CQC Inspection Reports – reports published in Dec 2025

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
SAFE	
Learning culture	• Following a recent incident involving the practice being unaware of a patient having a pessary fitted before accessing their services, they conducted an internal audit and recognised there were system wide issues. Therefore, they **shared this best practice** piece of work with other local practices through their integrated care board (ICB) to identify other patients in the local area who were potentially lost to follow up
Involving people to manage risk	• The practice had recently implemented a Monday-Friday **"sit and wait" phlebotomy clinic** where patients could drop in between 8am-12pm without an appointment to have their blood taken. The patient also had a choice to book an appointment for this service if they chose. • The service had recently made a blood pressure monitor available to patients, where patients who had not had their blood pressure taken for over 5 years were invited in to take their blood pressure. The service gave them guidance on how to use the machine, where to put their recording and if the reading was over a certain threshold who to contact. The practice told us this process had recently identified a patient had hypertension and they were treated immediately at the practice.
Safe and effective staffing	• The service had a robust on call system in place where there were 2 doctors and 1 nurse were on call every day to see patients who required appointments on the day, call back patients requiring advice, advise staff triaging calls,

	take calls from partners such as safeguarding teams and schools or respond to emergencies on site. The service held a daily morning briefing where they discussed possible staffing pressures due to sickness and put appropriate mitigation in place. All staff attended these meetings, and it was clearly noted who the on-call team was, if anyone was off sick, (and the provisions in place), who the trainee GPs were and who would be leading their debriefs (if required). • Management had put additional measures in place within **staff rotas to prevent exhaustion**. For example, reception staff worked on a daily rota consisting of time taking calls, front desk and administrative time and GPs were allocated time for clinical debriefs and administrative tasks.
EFFECTIVE	
Assessing needs	• The surgery worked around a **continuity of care** model. This was implemented into practice in March 2025, we reviewed evidence which indicated the practice had worked on the project since 2024,the planning had been clearly focused around patients and worked on the basis that patients would be **aligned to a specific/named GP**. This clinician took responsibility for overseeing this patient for all appointments (unless an urgent appointment was required), test monitoring and referrals. It was decided that if a GP required more than two contacts with a patient the system would align the patient to that clinician, ensuring outcomes could be more closely monitored for patients. The leadership team had outlined which groups of patients needed to be aligned to a GP first, for example, those with complex health issues. The purpose of this project was to ensure needs of patients were met by a clinician who already knew their story and understood health needs and any protected factors. 57% of patients stated they felt more confident in the practice since being aligned with a named GP. • Reception staff used **digital flags** within the care records system to highlight any specific individual needs, such as the requirement for longer appointments or for a translator to be present. An audit was commenced in 2024 which looked at patients who required a digital flag on their records. This was a group of patients who had 3 or more clinical codes. It was highlighted by leadership that this was not being done effectively by staff. Management provided relevant staff with an education session on this issue. It was closely monitored, and two re-audits had taken place in 2025 with numbers increasing significantly from 8 patients to 125. • There has also been a recent quality improvement project carried out around the pre-diabetic letter, which was sent to patients, it was noted that information was not populated accurately, this was corrected by leaders, to ensure that the assessment of this cohort of patients was accurate. • Staff could refer people with social needs, such as those experiencing social isolation or housing difficulties, to a **social prescriber**. The practice utilised an employed care navigator who strived to enhance the lives of the patient population, we spoke to this member of staff who told us they had chosen to enhance a knowledge of what the practice could utilise for patients with long term conditions.

Delivering evidence-based care and treatment	• In 2024, the practice responded to a **safety alert** which affected male patients prescribed sodium valproate. The concern was surrounding potential pregnancy and implications for a baby who may be born whilst a father was taking this medication. At the time of the alert, there was no protocol in place to alert this group of patients, the practice implemented this and embedded it within practice, this risk is now discussed with all patients newly prescribed this medication. • The provider demonstrated numerous audits that had been carried out following the two-cycle method that had a positive impact on patients. The practice had implemented an audit looking at patients who may require a medication to protect their bones. This is calculated using a Fracture Risk Assessment Tool (FRAX). Certain medications are known to increase this risk. The practice audited patients who had been on these medications for longer than three months. The audit highlighted 47% of eligible patients had an accurate FRAX score. A protocol was put in place, and when data was re-collected three months later 100% had the correct scores in place. • The practice had **recognised a difficulty in coding patients** with chronic kidney disease who did not fall into a set characteristic resulting in clinicians constructing an audit based on ensuring these patients could be coded. There was a two-cycle audit carried out which demonstrated an improvement on coding, a new protocol was implemented and shared with all clinical staff. The practice has continued to review data from this audit and have constructed a new aim of a 90% achievement rate. • Continuity of care is being introduced periodically to minimise disruption with the most vulnerable patients being allocated first. This implementation was reviewed regularly and amended where necessary. The practice undertook an audit of non-medical prescribers (NMP) which looked at the prescribing of antibiotics and controlled drugs. The audit involved **spot checking 10 randomised prescriptions** from each NMP.
Monitoring and improving outcomes	• The leadership had considered the needs of the local population and community, and where there were risks, for example their area was historically industrial, therefore there was a higher demographic of patients who were **potentially at risk of developing industrial diseases**. The practice had developed innovative screening processes for those at risk of lung cancer and we saw evidence of positive outcomes for patients because of being treated earlier than they would normally have been. Due to the work carried out by the practice and others, there is now a nationally recognised Lung Cancer screening programme in place. • We saw evidence of the introduction of **continuity of care** being introduced periodically to minimise disruption with the most vulnerable patients being allocated first. This implementation was reviewed regularly and amended where necessary. The practice undertook an audit of non-medical prescribers (NMP) which looked at the prescribing of antibiotics and controlled drugs. The audit involved spot checking 10 randomised prescriptions from each NMP. There were no concerns following this audit, with no themes identified or areas of concern.
Supporting people to live healthier lives	•
CARING	

Kindness, compassion and dignity	• Staff within the practice told us that they **provide gifts to patients in care homes** who have no family at Christmas time. Staff had run an initiative to ensure all children in the local community had access to a **winter coat**. They worked in partnership with local schools to deliver the coats, they intended to run this scheme again this winter. • Leaders went the extra mile when supporting families following a patient death, with a phone call from their GP, followed by **a card from the practice consisting of support information**. Staff told us leaders also shared this information with other team members including the reception team to increase their awareness around the support families may need when they contact the practice.
Workforce wellbeing and enablement	• The practice also supported their staff by having a '**Wellbeing Champion'** who held weekly drop-in sessions, organised social events, and feedback surveys. • Leaders demonstrated the systems they had in place to support staff, and staff reported how their views and feedback were listened to, carefully considered and used to drive change. For example, **reception staff were asked to feed back about the appointment system**, what was working well and what were the challenges. The results of these were discussed by the partners and changes made. • Managers took a conscious decision to ensure all staff **took a lunch break together** to allow them to share any concerns and build team spirit. They listened to staff feedback and responded accordingly. For example, reception staff had recently requested new chairs which were being ordered. Leaders collected feedback from staff and acted on suggestions. For example, through recent implementation of the daily 4-hour phlebotomy clinic it was recognised that 1 individual delivering this service for 4 hours was impacting staff wellbeing. As a result, the **delivery of this service was split** between 2 staff members for 2 hours at a time
Treating people as individuals	• The practice had provided **support in relation to finances, housing and employment** to patients who were struggling. Administrative staff demonstrated a knowledge of vulnerable patient groups and were able to recognise where a patient may need extra support around protected characteristics. Leaders continuously reviewed feedback and amended care where needed, for example introducing early morning appointment slots for patients who work. • Patients with learning disability were asked to attend their **annual review during their birthday month**. The practice had an improvement project to assist their neurodiverse patients in requesting reasonable adaptations they may need to access and/or attend healthcare appointments. The practice created a **passport where the patient could add things** that were important to them, and this could be worn as a lanyard. For example, patients could highlight 'things to know and ways to help me: give me specific instructions and explain why, check my understanding, ask me direct (closed) questions'. • The practice worked closely with a range of local organisations to support patients' health and wellbeing. For example for dementia patients, a Day Centre for loneliness and "meals on wheels" service, NHS volunteer befriending service, Hoppa bus, Age UK, local free support groups, local walks, and free local sports for people struggling with mental wellbeing.

	• All staff had received training about autism and learning disabilities and were able to support people who found it difficult to be independent and to access services. The practice offered **quiet waiting areas** and **fidget aids** for patients requiring this support. Staff told us some patients were also offered the choice of **waiting in their car** until it was time for their appointment if they struggled with the sensory environment of the practice. • As part of the health commitments of the Armed Forces Covenant, they had a dedicated clinician who has a specialist knowledge of **military related health conditions** and **veteran specific health services**.
Independence, choice and control	• Within the last 12 months, the practice had **identified carers as a group** of patients who required further support. This was after a review of patients who chose not to attend health reviews. The overview highlighted that carers who did not have a long term condition would not routinely be invited into the surgery for a review. The practice aimed to ensure all carers had the opportunity to attend the practice. The practice added flexibility around appointments, early morning, weekend or evening appointments. A dedicated appointment was created for a carers review. In the 12 months since implementation, attendance for carers has increased by 52%.
Responding to people's immediate needs	• The service had a daily clinical triage and on call team in place consisting of 2 GPs and 1 nurse. This team saw patients requiring the need to see a clinician on the day and supported staff who triaged calls including those requiring immediate assistance. This team were also available to take calls from partners such as safeguarding teams and schools or respond to emergencies on site.
RESPONSIVE	
Person-centred care	• The practice is exceptional at recognising the needs of patients, they understand the complexities of patient circumstances and can recognise if someone needs further support. An example provided was the coding of patients who may be deaf and therefore find it difficult to order medications over the phone, allowing either a family member to order on their behalf. The patient participation group told us that this issue was raised and resolved quickly and effectively. All staff who completed our questionnaire told us that the practice puts patients at the centre of the practice. 93% of patients who completed the patient survey indicated that reception and admin staff were helpful and friendly. • A **passport had been created for neurodiverse patients**. The passport included important information that the patient felt they wanted people to know, including if they needed a quiet place to wait for their appointment or how they liked to be provided with information. This was entirely up to the patient if they wanted to create a passport or use it while at the practice. • The practice was able to offer **appointments with a GP Chaplain**. Appointments with the Chaplain were available on a Friday at the practice. The role of a GP Chaplain was to provide holistic, person-centred care by focusing on the spiritual, pastoral, and emotional wellbeing of patients, and their families. The practice had audited the number of people attending and had noted a marked increase in 2024.
Care provision, Integration and continuity	• The practice acknowledged the importance of working with other services and provided examples of demonstrating learning from within the practice nationally at conferences, this involved **care navigation, and a**

	quality improvement project focused on lipids (high cholesterol). This project was led by the practice pharmacist, and we reviewed evidence which demonstrated a project which improved outcomes for almost 1000 patients. The project is currently in its third cycle and had been rolled out to more patients within the PCN. Leaders of the aligned care homes told us that they had no problems in accessing care for their residents, and there was good continuity of care provided by the practice. Care homes had a named GP to ensure consistency. • The individual needs of people were always considered, and people were involved in decisions about their own health. For example, patients who requested for a gender to be documented differently, or pronouns be altered would be offered **discussion with a clinician and a personal care plan commenced** to ensure they were involved in decisions about care. Furthermore, when the surgery made significant changes in practice, patients were sent surveys which were clearly reviewed and actioned where needed.
Providing Information	•
Listening to and involving people	• We saw complaints were managed in line with the practice's policy. The practice had a positive approach to receiving feedback and complaints we reviewed showed the practice responded to feedback appropriately, openly and in a non-defensive manner. Learning from complaints was evident and staff were able to identify changes made as a result of patient feedback, including complaints. Staff were aware of their duty of candour and to be open and honest when things went wrong.
Equity in access	• The practice gave us examples of where additional support had been identified for patients. An example included: a patient with impaired hearing had an agreed emergency procedure where the patient could contact the practice by sending a text message to a landline phone number. When the practice responded to the patient, a spoken message would be converted to text, ensuring the patient was able effectively to convey an urgent message and be responded to. • The practice also provided an example of feedback given by a visually impaired patient, regarding practice signage. The patient was **invited back to the practice to review where new signage needed to be placed** to make the signs clearer for them and other patients with visual impairments.
Equity in experiences and outcomes	• The practice had a lead GP for their patients who resided in a care home which ensured this patient group were known to a clinician and reviewed regularly. This benefited patients who may have fluctuating capacity or who struggled with decision making as the GP would be aware of the baseline of these patients. • The National GP Patient survey demonstrated that 100% of patients with a long-term condition knew what would happen following an appointment at the surgery, compared with 93% national and 94% locally. • Staff had recently appointed a **domestic abuse lead** who worked within the administration team, the aim of this staff member was to ensure victims who may not attend appointments, or who required flexibility in how they accessed the service could be overseen. • When the practice implemented the Continuity of Care project, which aimed to **align patients to one regular GP**, they commenced with the most vulnerable patients first in order that those who needed access to a regular GP

	were able to be prioritised. The National GP Patient Survey which took place prior to the project commencing demonstrated that 61% of patients were able to access their preferred clinician against a national result of 40% and local 41%. • The practice had **created a Walking Group**. Originally this was run by a GP partner and HCA. The initiative was specifically designed to promote patient wellbeing, by providing a safe and inclusive environment that fostered community and broke down social barriers for those managing physical or mental health challenges. The walking group has now been taken over by a group of volunteers with practice staff still attending and renamed 'Wellbeing Walks'. Since its formation, the group has recorded attendance from over 400 people. • The practice had created **a pilot for patients suffering with chronic pain using a more holistic approach**. Following training one of the GPs invited 20 patients to attend 4 **sessions held at the Community Garden**. The first session was run in October 2025 with 10 patients attending. The pilot included a structured four-topic curriculum. The patients were sent a questionnaire to complete before the first session, and an evaluation will be completed at the end. A further evaluation, 2-3 months after completion of the pilot, will be completed to see the impact of the sessions on quality of life, level of pain and use of pain relief. • The practice organised annual **free seminars for patients and residents at a local church**. Past topics included generalised anxiety, women's health and challenges associated with ageing. In October 2025 a chronic pain seminar was held. Approximately 80 people attended, and feedback was very positive.
WELL-LED	
Shared direction and culture	• At a recently protected learning time day staff had completed team activity around what they felt described the service they provide to patients. The practice had these on display on a large banner in a staff corridor. The practice's vision was printed on mouse mats and screen backgrounds. • Management told us when they chose the name of the practice, they had made a conscious decision to call it **"[location] Healthcare" and not "surgery" or "practice"** as they did not want the practice to be medically led but have a holistic approach to healthcare for the local community.
Capable, compassionate and inclusive leaders	• Leaders often set up campaigns (including the flu and covid vaccine campaigns) so that staff from all levels worked together **pairing clinicians with administrative staff who they would not always work** with daily to build team spirit and sense of belonging across the practice. Staff told us this was a positive way to get to know the whole team as they were such a big practice. • Managers had a **monthly lunch and learn session** in place where they invited external speakers including community teams or pharmaceutical reps to share information.
Workforce equality, diversity and inclusion	•

Governance, management and sustainability	• Staff could access all required policies and procedures. All practice policies and procedures were available on the practice's shared drive, which all staff had access to. There was a **clear policy review process** in place to ensure all policies and procedure were reviewed regularly and were in line with new guidance. • Following the pandemic the practice had **continued to have daily morning meetings** where they discussed the structure for the day and any emerging risk or changes. This was communicated through electronic cascade systems in place ensuring all staff were up to date with all revenant information and changes. Managers ensured there were **regular staff touchpoints** in the day to allow collaboration and debriefs; this included in the morning, at lunch and at the end of the day.
Partnerships and communities	• The integrated care board (ICB) informed CQC **the practice was engaged with the ICB** and the primary care network. Partners attended monthly operations meetings with their primary care network where they shared initiatives, referral processes and learning.
Learning, improvement and innovation	• The practice had bought several **blood pressure monitors that patients could borrow** to help improve their preventative practice. As a result of this initiative 1 of the first patients to use this machine identified they had severe hypertension and was treated immediately.

"Requires Improvement" and "Inadequate" CQC Ratings for GP Surgeries(Scores of 1 and 2)

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	• We observed a **CQC rating sign** on a notice board which offered misleading information about previous ratings.

	• **Safe recruitment practices** were not always followed, for example, contracts of employment were not always signed by the employee, change of contracts were not always signed, and references were not always within a staff members file, and staff had not always had the appropriate immunisations for their role. • Patients lacked choice in where they could obtain their prescriptions, as the service had turned off the electronic prescription service (EPS), the surgery had no agreement with the integrated care board to do this. • There were still **gaps in recording and identification of learning outcomes**. We also found that not all complaints described during our assessment had been recorded.
Safe systems, pathways and transitions	• There was a system in place to ensure urgent 2-week wait cancer referrals were sent in a timely manner and checks in place to ensure the patient had received an appointment. However, there was **no safety-netting system in place** to ensure the patient had attended for their appointment and outcome correspondence had been received by the practice. • During our remote clinical notes review we found a **backlog of outstanding scanned documents**, which dated back to February 2025, which had not been coded. • 75% of patient records had been summarised. At the time of the assessment, the practice had not completed any formal audits of the summarising process.
Safeguarding	• The safeguarding lead had not approved a staff member to conduct a home visit where some of the staff believed there may have been **safeguarding concerns**. • The practice did not maintain formal safeguarding children and adult registers which could be compared and reconciled with external agencies in MDT meetings to ensure the accuracy of safeguarding data and ensure all relevant patients had been correctly identified and flagged. • Gaps in formal **chaperone training** undertaken
Involving people to manage risks	• Leaders in the practice told us they planned to develop a **written protocol for triage**, but this was not yet in place. • Some of the emergency equipment was past its expiry date. We found that some staff were not aware of signs and symptoms which could indicate a deteriorating patient.
Safe environments	• When the practice made changes, **risk assessments** were not always updated accordingly. For example, after relocating the oxygen storage from one room to another, the hazard signage was not updated to reflect the new location. • The Electrical Fixed Installation Condition Report (**EICR) was overdue**. This had been highlighted in a formal fire risk assessment undertaken in August 2025 as a high priority.
Safe and effective staffing	• A member of the clinical team had not had recorded supervisions or **assessments of their clinical practise** since their appointment in 2023. On review of clinical records, we identified that this member of staff had not always acted in line with their agreed areas of competence.

	• Not all patient-facing staff, including some clinicians, had completed **mandatory training on learning disability** and autism. In addition, staff undertaking lead roles were not consistently provided with sufficient training or supervision to perform their responsibilities effectively. • DBS (Disclosure and Barring Service) checks were not always carried out in line with the practice policy and where **DBS checks** had not been completed there were not documented risk assessments. There was a lack of processes in place to seek assurances or to confirm whether appropriate recruitment checks, or training had been undertaken by clinical staff employed by the Primary Care Network (PCN) but who were working under the direction of the practice. • The **induction check list** was generic and was not tailored to specific staff roles. • We found some training was not at a level in line with guidance based on staff role and there were gaps in up-to-date training, which included safeguarding children, safeguarding adults, preventing radicalisation, mental capacity act, infection prevention and control, fire awareness, sepsis and equality and diversity.
Infection prevention and control	• The **general cleaning** of the premises, including clinical rooms and patient toilets were not sufficient. For example, the flooring in the consulting rooms and the baby changing station were inadequately cleaned. Processes to monitor that cleaning by the cleaning company met IPC standards were not effective. • The practice had a **staff immunisation policy**. However, we found that this was not always being followed, and the practice had not evidenced staff immunisations in line with UK Health Security Agency Guidance. • The most recent infection prevention and control audit had not been completed fully or accurately and had failed to identify all risks.
Medicines optimisation	• We reviewed the **dispensary rota** and noted on occasions, staff without the appropriate qualifications or training were involved in checking dispensed medicines. • The controlled drug records showed returned medicines had been issued to a patient after being returned from a previous patient, this is in contradiction to the practice's **Controlled drugs policy** and could mean patients receiving medicines which have been inappropriately stored. • Staff did not always take steps to ensure they prescribed medicines appropriately to **optimise care outcomes**, including antibiotics. The percentage of broad-spectrum antibiotic items prescribed by the practice was 10.9%, which was above the 7.2% England average. In addition, the total number of prescribed antibiotics items per 1,000 registered patients for the practice was 184.3 which was above both their PCN and England values, 145.0 and 121.9 respectively. • No established and effective system in place to ensure appropriate Medicines and Healthcare products Regulatory Agency **(MHRA) alerts** (providing alerts, recalls and safety information on drugs and medical devices) were consistently reviewed and actioned. For example, we identified 76 patients prescribed the medicine detailed in the alert. Out of our sample of five patients we found all potentially at risk of harm.

	• Some clinical records completed by GPs had been coded as having medication reviews completed but did not include a narrative entry on the record • The practice was identified as a **local outlier/high prescriber for antibiotics** by the local Integrated Care Board. The practice had audited their prescribing behaviours and identified significant improvement were required in the information provided to patients and their assessment of peoples need. However, they had not established systems to address individual prescribing behaviours. • Some suggested **emergency medicines** were not available to staff should they have to respond to an emergency. There was no risk assessment in place to identify an alternative medicine. For example; the practice did not have midazolam or diazepam to treat people who have a seizure. • There were 30 patients prescribed the DMARD Methotrexate, of which 3 did not appear to have had monitoring in the last 6 months. There was no documented evidence in the practice's clinical system that the clinician had checked that monitoring was up to date before issuing a prescription. For 2 patients reviewed, there was no shared care agreements saved in the practice's clinical system. • There were 187 patients prescribed a direct oral anticoagulant (DOAC), of which searches indicated 32 had never had a **creatinine clearance level calculated**. We reviewed 4 records in detail and found no creatinine clearance had been calculated for any of the patients. • There were 57 patients identified as having been prescribed over 10 prescriptions for benzodiazepines or Z drugs, of which we reviewed 4 patients. There was no documented evidence in the clinical notes that there had been an attempt to wean any of the patients off the medication and only two had documented evidence that they had been informed of the risk of addiction. • The practice did not have a system to **remove the stationery from printer trays** when not in use or overnight.
EFFECTIVE	
Assessing needs	• Some patients had been seen by a clinician who did not have the knowledge, experience and competency to assess and treat them appropriately. Some clinical records completed by one clinician lacked details of their assessments and supporting rationales for actions taken. • There were 45 patients with hypothyroidism who had not had **thyroid function test monitoring** for 18 months and searches indicated there were 7 patients with chronic kidney disease (CKD) 4-5 who had not had their bloods monitored in the last 9 months. • We reviewed current performance dashboards provided by the Integrated Care Board (ICB) and found that the practice were negative outliers in some areas. For example, the percentage number of dementia care plan reviews undertaken was 65.8%, the percentage of patients on the severe mental illness (SMI) register with all health checks complete was 18.9% and the percentage of patients who had a completed learning disability health check in the last 12 months was 57.1%.

	• There were 24 patients with a potential **missed diagnosis of diabetes**, of which we reviewed 5 patient records and found concerns about the missed diagnosis of diabetes for 3 patients.
Delivering evidence-based care and treatment	• 420 patients with long term conditions had not received appropriate monitoring for 18 months including a review of their prescribed medicines. Out of our sample of three patients we found all may be at risk of complications from undertreatment. These can include heart problems, increased cholesterol, and potentially, myxedema coma in severe cases. • Staff were not provided with **protected time to seek advice** and guidance from senior clinicians in practice. Staff told us they were mindful of seeking advice and potentially disrupting the senior clinician's clinical schedule and impacting negatively on patient care.
Monitoring and improving outcomes	• There was no formal **audit of clinical decision making** and prescribing for non-medical prescribers and minor surgical procedures undertaken by two GP partners had not been audited.
Consent to care and treatment	• Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training formed part of the practice's mandatory training schedule. However, not all staff had completed the training.
RESPONSIVE	
Person-centred care	• The practice did not always make sure patients were at the centre of their care and treatment choices. Our review of people's records showed gaps in systems and processes to recall patients in line with guidance. For example, there were delays in blood testing monitoring, medication reviews and potential diagnosis which impacted on person-centred care and treatment.
Providing Information	•
Listening to and involving people	• **Complaint responses** we reviewed did not include appropriate signposting to the Parliamentary and Health Service Ombudsman (PHSO). The practice did not have a consistent system to capture and record all verbal complaints to facilitate trend analysis.
Equity in experience and outcomes	• We saw that the practice had developed a learning disability information board in the waiting room and had recently nominated 3 learning disability and autism champions who were a GP, a practice nurse and an administrator. At the time of the assessment their roles and responsibilities were being defined and established so it was not possible for the practice to demonstrate how these roles would work. At the time of our assessment, all practice staff were in the process of completing learning disability training.
Planning for the future	• We reviewed 4 patient records and found in 2 records a ReSPECT care plan had been used and recorded by the practice with the patients' wishes regarding care and resuscitation and these were stored in the clinical records. In the other 2 records, we found that DNACPR decisions had been made in other health settings, and coded in the clinical records, but no documentation was available in the notes. The practice did not have a system in place to review and follow-up on any decisions made in secondary care or the community setting to ensure appropriate documentation was available.

WELL-LED	
Shared direction and culture	• The service dispensary had the **electronic prescribing system switched off**, restricting patient choice, the surgery told us they would give patients a paper prescription to go elsewhere if they requested this. However, this would mean the patient would have to come and collect the paper prescriptions which could be avoided using electronic prescribing. • It was not recorded anywhere that staff were aware of the **vision of the practice**. We also found that the practice did not have a clear strategy to achieve their vision, with a lack of prioritisation of actions. • On the day of the on-site inspection, the practice provided a refreshed mission statement and a 5-year business plan. These were not developed in collaboration with staff, people who use the service and external partners. The business plan **did not consider the local and wider health and social care community** or reference how it would plan services to meet the needs of the practice population groups. There was no indication of how the practice planned to monitor and review the plan. (Score of 1)
Capable, compassionate and inclusive leaders	• **Significant event and near miss spreadsheets** did not have comprehensive outcomes and actions taken and dated. Informal complaints were recorded on their clinical system within patient notes, which did not easily allow for complaints to be reviewed, or themes identified and were not recorded on the complaints register as stated on their website. Complaints should not be included in patient records to avoid any future prejudice, to maintain patient confidentiality as only those involved should have access and due to data protection as patient's records are for life whereas complaints have a retention record. • The CQC ratings poster shared on a noticeboard had inaccurate information. • A staff member was **undertaking tasks that were outside of their formal training** and competency having been asked to undertake this duty by senior leadership. When questioned, senior staff provided conflicting accounts regarding the re use of controlled drugs and why this was occurring. • Whilst leaders for key responsibilities were identified, the scope of their roles and responsibilities were not clearly defined and documented and they were not held formally accountable. This led to disparities in the timeliness and quality of care provided to people. • There was no formal and embedded **organisational vision and strategy**. We found there was a lack of effective governance oversight, and some systems and processes were not sufficiently embedded to ensure safe, effective and well-led care. (Score of 1)
Freedom to speak up	• Staff described a high level of recent changes where they had not always felt safe to speak up. There was a named speak up guardian in house and the practice had established Freedom to Speak up processes through the integrated care board. Staff were aware of how to raise concerns. However, some staff gave us examples of concerns they had raised, in some cases on multiple occasions, where leaders in the practice had **not taken appropriate action** at the time of our assessment.

	• The practice had not nominated a **Freedom to Speak Up Guardian** within the practice or at primary care network level.
Governance, management and sustainability	• Patient confidentiality and information security was not always taken seriously, informal **complaints were stored within patient clinical records** which could leave the patient open to future prejudice. • The medicine management lead did not effectively oversee and ensure the timely and appropriate actioning of Medicine and Healthcare product Regulatory Agency alerts. • The provider had not established effective governance systems to effectively reduce and improve the prescribing behaviours of staff. The practice remained a **high prescriber for antibiotics**. • Operational practices were not accurately reflected in the provider's policies. For example, we found different forms were being used than those stated and designed to support staff and promote effective and defensible decision making. We found documents recently reviewed and approved by the provider included references to discontinued organisations and failed to provide essential details for staff to undertake activities effectively and safely. • There was no established and effective system in place to ensure **consistent and accurate coding** of clinical information. • At the time of our assessment the provider **did not have a registered manager** in place. The provider must have a manager who is registered with CQC as a condition of the provider's CQC registration. The practice had failed to provide CQC with an accurate, up-to-date statement of purpose. • There was no active patient participation group (PPG) • There was no clear process and understanding of the practice's legal obligation to notify the Care Quality Commission (CQC) through **statutory notifications**. The regulations state that a provider must notify CQC when there is a change, event or incident that affects their service or the people who use it. (Score of 1) • The practice had a business continuity management plan which had last been reviewed in June 2024. The plan did not include current contact details for suppliers or staff should the plan be activated. There was no system in place to test key elements of the plan and identify lessons learned. (Score of 1)
Partnerships and communities	• Communication from other services had not been **acted upon in a timely manner**. For example, action requested on hospital discharge letter.
Learning, improvement and innovation	• The service had a patient representative who attended the Patient Participation Group (PPG). But there was no specific group or meetings held within the practice itself. Management told us they were trying to re-establish refresh their local PPG and were considering contacting several new members. • The practice did not have an **embedded culture of improvement and innovation**. There was no formal programme of quality improvement, systems and processes to support good governance were not operating effectively and there was no clear vision or strategy to drive a culture of continuous learning. (Score of 1)

First Practice Management