First Practice Management

CQC Inspection Reports Profile - Feb 2026

- 5 reports cited below were for GPs rated Requires Improvement
- 1 report cited below was for a GP rated Inadequate
- 1 report cited below was for GPs rated Outstanding

Outstanding Performance (scores of 4):

SAFE	***INSPECTION COMMENTS (all scored 4 by CQC)***
Learning culture	
Safe systems, pathways and transitions	• There were robust systems in place for processing information relating to new patients. The provider had developed **new patient health check templates** to meet the specific needs of the patient demographic. For example, there were questions concerning **housing status, trauma screening, depression and anxiety screening tools**. The templates included links to initiate tasks to other members of the clinical team for further follow up and additional templates such as blood borne virus (BBV) screening. This enabled the team to capture all relevant information at the point of registration. Leaders at the practice told us how the **templates had been seen as exemplars** and were used nationally across the country. • There was a **dedicated migrant health team** who supported patients with NHS registration by creating new NHS profiles and ensured personal information such as name and date of birth, was recorded correctly. The practice

	also worked closely with Primary Care Support England (PCSE) to ensure duplicate records containing incorrect information were eradicated. • The practice worked with the city's Community Healthcare to support people experiencing homelessness under the **Hospital In-Reach Team**. This service provided 20 beds within the community for ongoing support upon discharge from hospital. The practice provided a team of 2 GPs to carry out visits and ongoing care and treatment to reduce the risk of readmission.
Safeguarding	• The practice held regular multidisciplinary team meetings to discuss cases, coordinate referrals and ensure continuity of care. We were able to review case studies which demonstrated how the provider had worked to support patients at risk of or suffering from abuse. Interventions included **securing temporary accommodation**, prescribing to support withdrawal from illicit substances and Best Interest Decisions to support appropriate care provision.
Involving people to manage risks	• The practice offered a variety of services to meet the needs of local population, in a setting in which they felt comfortable. This included an **outreach vehicle – a bus**. The Bus hosted a dedicated team including a paramedic, nurses, an occupational therapist and a healthcare assistant. The aim of this service was to engage with people experiencing homelessness and vulnerable people who would otherwise fail to engage with healthcare services. The bus operated from 5am each morning around the city and looked for people sleeping on the streets or in tents to offer healthcare advice, support and treatment (under temporary registration with the Practice). The Bus staff looked to **overcome barriers to engaging with health and care services**, build relationships and encourage full registration for care at the practice. As part of our assessment, we reviewed numerous case studies demonstrating the impact of this service for patients. We saw that conditions such as leg ulcers, burns and addiction had been identified and addressed through this service. • The Bus also doubled as a **women's safe space on Friday evenings**. This provided a space for any women feeling vulnerable, including sex workers, to have company, a warm drink and access to healthcare.
Medicines optimisation	• There was a dedicated GP pharmacist who had oversight of prescribing processes and was available to provide support and guidance as required. Prescribing was tailored to the needs of the patient population and considered safeguards such as **short issue dispensing** and **access to medication across public holiday periods**. The GP pharmacist worked closely with community pharmacies to ensure patients continued to access required medication. We saw how this had a positive impact on patients, including examples of how the GP pharmacist had shared their personal mobile number with community pharmacists to make themselves available and ensure ongoing support for patients outside of practice hours. • Staff within the practice were able to provide examples of how they proactively supported patients with access to medication. For example, those who were advised to take **aspirin throughout pregnancy** but were unsure of how to access the medication. We were able to review cases studies which demonstrated how the practice worked flexibly with patients to optimise adherence with prescribed medicines. Examples included **flexible prescribing**, **liaison with community pharmacy** and the **use of dosette boxes**.
CARING	

Kindness, compassion and dignity	• All staff within the service were aware of the needs of the patient group and took steps to provide support over and above meeting their healthcare needs. For example, supplies and **items were available for patients to access in the waiting areas**. This included shoes, coats, sleeping bags and umbrellas. In addition, the practice worked closely with other services to ensure patients had access to essentials such as **food parcels and toiletries**. • The provider ran a scheme called **Bevan's Children** which worked with other providers to provide Christmas presents for patients. • We heard examples of when staff members had **accompanied patients to health and social care appointments** with other providers to ensure they were able to access the care and support they needed.
Workforce wellbeing and enablement	• Leaders at the practice were proud to acknowledge that staff employed by the service often **had lived experiences of the patient population**. As such, a comprehensive support package was in place which included counselling, psychological therapies, a staff wellness forum and trauma informed supervision. • The practice had recently introduced **annual staff awards** to acknowledge areas such as rising star employee of the year. There was also an award which was named **in remembrance of staff member who had sadly passed away during the COVID 19 pandemic**. All staff were invited to attend the **annual award** which was hosted off site as a social event.
Treating people as individuals	• The practice provided interpretation services for patients who required this. At the time of our assessment, only 23.9% of the practice population spoke English as a first language. A total of 55 languages spoken were spoken by the remaining 76.1%. We saw case studies where the practice had **supported patients to enrol on English courses** to make their transition into the country smoother. • All the staff we spoke with and received feedback from were committed to providing trauma-informed care and understood the specific needs of patients. We saw numerous examples where patients had been **supported using trauma-informed care**, with services being tailored to best support the individual. Examples of this included working with other services to facilitate remote prescribing so that medication could be accessed in a familiar setting, facilitating appointments at specific times of the day to accommodate patient behaviour and working with neighbourhood teams to ensure medication could be administered daily.
RESPONSIVE	
Care provision, Integration and continuity	• The practice had tailored its services to meet the diverse needs of its community. For example, the practice had recognised that many wound care services were difficult to access for inclusion health populations. In response to this, staff within the practice designed a **patient-led, trauma-informed wound care service**. This was delivered **through the Bevan Bus** and at multiple sites across the city. Clinical staff within the practice had undertaken chronic wound management training and specialist compression training in order support those people with severe wounds. • The practice provided a **drop-in service at a local homeless centre** to proactively identify people who may need access to healthcare services.

	• The practice worked closely with a local hospice and had a **specific inclusion health protocol** in place to support patients with early intervention and access to appropriate care.
Listening to and involving people	• Feedback was also used to improve services at a population level. For example, in response to patient feedback for more creative methods of engagement, the practice had **introduced art therapy**. This allowed patients to access support in a creative, accessible way which supports emotional expression and mental wellbeing. • The provider had created **Bevan Voices**, a dedicated platform for people to **share stories and experiences through various mediums such as art, writing and digital story telling**. We were able to review these via the website as part of our assessment and found that people spoke positively about how engagement with the service had resulted in positive impact on their lives.
Equity in access	• Examples of the outreach services included: ○ **Bevan Bus –** A mobile clinical team consisting of a paramedic, 2 nurses, an occupational therapist and a healthcare assistant. The team worked around the city delivering services to people experiencing homelessness in tents, within hostels and at other locations. People could access services such as COVID vaccinations, health promotion and advice, wound care and face to face consultations. ○ **Hospital In-Reach Team** – Provided by 2 GPs from the practice, this service supported people experiencing homelessness upon discharge from hospital. Patients are discharged into community beds and healthcare needs are met by the visiting GPs. ○ **Migrant Health Team** – A clinical team consisting of 2 nurses, 2 healthcare assistants and an occupational therapist. The team provided healthcare and support for refugees and migrants within the hotels they were housed in. Services included screening events such as tuberculosis, hepatitis B and hepatitis C, new patient health checks, creating NHS profiles and mental health support.
Equity in experiences and outcomes	• The practice carried out regular audit activity to review physical and digital activity and inform improvements in facilities, communication and service delivery. The provider had implemented a **physical accessibility statement** and regularly reviewed digital platforms to ensure compliance with accessibility standards. • The provider had an **accessible action plan which informed the accessible information standards policy** with improvements such as flagging and sharing communication needs, providing easy read appointment letters and health information, ensuring interpreter availability, and adapting physical environments. • The provider actively supported people in vulnerable circumstances to register with the practice and provided **education materials** and support to ensure people were aware that a residential address was not needed. Where people required health care treatment but were unwilling to register, due to mistrust of services, staff worked with them and offered **temporary registration** to enable care to be provided.

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.*

First Practice Management

	INSPECTION COMMENTS (*all scored 1 or 2 by CQC*)
SAFE	
Learning culture	• The provider had a complaints policy; however it was **not specific to the practice and the details stated, 'insert practice name here'.** The policy also did not specify how they were going to share learning. There was a significant event policy which stated that staff would be involved in learning but did not outline about how it would be achieved. • Some staff told us that they were **not provided with enough guidance, written procedures and/or policies** to perform their role. We found limited evidence that learning was shared to mitigate future risks.

	• The provider kept a clear staff training record and had good oversight of e-learning. However, it was unclear why learning was assigned to staff groups as there was **no training needs analysis**. Leaders confirmed that this was not in place.
Safe systems, pathways and transitions	• There were not established and effective systems in place **for processing information relating to new patients** in a timely and effective manner. The practice confirmed that 153 patient paper records, the oldest dating back to July 2025, were waiting to be reviewed and added to the patients' notes on the clinical system. The practice was aware of this backlog and advised this had occurred due to staff shortages. • We also saw **3,328 items of clinical correspondence awaiting review and action**, with the oldest dated August 2025. The practice told us they were aware of this and had taken action to address it. For example, they upskilled one staff member in March 2025 and another in July 2025 to support the processing of clinical correspondence. They explained that any correspondence requiring immediate action was identified and dealt with promptly. Following our inspection, the practice sent us an update outlining the immediate actions taken to reduce the backlog and the projected timescale for clearing it. They told us that as of 30 December 2025, the backlog had reduced, with 99 documents remaining to be processed. • We identified an instance where **a patient had not been reviewed following an attendance at A&E**, a patient still on a register and receiving treatment for a condition they no longer had, and a patient needing a change in treatment following testing that had not been actioned. The provider could not demonstrate that all communication was reviewed and acted on appropriately.
Safeguarding	• The GP and nurse told us that where only 1 parent brought their infant to the circumcision clinic, social services attended with them. There was **no evidence of social services involvement for any of the records we checked** where only 1 parent had been present. This meant the practice could not be assured the needs and safety of the infant had been fully considered. (Score of 1 – inadequate) • A review of staff's recruitment files showed that **not all staff were appropriately trained in safeguarding** and the Mental Capacity Act specifically required for clinicians. Following the assessment the provider evidenced that staff had completed the relevant safeguarding training; however, Mental Capacity Act training for two clinicians was not completed until after the assessment. • The practice had a lead for safeguarding adults and children, however, some processes to make sure people were protected from abuse and neglect required improvement, for example, the safeguarding lead could not confirm during assessment **how often the safeguarding register was reviewed** and when asked if children who were not vaccinated were routinely discussed at clinical meetings as a safeguarding concern, staff were unsure. • Our review of safeguarding training identified **gaps in safeguarding children training** across both clinical and non-clinical staff, and where it had been completed, it had only been completed to level 1. We also identified gaps in adult safeguarding training with non-clinical staff only having completed level 1 of the training and 1 member of clinical staff also having only completed level 1 of the training. This was not in line with intercollegiate guidance.
Involving people to manage risks	• 41 members of the public told us that they had experienced **delayed referrals or missed episodes of care**. We were told that this had resulted in **some people accessing private healthcare**. This feedback was consistent with

	data from our stakeholders, people had told 'Healthwatch' that there were delays and barriers to care and that some patients were unable to get the advice and support required to manage their illness.
Safe environments	• The practice **did not document routine monitoring of day to day fire safety risks**, for example checks of escape routes and fire doors. After the inspection, the practice told us that escape routes and fire doors were checked during the weekly fire alarm test; however, we did not see documented evidence of this. The practice also told us that these checks will be documented in a new format going forward. • We found the practice had **not formally assessed the risk to health and safety**. They told us informal visual checks were conducted and we saw these were documented on an infection prevention and control risk assessment. However, they were unable to evidence that all risks relating to the health and safety of staff and patients had been fully identified, considered and mitigated. • The practice was **not following their Legionella management procedures** in line with the practice's risk assessment. Although an external contractor had undertaken temperature checks, which showed no concerns, these were not completed monthly. The practice had also not flushed little used outlets on a weekly basis, as recommended in the practice's legionella risk assessment. Actions raised in previous audits regarding legionella had not yet been completed. Recent improvements to audit processes had not yet been fully embedded. • Clinical rooms we observed during assessment were carpeted and taps were not lever operated, leaders told us that they had communicated with the landlord about changes but that the landlord was resistant.
Safe and effective staffing	• A review of **staff files revealed significant gaps in evidence**. For one staff member, there was no proof of ID, appraisal, or nine mandatory training certificates available at inspection. While the provider later supplied evidence that most training was completed, two certificates (infection prevention and information governance) were only finalised after the assessment. Furthermore, the provider's **system for maintaining ongoing Disclosure and Barring Service (DBS) checks was not followed**; for a locum GP, reliance was placed on an online update service without evidence of the three-yearly checks required by practice policy. These issues reflected a systemic failure in administrative oversight and record-keeping. • Patients and patient representatives raised concerns about the staffing levels at the practice directly to us and via stakeholders. 14 people raised concerns to us about the retention and recruitment of staff, 23 people expressed concerns about the **visibility of the GP partners**. We received mixed feedback about the attitude of staff; 57 people had a negative experience and 108 people provided positive feedback. • The practice confirmed there was **no contract for the nurse to work at the practice** [for the purposes of a circumcision clinic], and there was a verbal agreement only. The nurse stated they had worked at the circumcision clinic since 2019. The practice or GP had never carried out an appraisal or formal assessment of competency for the nurse working at the circumcision clinic. (Score of 1 – inadequate)
Infection prevention and control	• We reviewed the recruitment files of four staff members and found that two had **not completed IPC training** at the time of assessment. The provider explained this lapse was due to a configuration error in their training platform, which has since been rectified.

	• **Methotrexate prescribing** also did not follow best practice guidance, as the days of the week were not clearly marked on the prescription, a key safety measure to prevent dosing errors. • The circumcision clinic gave each patient a pack on discharge, and this contained a bottle of disinfectant. Instructions on how to use this during bathing were provided. The disinfectant was labelled "Not suitable for babies under 9 months old", and "Never use on broken skin". The GP told us they supplied this as it had been used during their training, and they said they would ask for advice about this. We informed them that they should not supply this as it was **against the directions stated on the bottle**. (Score of 1 – inadequate) • An IPC audit had recently been completed, and an action plan was in place to address identified issues. However, the audit had not identified that **purple lidded sharps bins, required for the safe disposal of cytotoxic waste, were not available** in the practice nurse's room. The practice confirmed that 3 cytotoxic medicines were in use and acknowledged the requirement for the correct sharps bins.
Medicines optimisation	• There was a negative variation in the **prescribing of a specific group of antibiotics**, with the practice rate at 13% compared to the national average of 7.8%.The provider had conducted a prescribing audit on co-amoxiclav, one of the overprescribed antibiotics, between 2023 and 2025. The audit revealed a 48% increase in prescriptions, from 160 in 2023 to 237 in 2024, with data broken down by prescriber. In response, the provider implemented an action plan that included regular audits, patient education, and targets to maintain a justification rate of over 90% for prescriptions. The audit indicated a positive trend in prescribing justifications between 2024 and 2025; however, overall prescribing volumes increased, and some prescribers continued to demonstrate instances of non-justified use. • We identified 110 patients aged over 65 who had been prescribed medicines commonly used to relieve pain and reduce inflammation, or patients over 75 who had been prescribed medicines to prevent blood clots. These medicines can increase the risk of gastrointestinal complications. We reviewed a sample of 5 patient records and found that for 3 patients, there was **no documented assessment of gastrointestinal risk** to determine whether gastroprotective medicines were required in line with national guidance. • We found 2 out of 5 patient records reviewed, did not include necessary information to support continued prescribing. • One search focused on elderly patients prescribed oral nonsteroid**al anti-inflammatory drugs without a proton pump inhibitor** (PPI), unless declined or not tolerated. Of 93 patients identified, 14 were not prescribed a PPI. We reviewed five patient records and found that none had been prescribed a PPI alongside their non-steroidal anti-inflammatory drugs, which was assessed by the GP SPA as a moderate risk. This omission increases the potential for gastrointestinal complications and highlights a gap in adherence to prescribing guidelines. Additionally, one patient's medication review lacked sufficient detail to support safe and effective ongoing treatment, indicating inconsistencies in clinical documentation. • A search for patients on ACE inhibitors identified 75 out of 567 patients who had **not received the required monitoring.**

	• A search for patients with chronic kidney disease stage 4 or 5 who had not been monitored appropriately in the last nine months identified six out of 22 patients. • For patients with hypothyroidism, 21 out of 205 had **not received appropriate monitoring within the last 18 months**. Five records were reviewed, and all patients had been contacted after the assessment announcement. One patient's last recorded blood test since 2022. Following the assessment, the provider confirmed that all patients identified have been contacted and remedial actions put in place. • **Emergency steroid cards were not provided** to patients who were taking regular steroids in line with national guidance. • **Blank prescription forms (FP10s) were not recorded adequately** so the service would not be able to tell if any were missing. • When people were discharged from hospital the processing of the information in the discharge letter was outsourced to the Primary Care Network pharmacists (PCN) pharmacists. There was **no written feedback provided to the practice about the turnaround times** to process this information, although pharmacists processed those that had been flagged as urgent first. In the meantime, patients could potentially order repeat medicines that were no longer appropriate. • Staff at the practice told us that searches of the electronic system to ensure the safe monitoring of medicines were conducted by the supporting pharmacists from the PCN, however the PCN pharmacy team told us they are not involved in providing any support to run searches or audits. • The practice administered Lidocaine to the infants as an anaesthesia prior to carrying out the procedure. Although there was a **prompt to record the dose, it had not been recorded** in 21 of the 22 records we examined. In addition, the weight of the infant was not recorded in any of the 22 records we examined. there was no evidence there had been time for the Lidocaine to take effect. In addition, records included a space to record 2 separate pain scores. These had never been completed in any of the 22 records so there was **no evidence that levels of pain had been assessed**. The medicine store contained 2 unopened boxes and 1 opened box of Lidocaine. The opened box was for 5ml ampoules of the medicine. However, it contained 3 x 2ml ampoules, and these were a different batch number and expiry date than the box indicated. (Score of 1 – inadequate) • The practice policy stated that it was the task of the Primary Care Network (PCN) pharmacist linked to the practice to run and action searches for the alerts, however it **did not detail when and how often searches should be run** for previous and historical patient safety alerts and we saw no evidence of a practice led initiative to review historical alerts. The service submitted evidence of a PCN created document of patient safety alerts for 2025 of which 2 needed actioning. • Records searches identified eight patients as having a **potential missed diagnosis of diabetes**. Where appropriate, repeat monitoring was not carried out within the required timeframe as specified in guidance. One patient had not been correctly coded meaning the potential risk for missed monitoring was high. • Records searches identified 54 patients as having a **potential missed diagnosis of chronic kidney disease** (CKD) stage 3, 4 or 5.

	• In line with NICE guidance our search identified 29 out of 280 patients with diabetes whose latest HbA1c readings was over 75mmol (HbA1c > 75). The service could not demonstrate that these patients received appropriate follow-up and support. • We saw some evidence that patients were being sent text reminders to ask them to come in for monitoring, but **staff often didn't act when patients didn't respond**. It was unclear as to whether alternative methods of communication were tried, and medication quantities adjusted to prevent potential harm. We raised these concerns with leaders. The GP partners agreed that not all staff were properly checking that monitoring was up to date and that it was safe to issue a prescription. • Cold-chain monitoring for the vaccine refrigerator was not consistently robust. Temperature records indicated a potential **cold-chain breach**, with the refrigerator showing a **sustained recorded temperature of 13.5°C** from July through the end of October 2025. A process was not in place to investigate whether this was a genuine breach until November 2025. A staff member responsible for checking the fridge temperatures was not aware of the manufacture's recommended temperature range in which the vaccines were required to be stored.
EFFECTIVE	
Assessing needs	• Processes to ensure that support information for carers was kept up to date were not effective. For example, the **carers identification form referred to staff no longer working in the service**. We saw minimal information for carers support on the practice website. We were not told about any other activity planned for carer support by staff and leaders. • Our searches identified 41 out of 1124 patients on the asthma register who had been prescribed 2 or more courses of rescue steroids. This is an indication of **poor asthma control**. We reviewed a sample of records which found that not all of the patients had received a review in 48 hours following the exacerbation in line with NICE guidance. In addition, there was not always an appropriate follow up of the service users' asthma and medicines to check treatment was working. • Our searches identified 32 patients as having a **potential missed diagnosis of Diabetes**. • 135 patients had **not had a medication review in the last 18 months**. The templates for annual medication reviews were not always being consistently used and therefore documentation was unclear.
Supporting people to live healthier lives	• Out of 2086 patients eligible for an NHS Health check, 466 people had been offered an annual NHS health check. A total of 207 patients had received a completed review. We did not see evidence that the people who had not received a health check had or would be followed up.
Monitoring and improving outcomes	• The service had not met the national target of 80% **uptake for cervical screening** (NHS England Digital data dated June 2024) achieving 52% and 65% respectively for the two indicators; the number of women aged 25 to 49 years old who have had an adequate screening test within the last 3.5 years as a percentage of the eligible population and the number of women aged 50 to 64 years old who have had an adequate screening test within the last 3.5 years as a percentage of the eligible population. The provider told us that they had improved across both indicators and as of April 2025 they had achieved 70% and 99% respectively for the two indicators.

Consent to care and treatment	• The practice had a **consent policy, but this did not give sufficient information and guidance**. It mentioned a patient giving consent, but it did not mention the need for 2 parents to give their consent. This is required under UK law and British Medical Association guidance. There was no guidance regarding what action to take if only 1 parent was present, if 2 parents disagreed about providing their consent for the procedure to be carried out, or if someone other than the parent attended. The practice had a circumcision clinic introduction document stating, "Both parents need to be present to sign the consent form". This was not happening consistently. The circumcision clinic consent form did not prompt 2 parents to sign. On 5 documents there appeared to be a 2nd signature, but it was not recorded who the 2nd signatory was. On 5 records there was reference to a video call, but the name of the person the call was with was not recorded, nor was any mention of consent. • The provider informed us they had recently reviewed all of the Recommended Summary Plan for Emergency Care and Treatment **(ReSPECT) forms** at the care home they provide care and treatment to. However, they had **not scanned these forms into people's records**, in line with guidance. Where ReSPECT forms had been completed by the hospital these were in people's records. We discussed completing an audit of people with ReSPECT forms in place to identify which patients require these to be scanned into their records.
RESPONSIVE	
Providing Information	• People told us through our Give Feedback on Care that they had poor experiences of getting information from the practice. We heard from 18 people who highlighted concerns regarding the challenges in comparison to 2 people who had positive feedback regarding this. A listening event held by Healthwatch in 2024 also heard from patients **struggling to obtain information**.
Listening to and involving people	• Patients raised concerns that a **public meeting arranged by the practice to address concerns was not attended by any of the GP partners**. They stated that they were concerned by the lack of engagement and visibility of the partners.
Equity in access	• Patients who had **reasonable adjustments** in place due to a disability told us that these were not always followed such as alternative methods of contacting the practice for people with a hearing impairment that could not use the telephone. This had led to delays in care when **the agreed adjustment was not responded to**.
Equity in experience and outcomes	• **Digital exclusion** was a concern raised by patients and the PPG. Although there were policies in place regarding accessibility, we saw evidence that these were not embedded such as reasonable adjustments not being honoured. • The practice **complaints procedure was not wholly effective**, and we saw that not all complaints were responded to in a timely and effective way to improve the quality of care.
WELL-LED	
Shared direction and culture	• There was **no business continuity plan** provided to us by the practice.
Capable, compassionate and inclusive leaders	• The **lack of visibility of clinical leaders** had a negative impact on staff perception of the support available to them. Staff told us a lack of consistent supervision impacted on their confidence and wellbeing. This had been exacerbated by absences and the use of locum staff.

	• The practice demonstrated a **lack of awareness regarding its obligations in relation to Patient Specific Directions** (PSDs). There was ambiguity surrounding the processes for recording and evidencing clinical supervision.
Freedom to speak up	• There were external Right to Speak Up contacts in place but staff who were aware of this were unsure that concerns raised regarding staffing and capacity would be addressed. Some staff were not aware that this was in place.
Governance, management and sustainability	• There were **not effective systems to identify and act on environmental risk**, monitoring of fire warden training, management of new patient information and processing of incoming documents. Improvements were needed in the oversight of patients prescribed some high-risk medicines, long-term condition reviews, documentation of medicine reviews and the tracking of urgent cancer referrals. • Failures were evident in the **handling of DNACPR decisions and clinical searches**, where inconsistencies were present. These concerns were not detected or addressed through the provider's governance arrangements, including audits and oversight processes. • Although policies and procedures were in place to support a learning culture, this was not consistently reflected in practice. **Recruitment records contained gaps**, and **training provision lacked consistency**. These issues were similarly missed during routine governance checks, further highlighting the ineffectiveness of systems intended to identify and mitigate risks. These failures raised concerns about the provider's oversight of staff suitability and safeguarding compliance. Collectively, they demonstrated an absence of robust systems to assess, monitor, and mitigate risks, and reflected a failure to maintain accurate and contemporaneous records. These systemic issues demonstrated a lack of good governance, resulting in a breach of Regulation 17 of the Health and Social Care Act 2008. • The practice provided us with patient feedback forms following clinics in April 2025. For 1 clinic date they provided us with **more forms that the number of patients or parents that attended the clinic**. For another date they sent us feedback forms for a date a clinic had not been running. Neither the GP nor nurse could explain this discrepancy. The nurse confirmed that they completed all the feedback forms, and they did not include any patient or parent details as they did not always want to be identified. • The provider had not **displayed their Care Quality Commission (CQC) rating** within the practice premises, as required by legislation. Upon enquiry, leaders indicated they were unaware of this statutory obligation.
Partnerships and communities	• Performance in **cervical cancer screening and childhood immunisations** was below national targets, and we saw no evidence of proactive engagement with the community beyond the standard recall process. This was despite the service recognising that individuals from certain cultural backgrounds may be more reticent to attend cervical cancer screening or immunisation appointments. • Feedback from the integrated care board indicated that the service did not consistently provide required information in a timely manner, and on several occasions, follow-up was necessary to obtain the relevant data. The provider attributed some delays to outdated contact details following a management change, which highlights a **breakdown in a fundamental communication process**.

Learning, improvement and innovation	• Not all staff were trained in **autism and learning disability awareness** and there was no policy in place to determine what training each staff group required. • Learning was not always clearly or correctly identified in those incidents that we reviewed. We saw some events where the **outcome was recorded as patient error when there had been a failure in process**. This meant that steps to prevent recurrence were not taken. • We saw a clinical audit carried out between January and March 2023 which stated of 50 infants undergoing circumcision between those dates there had been no incidences of bleeding and on 1 occasion an infant developed an infection. **No audits had been carried out** following this date. Prior to this a clinical audit had been carried out on 3 August 2021. This stated standards were met with regards to infection control and there were "very few" complications during and after the procedure. It gave no further information and did not document how many procedures had been carried out, how many complications there were, or what the timeframe of the audit was. The GP told us there had been no significant events since 2019 when a complication led to an infant needing a blood transfusion and further surgery. We saw the record, and the GP told us this had been recorded for their appraisal and **not recorded as a formal significant event** for the practice.