immunising between 25-29% of their population and the national target is 95%. • The percentage of women aged 25-49 years old who had cervical screening at the practice was 33.5% and for women aged 50-64 it was 56.7%. The practice was made aware of the **low cervical screening uptake** at the previous CQC assessment. Leaders told us that they struggled to encourage the younger age group to attend because there were cultural barriers and a general lack of understanding as to why screening is important. However, lack of access may also have been a factor given there were limited clinics available as the practice had only 1 nurse, 1 day a week who was the only staff member carrying out cervical screening. • Leaders explained they had engaged with their Patient Participation Group (PPG) to provide education including some outreach work into local religious institutions. However, **none of the PPG members engaged in this work were female** which may have impacted its effectiveness.
CARING	
Treating people as individuals	• CQC had received information prior to our assessment which showed that the practice did not always ensure reasonable adjustments were made for patients with a learning disability. We noticed a lack of person-centred care in the **blanket approach taken to some aspects of care such as diabetic foot checks**. The inaccurate coding of diabetic foot checks described previously, is an example of where each patient's individual characteristics and circumstances were not considered when making decisions about their care.
Responding to people's immediate needs	• Staff we spoke with said there was a triage protocol for reception staff to follow, but they did not have a copy and were **not sure where it was kept**. Staff we spoke with knew the process for dealing with emergencies. We found that reception staff were not able to see the entire waiting area from the reception desk and so may not be aware if a patient became unwell and required emergency treatment. • The provider did not have any **signs informing patients that CCTV was operating** the waiting area.
Workforce wellbeing and enablement	• The **GPs did not maintain their own work-life balance** as both reported working excessive hours in order to complete their workload. Both GPs had an excessive administrative workload partly due to a lack of willingness to delegate appropriate tasks. They told us that a lack of medical staff had contributed to them overbooking clinics and rushing consultations with patients which may have caused some of the inaccuracies we found. We identified several factors contributing to this situation; a heavily GP led model of practice, not utilising their practice nurse to her full scope of practice, a lack of nursing hours, a lack of administrative staff, a lack of space, complex building work that required project management and inadequate development of the practice manager role.
RESPONSIVE	
Care provision, integration and continuity	• The patient participation group (PPG) members involved in outreach work about cervical screening were **all male**; staff did not demonstrate how they would attend to the preferences and choices of their female patient group accessing cervical screening.

Providing Information	• Our clinical records reviews showed an unusually large number of patient record entries were blocked from online viewing. This meant they would not appear on the patient's NHS App. When we asked leaders about this, they said some patients requested information to be blocked for privacy reasons, however some staff said they routinely **blocked records and could not explain why they did this**.
Listening to and involving people	• The practice provided a local patient survey from 2023 which had 50 responses (**1% of their population**) however, this had not been repeated since. The methodology was that paper copies of the survey in English were left on the reception desk for patients to complete if they wished. The practice was unable to provide any recent data from the Friends and Family Test.
Equity in access	• We also observed a lot of patients dropping into the practice to book appointments in person. We found that historically unrestricted access to the practice meant that patients often had unrealistic expectations regarding access and treatment. The practice recognised this as a problem; however, did not provide evidence of any actions they were or intended taking in order to address these issues. There was a limited system of triage for appointments. Receptionists had to telephone the doctors room or physically knock on the GP's clinic room door to ask for advice about whether a patient should be given an urgent appointment, however the reception staff said they never had trouble accessing a doctor for advice. We observed that the receptionists **did not record on the appointment system the reason why the appointment had been booked**. This is a potential risk if a patient does not attend for example, a safeguarding issue could be missed. Leaders told us that reception staff had information to guide their decision making when allocating appointments, but the reception staff we spoke with were not sure where to find it.
WELL-LED	
Shared direction and culture	• The staff we spoke to did not appear to understand the term "**succession planning**" and no succession planning was evidenced.
Capable, compassionate and inclusive leaders	• We observed that the **clinical lead for the practice had minimal participation** throughout our inspection; only contributing to some discussions relating to clinical concerns when raised as part of the feedback we gave the practice. There was a lack of oversight of clinical work such as regular audit cycles and formal supervision for clinical staff. Feedback we had from key stakeholders demonstrated a lack of willingness to engage with external bodies. Due to an unwillingness to appropriately delegate and a lack of suitably qualified administrative staff we observed that both GPs had an excessive administrative workload. • The practice manager worked across 2 sites. Staff told us they were not always made aware of the days the practice manager was working from the practice but told us they were contactable by phone, and they had access to an assistant practice manager, who had been appointed since the last inspection. Feedback from staff was mixed regarding support, guidance, views being listened to and visibility of leaders.
Workforce equality, diversity and inclusion	• Individual **risk assessments for staff were not consistently available** where reasonable adjustments should have been recorded. A spreadsheet was used to log actions taken by the service, but it did not specify which staff members the adjustments related to or how changes would be monitored and assessed. Staff told us this

	approach was used because there was no private way of recording the information without making it accessible to all staff. The service had not considered any alternative ways of monitoring this information despite this issue. • Staff working with display screen equipment (DSE) are required to complete a **mandatory DSE risk assessment** in line with the Health and Safety (Display Screen Equipment) Regulations 1992. Evidence of individual completion was not provided, and leaders told us while staff were encouraged to complete assessments, this was not formally monitored or recorded.
Governance, management and sustainability	• Speaking with leaders we found that there was an **excessive reliance on the two GPs to manage governance** and administrative tasks. For example, the clinical lead was also the lead staff member for IPC, safeguarding, complaints, performance, end of life care, governance, for investigating significant events, for managing MHRA (medicines and healthcare products regulatory agency) alerts and was the digital exclusion champion. • A range of policies and procedures were available; however, we found leaders were **not consistently working in line with these** and did not always act on the best information about risk, particularly concerning health and safety and staff recruitment and appraisal. The provider had displayed the CQC rating on their website as required in addition to in the practice. However, the poster displayed in the practice was for the 2022 inspection and not the 2023 inspection. • Prescription pads were returned to storage without serial numbers being recorded, meaning the service could not maintain an accurate audit trail. • **Legionella monitoring** records were not maintained, with the last test completed in 2022, and there was no evidence of flushing infrequently used outlets. • A fire risk assessment was completed in October 2024, but several actions due by December 2024 remained outstanding. There were **no records of in-house fire drills**, and CCTV signage was missing at the time of inspection. • There was uncertainty among the management team regarding responsibilities for key aspects of health and safety, including fire safety. It was unclear whether these responsibilities sat with the service or NHS Property Services. • During our onsite visit, we noted **policies and procedures were not stored in a designated or centralised location**. Staff also reported difficulty locating relevant documents when requested, which led to delays during the inspection. The Fire Safety Policy could not be located on site. There was also no structured system for policy review or version control. This lack of organisation and accessibility increases the risk that staff may follow outdated or incorrect procedures, potentially compromising safety, compliance, and the quality of care provided. • Based on the training matrix provided, **19 different training topics had not been completed by various staff**, including clinical and non-clinical team members. Although staff were encouraged to complete training in advance of their appraisals, and automatic reminders were sent via the eLearning system, the leaders could not confirm how often the training matrix was reviewed or who held responsibility for booking and monitoring training.”

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
EFFECTIVE	
Assessing needs	• "The practice had recognised an increase in referrals for those patients with **neurodiversity**. However, it was also recognised the difficulties patient and parents/carers had in ensuring the practice had the correct information to make the referrals. In response the practice created **a 'pack' for patients to take away with a step-by-step guide** as to what to do. The pack consisted of 'a do list', a breakdown of 'Right to Choose' providers, the questionnaires required, FAQs and a letter to complete so the patient could list their provider of choice. • The practice **proactively used population health management tools** to improve treatment for those patients whose health needs had changed, and their care needs evolved. For example, the practice had highlighted a cohort of 424 patients who were **persistent attenders**. The patients had an alert on their patient record to encourage care navigators to book these patients with their usual GP and for GPs to 'dig a little deeper' into reasons for attending. By analysing patterns of presentation, flagging persistent attenders and by re-allocating persistent attenders to the GP they see most often, the proportion of appointments taken by this group had reduced by 24% over a 12-month period.
How staff, teams and services work together	• The practice followed the '**Daffodil Standards'** which are an evidence-based framework created by the Royal College of General Practitioners (RCGP) and Marie Curie to help GP practices provide consistently high-quality end of life care. • The practice ran a yearly flu clinic which patients could self-book through Accurx (NHS-approved communication tools for healthcare professionals to connect with patients). Pneumococcal and shingles vaccine had also been included in the invite where required. Due to the whole practice working closely together as a team**, 1838 patients were vaccinated in one morning**. The practice also ran a separate children's flu clinic. Staff told us that 2 members of **staff had dressed as children's TV characters**, and we saw patients had sent feedback saying how their children had enjoyed the experience.
Supporting people to live healthier lives	• The practice had developed a wide range of tailored patient resources and had created a **dedicated digital platform** to ensure patient information and local support was easily available. This included topics such as mental health, men's health, and menopause. The practice had also designed and built a collection of printable, easy-to-understand resource packs which could be shared with patients according to their condition or support needs. • The practice published **monthly newsletters** which included health promotion, seasonal health advice, general information and charity groups offering support. For example, staying hydrated in Summer, free meals for children

	over school holidays and a charity that supports men who may be struggling with their mental health or experiencing social isolation.
CARING	
Treating people as individuals	• The **in-reach work carried out with the Gypsy, Roma and Traveller community** identified communication barriers. This enabled the practice to put in place plans and arrangements that supported this community to understand and engage more positively in decisions about their healthcare. We found this demonstrated exceptional help in supporting this often-marginalised community to express their needs and preferences and supported the practice to understand their preferences, wishes and choices. • We reviewed a reflective account where a clinician had undertaken training specifically for **inequalities in LGBTQ screening.** They had shared this training with other staff members and had ensured that patients attending screening for the first time was called by their **preferred pronoun** and processes were explained in detail, so they were aware of what the procedure involved and would be encouraged to attend other appointments for required screening. • The practice had taken part in a **pilot supporting frail and vulnerable patients** through a programme called My Care My Way. Initially practices were capped to 4 patients, but this was relaxed, and the practice was able to invite 17 patients with 14 accepting to be included. The patients were identified as individuals who were frail or vulnerable and at risk of deterioration or could be helped to avoid hospital admission. Patients had a ReSPECT form in place and a personalised safety plan. The plan incorporated safeguarding considerations, medication reviews and a holistic assessment of medical, personal and social care needs. This was overseen by a GP partner and each patient had access to the My Care My Way Matron, who coordinated multidisciplinary input, which included social prescribers, hospital at home team and community and specialist nurses.
Independence, choice and control	• The practice had supported the local **Gypsy, Roma and Traveller community** to have a better understanding of their own health risks, by supporting them to undergo NHS health checks. This gave them more information about early signs of ill health and ways to prevent conditions from developing. They were signposted to services that could benefit them. Staff helped patients and their carers to access advocacy and community-based services. The practice had **implemented personalised communication strategies** to provide additional support to help this community understand and act upon information about their health. We found the service went above and beyond for this often-marginalised community to support them with their social needs and to manage any potential health risks. We saw specific examples where this support had led to patients to take up health initiatives that had previously been declined.
Responding to people's immediate needs	• The practice told us they had considered a total triage approach to support access to the practice. However, they had decided not to pursue this given the sustained positive feedback they received from patients about access to the service and profile of patients on their list. There was a system to ensure people with immediate needs had access to services. Staff we spoke with knew the process for referral to emergency support, including mental health crisis teams.

	• The practice had conducted a **review to identify patients who would benefit from continuity of care** by seeing the same GP each time (this may not be the assigned GP to the patient but instead a GP that the patient had seen the most so was more aware of the patient and their needs). An **alert was placed on 424 patient records** which encouraged care navigators to book with the GP they saw most often. This had seen a 24% reduction in the number of appointments taken by this group of patients. • The practice completed yearly **Before and After Death Audits** to assess how effectively carers and patients approaching the end of life were identified, supported and followed up after death. The June 2025 audit reviewed 358 patients on the carers list and 74 patients on the palliative care list. All were coded correctly on the patient record system and had the correct alerts. It was noted that each year the number of cares had increased and in 2025 the practice had registered 82 new carers. The audit also showed that recognition and earlier identification of patients with palliative care needs had also increased with an increase in numbers on the palliative care list. The practice planned to complete a further audit in 6 months' time rather than 12 months to ensure staff awareness and coding was continuing to improve. • Findings from the audit also showed where improvements could be made including bereavement follow ups being standardised and being more consistent where support for carers before a patient death was offered. The practice created an action plan from their findings. We saw evidence of a **new patient bereavement support pack** which was being used. This contained practical guidance, emotional support resources, and helpful contacts for patients. • We observed several examples where patients and their carers received timely, coordinated support. For example, for a patient who lacked capacity and required a blood test, an ECG, and dental treatment. Rather than subjecting the patient to multiple stressful procedures, a **Best Interest Meeting was convened** with relatives, carers, and consultants to ensure their needs and rights were fully upheld. The outcome was all 3 procedures were completed in one session under a single general anaesthetic. This approach safeguarded the patient's wellbeing, significantly reduced stress and ensured that the patient received the care they required in a timely manner.
Kindness, compassion and dignity	• We noted in the staff lunch area a book titled [..] **Meaningful Moments**. This was updated monthly and held letters and testimonials to the practice thanking staff for their care and support during difficult times. Comments reflected how staff went the extra mile and supported patients. The management team told us this was shared with all staff members to celebrate achievements, reinforce good practice, and foster a positive culture. • 96% of patients felt their needs were met during their last general practice appointment. This was above the local average and national average of 90% • Staff had provided additional care for patients. This included a paramedic completing a home visit where it was observed that the house was very cold and there was a concern that the patient would be unable to remain in their own home. The **heating was put on for the patient, and they were also made a warm drink**. The paramedic informed the GP who then organised a second visit from a paramedic later in the day. On the second visit it was discovered the heating was not working properly. The staff member **bled the radiators** and **sorted the thermostat** for the patient who was then able to stay in their own home.

	• A second example of where during a home visit, **environmental and safety concerns were raised**. With the patient's consent, arrangements were made for a local plumber to attend the property, and a referral was made to the Fire and Rescue Service, as well as the Safe and Well team for a home safety assessment. The patient's GP was also informed and liaised with the **social prescribing link worker** to explore additional community support.
Workforce wellbeing and enablement	• We saw **team building days** were established within the practice. The practice also supported their staff by having organised social events, such as quizzes, in house crazy golf, Get Fit sessions, and a weekly conundrum. Staff we spoke with were enthusiastic about these events and were proud to have won The Big Team Challenge (a virtual activity challenge, used to motivate people to be more active through walking or cycling). They told us these events helped staff to bond and created an inclusive working environment. • They told us the **support leaders gave them in relation to bereavement** was highly valued and reflective of the approach taken in the practice more generally. This was to support staff with difficulties which impact on their ability to do their job, whether this was specific to their work or more generally related to their wellbeing. Staff reported high levels of satisfaction with their role and with working within the practice.
RESPONSIVE	
Person-centred care	• We saw the practice took steps to enable seldom heard communities to be involved as much as possible in decisions about their future care. For example, the practice had significantly improved uptake of annual reviews for people with learning disabilities, and the practice had carried out in-reach NHS Health checks for the local Gypsy, Roma and Traveller Community to ensure their needs were met. They had provided earlier immunisation against influenza for housebound patients, meaning patients were protected several weeks earlier than in previous years.
Care provision, Integration and continuity	• The practice had tailored its services to meet the diverse needs of its community. For example, building relationships with community groups to promote the take up of screening programmes. This was most evidenced by the in-reach work they had taken to support patients from the local Gypsy, Roma and Traveller community to access the service and the proactive approach they had taken to ensure housebound patients were vaccinated early against influenza. There was an **increase in annual health checks for the Gypsy, Roma and Traveller community** from 25 in 2023/24 to 38 undertaken in the current financial year (a 52% increase) and 95.9% of housebound patients had received influenza vaccination several weeks earlier than in previous years.
Listening to and involving people	• There was strong support from the Practice Participation Group (PPG), and they felt like the practice was very good at identifying and responding to the needs of patients. Members told us they felt listened to, for example, they told us their ideas were listened to in **streamlining the process** for managing routine urine samples. Although the initial idea was to enable patients to drop off urine samples without the need for a GP appointment, following discussion with the group it was agreed the risks to this outweighed the benefits. However, it did highlight the need to improve the monitoring and audit of sample with haematuria in urine. A new process was implemented in November 2025, following discussion with the PPG, to improve the follow up to ensure patients were offered further urine tests to ensure the haematuria had resolved or further referral had taken place. This was due to be reviewed after 2 months.

	• **Learning from complaints** was evident and staff were able to identify changes made as a result of patient feedback, including complaints. For example, the practice implemented the following improvements following complaint investigations:
	  ○ Implementation of an improved approach to support good information **governance where patients have similar names.**
	  ○ Carried out an audit to identify patients coded as having **early signs of chronic kidney disease** which required no medical intervention, to allow them to inform and offer appropriate advice to these patients.

Equity in access	• A member of the practice team participated in a **weekly outreach walk alongside the county council's homeless outreach team**, engaging directly with individuals experiencing homelessness in the community. This initiative aimed to raise awareness of the services available at the practice and to maintain contact with patients already registered. It also provided an important opportunity to build trust, encourage individuals to access healthcare, and ensure that the care provided remained relevant, compassionate, and responsive to the realities of patients' lives.

Equity in experiences and outcomes	• There were several examples of action the practice had taken to meet the needs of those most at risk of discrimination and inequality in access and outcomes from health and care. For example:
	  ○ They had significantly increased the number of **people with learning disabilities accessing annual health checks**. People with learning disabilities are statistically more at risk of avoidable and earlier deaths. Annual health checks help pick up new health concerns or deteriorating health at an earlier stage.
	  ○ They had enabled 95.9% of housebound patients to receive influenza vaccination several weeks earlier than in previous years, with 100% offered the opportunity for it. Housebound patients are at risk of missing out on necessary healthcare, which can result in higher rates of physical and mental health problems, social deprivation and mortality.
	  ○ They had supported 38 patients from the Gypsy, Roma and Traveller community to receive NHS health checks, an increase from 25 in 2023/24. The Office for National Statistics reported in a 2022 study that people from this community are more at risk of vulnerability and negative health outcomes, due to delayed healthcare seeking and perceived barriers to accessing healthcare.
	  ○ They had **6 patient's uptake a 'Man Up Durham' walk to help men's physical and mental health**. The Office for National Statistics report that since 1990, men have been at least 3 times more vulnerable to death by suicide as women. They had implemented a Primary Care Network wide initiative to provide annual reviews for house bound patients with long term conditions. They had found this enabled the entire process to be completed more effectively and to the same standard as those completed within the GP practice.

Planning for the future	• A member of staff attended the **local Drug and Alcohol Death Review Panel** and shared key outcomes from these meetings with the wider practice team. This learning was used to inform and adjust care delivery, ensuring there was ongoing awareness of the risks faced by the patient population. It also supported a proactive approach to safeguarding and tailoring interventions for those most at risk.
WELL-LED	

Shared direction and culture	• They had a focus on ensuring often-**marginalised communities** were offered checks on their health to promote early intervention and healthier lifestyles, with staff contributing to identify and establish these initiatives. For example, they had increased the number of people with learning disabilities accessing annual health checks. They had increased patients from the Gypsy, Roma and Traveller community receiving NHS Health checks. They had implemented the PCN wide initiative to provide annual health checks for housebound patients with long term conditions.
Governance, management and sustainability	• Staff were recognised and thanked for their contribution. There were **staff recognition schemes** to identify and reward staff, one of which was voted for by staff themselves.
Learning, improvement and innovation	• The practice told us they had a sustained commitment to primary care research, and a GP Partner had undertaken additional training in good clinical practice for conducting research. Research projects they were involved with included: ○ Improving the **Wellbeing of People with Opioid Treated Chronic pain** (IWOTCH). The practice reported they had no patients on high dose opioids for chronic pain. ○ **Screening for atrial fibrillation** (SAFER research), 20 patients joined this study and no extra diseases identified for these patients. ○ They were a recruitment site for **Genetic Links to Anxiety and Depression** (GLAD) and the Immune Defence study”