First Practice Management

CQC Inspection Reports Published During October 2025 included in this analysis:

- 7 reports were for GPs rated Requires Improvement
- 1 report was for a GP rated Inadequate
- 1 report was for GPs rated Outstanding

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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	• Staff told us that if they raised concerns, these were often ignored or dismissed. They talked about a '**blame culture**' where safety was not seen as a top priority. • For the significant event records, the practice had not taken appropriate action to prevent re-occurrence. The practice had not raised significant events in relation to the known backlog of test results and the delays to patient care and treatment. Partners at the practice had **ignored concerns raised by staff** about this. • The practice did not have an effective system for recording and acting on safety alerts received into the practice, such as those from the MHRA. A search of the practice's clinical records system showed the practice had not made sure they had taken actions to protect patients affected by a MHRA safety alert about prescribing Clopidogrel and Omeprazole or Esomeprazole at the same time.

	• Not all **complaints** were recorded within the practice as minor complaints were not always reported formally, however it was not clear what was classified as lower level. Some complaints we were made aware of had not been recorded via the reporting system so we could not be assured they had been acted upon. Learning from complaints was not always evidenced to be shared with staff. • Minutes from a practice safeguarding meeting did not record the learning from a child safeguarding concern in April 2024 or record the changes that had been made as a result of identified learning. • Although the practice had sent acknowledgement letters for complaints, written responses had not always been sent in line with their internal protocol to ensure that even when complaints were resolved verbally, a written response would still be issued.
Safe systems, pathways and transitions	• Referrals and test results were not managed in a timely way. We identified a **backlog of 495 blood tests** results which had not been reviewed with the oldest dating back to July 2025. 254 of these results were urgent, abnormal or seriously overdue. The practice told us this was because they had decided not to extend to extend the employment of 2 locum GPs, whose role it was to review test results. However, they had failed to make alternative arrangements. • There were issues with the oversight of **incoming diagnostic results and workflow**. We reviewed the outstanding workflow for the practice; the oldest report was dated from 6 weeks earlier (an abnormal serum folate report). There were further reports for an abnormal anaemia test and an abnormal HbA1C (a test for diabetes control) from over 2 weeks earlier. There were multiple abnormal reports outstanding from a week earlier; these included kidney function tests, liver function tests, full and blood counts. Following the inspection, the practice advised they had implemented a new system where results would be checked and cleared 3 times a week • There was a backlog in dealing with **incoming mail** due to staff shortages. Some emails had not been dealt with for three weeks which included safeguarding alerts. • Our search of the practice's clinical records system showed the practice did not always **process letters and test results** coming into the practice in a timely way.
Safeguarding	• The practice did not effectively maintain a **list of vulnerable people** due to the way in which their records were coded. The practice was unable to produce, when requested, an accurate list of vulnerable patients, such as homeless persons, veterans, children living in a household where a child was on a protection register, those at the end of their lives, those with DNACPR records in place, and carers • Clinical staff told us if they had a concern they would message a doctor, for the doctor to "deal with" it. These staff also told us that although they would raise the concern with the practice manager, the practice's safeguarding lead or with the patient's usual doctor, they may not record their concerns on the patient's medical records. • The practice did not review registers of these patients that had been generated by the clinical records system to make sure they were kept up-to-date.

	• The practice did not routinely discuss children and adults at risk of, or experiencing, abuse or neglect either within the practice or with other services. Safeguarding meetings had stopped due to the COVID-19 pandemic and had not restarted. • The practice did not provide evidence 6 of the 10 members of clinical staff employed by the practice had completed the required training in safeguarding children, nor that 5 of the 10 members of staff had completed appropriate training in safeguarding adults.
Involving people to manage risks	• The **induction checklist** for reception staff did not include guidance on how to identify and what actions to take if they encountered a deteriorating or seriously unwell patient. • The practice GP lead had run an introductory session on 'The deteriorating patient.' However, it was unclear how many staff had attended this and what checks had been completed to **assess understanding and competency**. • There was limited evidence to show that the practice had its own **policies and procedures** for identifying and prioritising 'same day' care which meant people requiring urgent appointments may not always be identified and prioritised appropriately • The full **recommended list of medicines** was not present and there was no documented risk assessment or rationale as to why they were not present or not required. • The practice did not have all recommended equipment for use in an emergency, including absorbent towelling, monitoring equipment, and a variety of equipment to support a person's airway and breathing. • Some consumable items had passed their expiry dates, for example masks to help deliver oxygen to a patient had expired in 2019. • **Checks of the emergency medicines and equipment** were not carried out in line with national guidance. Checks had been recorded on 8 occasions between January 2024 and 2025, with gaps of up to 11 weeks between checks. The practice did not record checks of the defibrillator. • Not all staff confidently recognised the signs of sepsis. Some staff told us they could not remember having any training about sepsis and were not aware of any aides to help them identify symptoms and take suitable actions.
Safe environments	• The most recent fire risk assessment the practice showed us for this inspection was dated **November 2015.** Records showed the practice had not recorded tests of the fire alarm system weekly, in line with the recommendation in the fire risk assessment. Records showed the system had been checked 29 times between January 2024 and February 2025, with several occasions of gaps of 2 or 3 weeks between tests. • The practice did not provide evidence of weekly checks of the emergency lighting system. Records showed a monthly check of the emergency lighting system had last been completed in October 2016 and the system last serviced in August 2022. • Systems for ensuring emergency medicines and equipment were fit for use, remained ineffective. • **Items were out of date** (syringes and face mask). Some **items were missing** including a child pulse oximeter, airways, an 'ambubag' and portable suction. There were 2 adult pulse oximeters, 1 was in working order, the other was not fit for purpose indicating they had not been checked

	• The practice operated in an old building which had not been updated or decorated for some time. For example, in the baby changing room, a wallpaper border was hanging loose over the changing mat which meant babies and young children could be at **risk of cross infection**. • When external risk assessments had been carried out and remedial work was required, the practice did not always have assurance that this had been **completed in the appropriate timeframe**. For example, the fire risk assessment was overdue from April 2025, failed PAT testing items were still on site despite having live wiring exposed and remedial works from the previous fire risk assessment could not be evidenced. Although this was the responsibility of the landlord, the practice did not have oversight that risks within the building were addressed. • The practice's Health and Safety Risk Assessment relating to COSHH was dated January 2023. This document did not relate to a GP practice generally nor specifically to their own practice. The practice provided a COSHH Risk Assessment Template, however this had not been filled in. • The practice did not store the liquid nitrogen in line with the safety information that came with the chemical, for example in a way that restricted access to it and helped to reduce the risk of accidental spillages.
Safe and effective staffing	• For one staff member undertaking minor surgery in the practice, no **audits of minor surgery** had been undertaken and there was no evidence an accredited Direct Observation of Procedural Skills (DOPS) assessment for them. • There was no evidence that clinicians working in advanced clinical practice or in non-medical prescribing roles had an **agreed scope of practice** • The provider did not have oversight of the performance and competence of clinical and non-clinical staff. Apart from appraisals, there were no systems to enable the provider to know staff worked safely, effectively and in line with guidance. • The practice was unable to provide any evidence of **regular review of their prescribing practice** • The practice provided details of two audits of minor surgical procedures that had been undertaken since our last inspection. However, the audits did not include any details about the patient, the type of procedure, the clinical diagnosis, outcome or patient satisfaction. There was still no evidence that this staff member had undertaken **accredited DOPS training** to ensure safety of patient procedures. • At the time of the inspection there were **insufficient permanent GPs in post** which meant the practice was not always able to fulfil its own staffing model. To fill the staffing gap, locum GPs were employed, which meant the practice was not always able to provide continuity of care where it was clinically appropriate to do so, for example for patients with complex mental health needs. • Staff often sought physical or urgent advice and guidance from the single salaried GP in-between their fully booked clinical sessions which often led to interruptions and delays. • There were no **regular, structured supervision sessions** for clinical staff with the clinical lead or other appropriate clinician. • We checked a sample of employed staff, and we found that the most recently recruited staff member had **only 1 reference** whilst the policy stated 2 must be sought.

	• A member of staff had been recruited a year before and the practice did not have a copy of their **proof of identity** nor their full employment history. There were also gaps in evidence for staff recruited 8 and 9 years previously. • **No evidence of ID for a salaried GP** recruited in 2016. • The practice had an appraisal policy in place, which stated all employees should have an annual appraisal. However, the practice **did not include GPs in the appraisal process** even though they were employed by the practice. • Members of staff who had left had not always been replaced, and often administration staff would be taken from the practice to cover shortages at other locations managed by the provider at short notice which would put more pressure on staff. We were told that clinical staff **rotas often changed at short notice** to cover other locations owned by the provider. • The IPC lead had completed an IPC audit in February 2025. However, the audit had not effectively identified areas needing attention from the practice. For example, the practice had stated in this audit clinical handwash basins did not have plugs or overflows. During our site visit, we found and asked the practice to remove a plug from a handwashing basin in a clinical room. The audit stated there was documentary evidence staff had received training in IPC that included hand hygiene and the management of sharps. However, the practice did not provide evidence 7 of the 10 members of clinical staff and 9 of the 15 non-clinical members of staff had completed training in IPC
Infection prevention and control (IPC)	• Issues raised in an IPC audit conducted in April 2025 had not been addressed. For example, the fridge used to store vaccines was in poor condition and very dirty inside. • **Stained carpet** in the waiting area and the baby changing station, which **lacked antibacterial wipes** for cleaning the mat and surrounding surfaces. Although a notice directed patients to request disinfectant from reception, this approach was not safe or practical for parents with babies and young children. • In the GP consultation rooms, the floors and **skirting boards were visibly scuffed** and this meant they appeared to be unclean and could be an infection risk. These rooms were used for invasive procedures such as joint injections. • The infection prevention and control audit highlighted that a risk assessment for the carpeted areas was required along with **cleaning schedules** of these which the practice could not evidence.
Medicines optimisation	• The practice was still unable to demonstrate that effective **reviews of patients' medicines** were always undertaken. • We identified 74 patients prescribed a medicine used to treat and prevent bone-related conditions for 5 years or over. We looked at 5 records in more detail and **none had been reviewed in the last 5 years** to ensure the prescribed medicine remained appropriate. • We identified 68 patients diagnosed with hypothyroidism who had not received monitoring for a minimum of 18 months. We viewed the records for 5 patients and identified necessary **monitoring was overdue** for all patients and most recent test results had been outside the normal range. • **Patient group directives (PGDs) were not managed** and authorised in line with guidance. They were either not dated correctly by authoriser or not signed at all. An employee who was not yet sufficiently trained to administer

	immunisations was included on and had signed a PGD. Prescriptions initiated by non-prescribing clinicians were authorised by GPs without any review or assessment of the patient. • Our searches indicated that out of 726 patients being prescribed medicines used to treat high blood pressure and heart conditions, **19 had not had the required monitoring**. We reviewed the records of 5 patients in more detail and found that none had up to date blood tests prior to issuing their prescription. • Non-steroidal anti-inflammatory and anti-platelet medicines were not always prescribed safely to patients over the age of 70. Out of 206 patients prescribed these medicines, **53 had not been prescribed the recommended medicines** to reduce the risk of gastrointestinal irritation and bleeding. • Our clinical searches showed that 2 patients out of 35, prescribed a medicine used to treat bladder problems, had **not received necessary monitoring**. • A few patients had missed diagnoses due to incorrect coding in their electronic records. This included monitoring for chronic kidney disease, where 4 out of 5 patients had been **coded incorrectly.** • The practice did not stock all recommended **emergency medicines** and lacked risk assessments to mitigate the associated risks. • We looked at people prescribed methotrexate, (for inflammatory conditions). Blood tests are required every 3 months for patients prescribed this medicine. We sampled 5 patients and found that **3 were overdue monitoring**, and 2 others had their tests done but were not recorded within their records. 3 of the 5 sampled did not have the day of the week stated for when to take their medicine, which is recommended. • We looked at people prescribed aldosterone antagonists, used to treat heart failure. Urea and electrolytes (UE) tests are required for patients prescribed these medicines. 1 patient had not had a UE test since 2020 and another since 2022. There were also potentially another 26 patients in this category who appeared not to have monitoring recorded. • We looked at people aged over 75 who were prescribed direct oral anticoagulants (DOACs). 2 patients were on these medicines where they were **contraindicated**. 86 further patients appeared not to have had the correct monitoring. • We looked at people prescribed teratogenic medicines. Of the 2 records we looked at in detail, we found issues with both of them, as there was **no pregnancy prevention plan** in place and a lack of clarity regarding effective contraception. • We looked at people prescribed citalopram or escitalopram, for depression. We found a lack of awareness of this **MHRA alert**, as none of the recommended checks or advice had been recorded or referred to for the 3 patients whose records we looked into. • Staff did not **manage prescription stationery appropriately** and securely: for electronic prescriptions we saw they made a record of the prescription serial numbers that went into the printers, but the records showed these entered the printer a year before and had not been checked since. There was no way of knowing what prescriptions remained in the printer or if they might have been misappropriated.

	• The practice did not have a programme of **regular clinical audits of prescribing** that focused on improving care and treatment. • The practice could not show vaccines/medicines had been **stored within an acceptable temperature range**. The practice had not recognised when fridge temperature readings were not within the acceptable range, nor taken actions to investigate and ensure the medicines remained safe and effective to use. • The practice did not always monitor the health of patients prescribed medicines where monitoring is required because of the risks associated with taking the medicine. Patients prescribed Azathioprine, to calm and control the body's immune system, had **not had monitoring for over 5 years**.
EFFECTIVE	
Assessing needs	• The use of **alerts and flags for vulnerable patients** was inconsistent and ineffective. Sometimes their needs were recorded as 'problems' in the electronic records and others were flagged in other places within the record. • Sometimes persons who were at the end of their lives (EOL) were recorded as gold standard framework (GSF), others as palliative care or sometimes **not coded** at all. This was similar for risks or vulnerabilities relating to DNACPR, carers, veterans, the homeless, looked after children, children in a household with a child protection record, or domestic violence. It was not possible to obtain accurate lists of patients who fell into these categories.
Delivering evidence-based care and treatment	• Systems were not always in place to ensure staff were up to date with evidence-based guidance and legislation. Clinical records did not always demonstrate care was provided in line with current guidance, this was seen from the results in clinical searches.
How staff, teams and services work together	• Various clinical staff gave examples of when they would refer patients to other services. However, some of these staff told us they **did not follow-up referrals** they had made, and that it was the doctors' responsibility to monitor the progress of referrals, respond to reports and letters from other services, and to take follow-up actions when needed. • Since June 2024, the practice had attempted to start monthly meetings with a palliative care nurse to discuss and coordinate care for patients nearing the end of life. However, evidence showed only one meeting had been successfully held by the time of this inspection. • 11% of the patients who were prescribed medicine for hypothyroidism were not up-to-date with the required monitoring. We found medicines reviews had not been completed in the last year and **monitoring was significantly overdue** for all of the patients whose records we looked at, by up to 4 years.
Supporting people to live healthier lives	• Searches of the practice's clinical records system showed the most recent test results for 14% of patients who had diabetes indicated their diabetes could be better controlled. These patients were at higher risk of developing complications because of their diabetes. For some patients, the practice had not acted on the most recent test results, taken between October 2023 and July 2024, and which were significantly outside the expected range.
Monitoring and improving outcomes	• Our clinical searches identified people with hypothyroidism who had not had their thyroid function monitored for 18 months. We examined 5 records and found all of them were overdue monitoring. For 3, the last thyroid function

	test showed their results to be outside the normal range, but no action had been taken. The practice had sent text messages to request monitoring in most cases but continued to regularly prescribe their medicine for periods of 2 months despite overdue checks. • Medicine reviews did not always pick up potential issues, such as the **MHRA alert** which advises of the contraindication of doses of more than 20mg citalopram and 10mg escitalopram in patients over age 65 years • Patients aged between 40 and 74 are eligible for an NHS health check. The practice told us they had completed a health check with 262 (10%) of the 2647 patients registered with the practice who could have one. Patients aged 75 and over are also eligible for a NHS health check. The practice did not record how many patients had received one. • On 30 June 2023, 69% of patients registered with the practice who were eligible for this screening had been screened adequately within the recommended time period. This period is 3 years 6 months for people aged between 25 and 49, and of 5 years 6 months for people aged between 50 and 64. The national target is 80%. We saw the coverage of patients being screened had been consistently below this target since 2016.
Consent to care and treatment	• We reviewed 5 records of persons recorded as having DNACPR status in place and found in 2 of the 5, there was **no DNACPR record on file**. For these 2 patients it was not clear if indeed a DNACPR was or wasn't in place as there was conflicting information within the records. Documentation of the mental capacity assessments and best interests decision-making was absent in all 3 patients who were believed to lack capacity. • Most staff members who gave us examples of when they had acted as **chaperones** did not describe following an appropriate procedure that was in line with national standards, such as standing the same side of any screens or curtains as the patient. • The practice did not provide evidence of **Disclosure and Barring Service (DBS)** checks for all staff who acted as chaperones.
CARING	
Kindness, compassion and dignity	• Results from the National GP Patient Survey 2025 regarding kindness, compassion and dignity were below national averages. 79% of patients said they had confidence and trust in the healthcare professional they saw or spoke to during their last appointment compared to the local and national average of 93%, and 70% felt the healthcare professional was good at listening to them during their last appointment compared to the local and national average of 87%. • The practice had not considered or taken actions to help maintain the privacy and safety of people using the service. For example, **removing or deactivating letterboxes** in doors to doctors' consultation rooms and taking steps to minimise any risks due to **poor soundproofing** throughout the building.
Treating people as individuals	• The practice was an accredited 'Veteran Friendly' practice, but although the practice asked patients newly registering with the practice if they had served in the Armed Forces and leaders told us the practice offered veterans quicker access to appointments, practice staff did not know what other support was available or which clinicians in the practice had this specialist knowledge.

Independence, choice and control	• Since July 2022, there has been a legal requirement for providers to make sure their staff receive **training** to help them support **autistic people** and people with a learning disability. The provider showed us evidence 12 of the 15 non-clinical and 4 of the 10 clinical members of staff employed by the practice had started suitable training.
Responding to people's immediate needs	• Several patients who provided feedback to CQC told us they felt staff were rude and unhelpful. People told us they felt the aggressive tone from some staff was a barrier to them, and others, accessing care and treatment. Others told us they felt the practice had not supported them as they had hoped, staff were dismissive of their concerns. • Although staff told us there was a small room off the reception area they could offer to people who were distressed or needed a private area, for example to have confidential discussions, this room was a working area and was not suitable to use as a **'quiet' and 'confidential' area**.
Workforce wellbeing and enablement	• Concerns were raised from and about staff at different levels of the practice. Feedback from staff regarding a culture of kindness and respect between colleagues was mixed, with several staff at different levels reporting a lack of support, kindness and respect from some colleagues. There were reports of **verbal altercations** between colleagues, and accusations about staff misconduct. Disputes between colleagues had resulted in limited communication between them. At the time of the assessment there were ongoing attempts at **mediation.** • The practice shared with us an incident where a member of staff had received a **verbal threat**. Although the Police were contacted for advice, leaders had not fully acted on the advice given or shared the advice and learning with other staff, to promote their safety. • Non-clinical staff told us there would be one person on reception during the practice's extended opening times. Staff told us they felt concerned about this because sometimes patients who had been 'buzzed' into the building would accidentally enter the front office. Leaders did not provide us with any assessments outlining how any risks were managed.
RESPONSIVE	
Person-centred Care	• Service users told us they did not feel clinicians treated them in a way that considered their individual circumstances. People told us they did not feel clinicians took time to understand their concerns or investigate the causes of their symptoms. Other patients felt there was a **lack of support and interest** from staff.
Listening to and involving people	• Information about how to complain lacked detail about the practice's **complaints policy and procedures** and what people could expect. People were also invited to share their suggestions to improve how the practice operates or by completing an online NHS Friends and Family Test Feedback Form. However, these forms were not available.
Equity in access	• Patients told us about their frustrations of fitting in appointments around their other commitments, such as work and caring responsibilities, because the practice **did not offer pre-bookable face-to-face appointments with doctors.** However, patients could pre-book an appointment with a nurse up to 3 weeks in advance.
Planning for the future	• Some of the Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions we looked at during this inspection had not been recorded in line with relevant legislation. Clinicians were sometimes unable to find

	information on the clinical records system explaining the patient's wishes and how the decision had been made. We also saw doctors at the practice did not always review DNACPR decisions.
WELL-LED	
Shared direction and culture	• The provider had an overall vision and mission based on providing responsive, safe, high-quality care and transforming people's lives across all services it managed. However, staff told us they had not been **involved in its development** and were unclear how it applied specifically to their local service. • There was no **formal robust business plan** detailing risks, objectives and how these objectives would be achieved. • The **two layers of management** for the practice, both site level management and provider level management, were not always working effectively, creating a negative workplace culture. For example, we found that risks had been highlighted to the practice manager who had escalated these to the provider and senior managers, however they had not been addressed, such as the **backlog of summarising** and **lack of administration staff**. • The provider told us they were currently developing a business plan and strategy and therefore could not share with us their vision and plans for the future of the practice. Staff told us they had not been involved in the planning or development of the vision and plans for the future of the practice. • The provider shared with us a succession planning template, however, this had not been filled in.
Capable, compassionate and inclusive leaders	• The practice was unable to provide assurance that they had effective processes to act on or escalate allegations of poor culture. Processes did not ensure appropriate actions were taken to address or prevent **bullying and harassment** for all practice staff. • We saw leaders had not **acted on concerns** raised by staff about a **significant backlog of blood tests** results and the consequent risks to patient safety. • Leaders told us they had an open-door policy to ensure staff had appropriate support when required, however there was mixed feedback from staff which informed us that this was not always the case.
Freedom to speak up	• At this inspection we asked staff to complete a confidential questionnaire, and we carried out staff interviews. Nine out of 15 staff who completed the questionnaire told us they were still not confident about speaking up without **fear of retribution**. Some staff told us they continued to experience or witness **staff being bullied**. • Evidence from our assessment did not demonstrate that all staff felt they could speak up about other issues without fear of retribution. • Some staff reported they would not feel comfortable raising concerns to someone who they did not know and were part of the managing team. • The majority of staff did not know they could contact a **Freedom to Speak Up Guardian** if needed.
Workforce equality, diversity and inclusion	• Staff told us the provider could have been more **understanding** and **supportive** in helping them to continue to work effectively with a long-term condition. • We did not see evidence of personalised support for staff, for example **personal emergency evacuation plans** for staff who may benefit from additional assistance.

Governance, management and sustainability	• There was no evidence that the practice had **effective oversight** of the **prescribing practices** of non-medical prescribers, and the competence of clinicians undertaking minor surgery. • One of the partners told us that they had disagreed with a partnership decision to relinquish the services of locum GPs who had been dealing with the blood test results. However, there was no **evidence of this in the minutes** of the partnership meeting where this had been decided. • The practice failed follow practice **procedures for managing employee performance**. Staff members had been invited to performance meetings without due process being followed. There was no evidence that issues had been identified during routine appraisals, complaints, audits, or colleague feedback. • Letters to employees inviting them to performance review meetings did not include their **right to be accompanied** by a trade union representative or colleague. • For nursing staff in particular there were **no team meetings** • There was no formal policy for assessing and **prioritising appointments** so that staff could safely and consistently direct patients to the appropriate clinician. Whilst the provider's policy for clinical supervision contained information about the structure, frequency and recording arrangements for clinical supervision, evidence from staff feedback and practice records indicated that the policy was not consistently implemented. • An external fire safety report highlighted several serious issues, including the **positioning of fire alarms**, which made regular testing difficult. Leaders had not arranged an **external fire safety risk assessment** for several years, so it was unclear how long the service had been non-compliant with fire safety regulations. Although they were working with the fire service to make improvements, this came at a significant cost which could have been avoided with regular reporting. • Staff told CQC most information was shared via an electronic system. While this was efficient, staff felt **less connected to leaders** and believed communication could be improved. • There was however a **backlog** of 481 **patient records to be summarised**; after the assessment the practice told us it had reduced this to 139 records. • We reviewed data for the NHS Friends and Family Test (FFT) for March to June 2025 and saw there were 5 or fewer responses each month. Results for the yearly National GP Patient Survey had been consistently poorer than local and national averages. However, the practice had **not carried out its own surveys** in an attempt to improve participation. • Our most recent data from March 2024 showed that uptake rates for 4 of the 5 **childhood immunisation** indicators had decreased since March 2023. • There was **no formal robust business plan** in place detailing any risks, objectives, and how these objectives would be achieved. After the assessment the practice produced a brief business plan which listed its key objectives and actions. • The provider had not established governance processes that were appropriate for their service. Managers met with staff regularly but there were some staff who had **incomplete appraisals** and performance reviews.

	• Meetings were held for all staff across the group practices however it was not clear how information from these meetings were **disseminated to staff** that could not attend. We were told that staff could listen back to recordings, however due to staff shortages we were told they did not have time to do this. • The provider shared with us **2 different Business Continuity Plans**. These plans outlined what staff should consider and what actions to take if there was a major incident or disruption to the service, such as a loss of computer or telephone systems, utilities such as gas, electricity and water, flooding, a pandemic, staff incapacity or terrorist attack. One of these had been reviewed in October 2023. However, the provider had not inserted information to make the plan relevant to the practice. The practice had reviewed the other plan in January 2024. However, this plan needed updating and specific details adding to inform staff how to respond to events affecting the practice. • The provider did not make sure staff worked **in line with the practice's policies**, national guidelines and within their competencies, such as through clinical supervision or running audits or searches on the clinical records system. • The provider was **not clear about training staff were required to complete**, and did not have an effective system to monitor training completed by staff. This meant the provider was unable to know what training staff had completed, what training staff needed to do, and when refresher training was needed. For example, the provider was unable to tell us which staff had completed up-to-date training in **sepsis** awareness, the **Mental Capacity Act** or **chaperoning**.
Partnerships and communities	• There was little information on the practice's website and in the practice's waiting areas about **how the PPG supported the practice** or how patients could join the group. Staff told us the practice manager interacted with the PPG and that they were not involved.
Learning, improvement and innovation	• We asked the practice to provide us with evidence that the quality of treatment and services had been monitored within the last 12 months, including 2 completed **clinical audit cycles**. The practice was unable to provide us with such because they did not have one in place. • The practice did not have a system of oversight or **audit of clinical consultations**, record keeping or prescribing for clinical staff, including advanced care practitioners. • Whilst some audits were only in the first cycle, and had not yet been reaudited to show improvement, some second **cycle audits parameters had changed** and therefore it was difficult to see if improvements had happened. • The practice did not benchmark their performance with other GP practices to identify areas for improvement, for example in the uptake of cervical screening.

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
CARING	
Kindness, compassion and dignity	• Patients said staff were generous with their time in that staff participated in community meetings such as the **patient participation group meetings** and also attended health walks which helped to develop positive relationships. • Patients were also positive about the guidance and support provided about areas other than physical health, such as **housing, benefits** and **social outlets**. • Patients said they felt listened to during consultations.
Workforce wellbeing and enablement	• Leaders attained recognition as a good employer by meeting the requirements of the regional **Good Employers Charter** in January 2025. The Charter is a voluntary membership and assessment scheme, which aims to elevate employment standards in the region. • Leaders provided **fresh fruit for staff** and **personal hygiene products** were available in the staff toilets. • Leaders had conducted a staff survey in 2024. This report indicated that staff were 100% satisfied with the leadership team. Action was being by the leadership team to address findings any matters raised by staff, such as stress. There was a strong **zero tolerance approach** by the leadership team in relation to conduct towards staff. Action taken included emphasising and applying the zero-tolerance policy with the practice and enabling staff with additional **conflict resolution training.**
Treating people as individuals	• Leaders ensured staff had the time and expertise to speak to people in a way which helped them to engage better with services. We saw that people would attend a number of appointments until all aspects of their health care needs were resolved in a way that was acceptable to them. It was noted that staff were persistent, but **adjusted their approach** according to the need of the patient. For example staff described getting to know patients at the beginning of their health care journey who were resistant to investigation and treatment, but through slowly **building trust** people accepted care and treatment which eventually supported their journey to better health.
Responding to people's immediate needs	• People accessing the Homeless service benefited from **direct access to drug workers**, tissue viability specialists and experts in infectious diseases to ensure immediate needs were responded to.

RESPONSIVE	
Care provision, integration and continuity	• In response to the findings of audits, the practice had **commissioned a mobile clinic** to take services such as health assessments and immunisation to people who found it difficult to access the health centre.
Person-centred care	• The practice was exceptional at making sure people who used the **Homeless service** were at the centre of their care and treatment choices. • We received more than 140 comments about the practice from patients. The overwhelming majority were very positive and many provided detailed examples that confirmed person centred care with effective outcomes. For example, patients said the practice had helped them get the correct medicines; helped them find a place to live and helped them back to health. • Many patients also described receiving **consistent care from single member of staff** or small team of keyworkers. People said they trusted their worker, and this helped them in their individual journey to recovery.
Equity in access	• Many patients praised the **use of technology to share test results** and book screening tests such as cervical smears • People identified that social events, such as **organised health walks with the physiotherapist, doctors and nurses**, provided additional less formal access to the practice staff. • People also commented that **weekend appointments** had helped increase accessibility. • People with a learning disability were provided with longer appointments if required. • Treatment rooms were on the ground floor and entry was via an automatic door. • In addition to consulting rooms there was a private room that could be used for nursing mothers or to provide a quiet space.
Equity in experiences and outcomes	• The PPG described how the **health hub approach** that has developed due to the work in the practice service for the homeless, had made a positive impact for the general practice population and local people in general. It was felt that the practice provided information about a lot of community activities, charities and not for profit organisations. They worked closely with established and expected services and took steps to forge new relationships with additional providers when required. • They were **inventive at responding to identified needs** and developing partnership working and shared care for the homeless people living in their city. Leaders pioneered new ancillary roles to meet the evolving needs of the homeless population. • In April 2025 the practice published a report outlining the many areas where the outcomes for homeless people experiencing health inequalities had improved. • A policy that homeless patients were screened for bloodborne viruses, and other infections, as a part of the new patient assessment, thereby taking the opportunity to offer care and treatment required to protect people from the long-term side effects.

	• Outreach work and engagement with women who are homeless or rough-sleep, encouraging and supporting them to access **cervical screening and contraception** to promote safety and meet individual needs. The practice confirmed 72% of the eligible homeless women registered with the practice, had accepted cervical screening, which met world health organisation target.
Planning for the future	• We saw leaders identified that **end-of-life care for homeless people** was disjointed and resulted in people not getting the person-centred care and treatment needed, and they were not cared for in a dignified and controlled setting that would minimise physical and emotional distress. Leaders identified that homeless people sometimes died alone, without dignity, even when a terminal diagnosis had been made and a care plan put in place. The practice worked with a local hospice; housing providers and other local services, helping other services to understand the particular stresses and omissions experienced by homeless people.