First Practice Management

CQC Inspection Reports of NHS GP Practices Published in July 2026

- 4 reports cited below were for NHS GPs rated overall Requires Improvement
- 0 report cited below was for an NHS GP rated overall Inadequate
- 2 reports cited below were for NHS GPs rated overall Outstanding

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
SAFE	
Learning culture	• **Significant Event Analysis (SEA) processes were comprehensive and well embedded**, incorporating robust root cause analysis and supported by annual thematic reviews to identify trends and recurring issues. Over the previous 12 months, 40 SEAs had been completed and reviewed, demonstrating a high level of engagement with reflective practice and continuous improvement. We saw clear evidence of thorough investigation and detailed reporting of incidents. Staff were able to provide examples of learning from prescribing errors, palliative care, and information governance, demonstrating that learning was effectively translated into tangible improvements. For example, a prescription was amended but not formally issued to the patient, resulting in a delay. This incident was reviewed, appropriate action was taken, and key learning was reinforced with staff, around completing a final issue check. Other additional learning included that during a Gold Standards Framework (GSF) meeting, coding to identify

First Practice Management

	palliative care patients was incomplete. This was reviewed and addressed, leading to the introduction of bi-monthly GSF audits to minimise the risk of missed coding and to improve the accuracy and completeness of the register.
Safe systems, pathways and transitions	• The practice had developed and delivered dedicated referral training for staff, ensuring they were confident and competent in making appropriate referrals. To further strengthen this area, the practice had created a detailed referrals resource pack, which included a directory of services available across the Dudley area. This resource supported staff, including locum clinicians, in identifying the most appropriate services for patients and facilitated timely and effective care coordination. The quality and innovation of this work had been recognised beyond the practice, with the **resource pack shared with the Integrated Care Board (ICB) as an example of good practice** to support wider adoption across the system.
Safe environments	• The practice demonstrated a **proactive approach to managing risks associated with power outages**. Following previous incidents, leaders had implemented effective mitigation measures, including the purchase of a **backup generator** to maintain the safe storage of medicines within fridges. They had also **introduced digital monitoring systems, with mobile apps providing real time alerts** to leadership staff if fridge temperatures fell outside safe limits, outside of normal operating hours.
EFFECTIVE	
Supporting people to live healthier lives	• At one practice, a wide-ranging physical activity and well-being offer included **a practice-funded Sports Academy**, developed in response to local childhood obesity data and co-designed with families. The programme combined free activity sessions with health education and resulted in increased physical activity and improvements in weight among participating children. Community initiatives, including family events and cycling programmes, further supported engagement and enabled opportunistic health promotion. • **Mental health prevention was supported through a long-standing programme of funded well-being sessions**, including mindfulness and yoga, delivered both in person and online. These provided accessible, non-clinical support alongside traditional treatment pathways and demonstrated sustained improvements in patient-reported well-being. • Targeted interventions supported patients with complex needs. A **virtual group consultation programme for chronic pain** combined peer support, lifestyle approaches and clinical input, improving patient-reported outcomes and subsequently being adopted by other Primary Care Networks. • The service also delivered a **comprehensive programme of patient education, reaching a large number of patients through workshops** led by clinical specialists and external experts. These sessions supported patients to make informed lifestyle changes and improve self-management. Additional initiatives included funded antenatal education and basic life support training, extending prevention into practical life skills. • **Focused work addressed health inequalities and high-risk groups**. Targeted diabetes engagement, supported by risk stratification, enabled patients with poorly controlled diabetes to access reviews and specialist input. Patients

	were also supported to access national programmes for smoking cessation, weight management and diabetes prevention, alongside digital therapeutic interventions. • A strong community presence extended the reach of health promotion beyond the service. Regular engagement at local events enabled delivery of health checks, brief interventions and signposting at scale. The practice also **established a monthly Health Hub, providing access to housing, financial and well-being support**, recognising the impact of social determinants on health outcomes. • The practice demonstrated a commitment to innovation through the introduction of a **virtual hypertension clinic model**, led by a GP Partner and supported by a Healthcare Assistant. This approach shifted care from reactive to proactive management, with patients identified and prioritised based on clinical risk. Each patient received an **individualised care plan, including medication optimisation, investigations, and structured follow-up**. Flexible options for blood pressure monitoring were offered, including home readings, in-practice checks, paper-based recording, and support from community pharmacies. To further reduce barriers, the practice introduced a blood pressure monitor loan scheme, with over 180 monitors issued in the previous 12 months. A total of 1,074 patients submitted home readings (12.1% of the practice population), representing a 31% increase in monitoring compared to the previous year. The programme showed clear improvements in blood pressure (BP) control. Patients with very high starting levels (≥160/100 mmHg) had noticeable reductions after treatment. Overall, 88% of eligible people with hypertension reached a BP below 140/90 mmHg in 2025/26, showing strong control across the population. • The practice has also strengthened support for vulnerable patients by working in partnership with a **dedicated migrant social prescriber.** In the last 12 months, 67 patients were referred for support, including assistance with registration into primary care services.
How staff, teams and services work together	• Staff ensured that **patients only needed to tell their story once** by sharing assessments and relevant information, including communication and accessibility needs, at the point of referral. • High-risk pathways were closely managed. **All two-week-wait referrals were audited** to confirm they were sent within 24 hours, with safety-netting processes in place to confirm attendance and follow up non-attendance. This ensured patients did not fall between primary and secondary care services. • End of life care plans were recorded across shared systems, enabling real-time access for ambulance, out-of-hours and secondary care teams. This ensured patients' wishes were known and respected across services. The service maintained a structured end-of-life register, with **all 53 patients having a Universal Care Plan in place** and documented entries for resuscitation status, preferred place of care and preferred place of death, supported by regular review dates to ensure plans remained current. Regular multidisciplinary team meetings brought together health, social care and community professionals to coordinate care for patients with complex needs, supporting anticipatory care and reducing the risk of deterioration.

	• The service demonstrated strong system-wide integration. A primary care network level **single referral pathway enabled streamlined access to well-being and social prescribing services**. The referral process was structured, risk-aware and outcome-focused, integrating multiple services into a single pathway and ensuring patients were directed to the most appropriate support while addressing both clinical and wider determinants of health. • The service had also **co-founded an integrated adolescent GP service co-located within the local Youth Hub**. This brought primary care into a trusted community setting and created a direct clinical and administrative link between the practice, the CAMHS Alliance and the Children's Integrated Commissioning Service. A salaried GP delivered the weekly clinic, with care linked back to primary care records, ensuring seamless continuity between the community-based service and the registered patient record. • **Wider partnership working**, including a neighbourhood leadership group, brought together health, social care and voluntary sector organisations to coordinate care across the community and support joint service development.
Monitoring and improving outcomes	• The service implemented a targeted approach supported by dedicated roles, proactive engagement and continuous monitoring. Over three years, performance improved from below national benchmarks to approaching national targets, with nationally validated data showing achievement ranging from 77% to 89% for age 5 MMR. The provider told us that their own **internal monitoring indicated a 36% increase in full immunisation coverage by age five**, demonstrating substantial improvement in uptake, which, while unverified and not directly comparable with nationally validated datasets, suggested further improvement. This work was also recognised externally, with the service commissioned to lead a wider MMR catch up campaign. • For cervical screening, the national target of 80% uptake (NHS Digital, 30 June 2024) had not been met, with uptake at 67% for those aged 25–49 and 74% for those aged 50–64. The provider shared its own 2025 data which, although not validated through national reporting processes and therefore not directly comparable, indicated that the service had met the cervical screening target for the 50–64 age group. • Although national targets were not fully met, uptake had improved over time and a comprehensive, targeted approach was implemented to address known barriers within this population. The service **recognised lower uptake in younger cohorts and implemented a targeted improvement strategy**, including extended access, trauma-informed care, patient choice of clinician, personalised recall systems and opportunistic engagement during routine consultations. These actions reflected a proactive approach to addressing known barriers within the population. • Quality improvement activity was systematic and produced measurable outcomes. A **coding audit identified patients with unrecognised chronic kidney disease**, leading to appropriate coding, clinical review and optimisation of care for all affected patients. A **chronic kidney disease (CKD) coding audit** identified 38 patients meeting biochemical criteria for CKD who were not formally coded, leading to individual clinical review, appropriate coding, monitoring plans and cardiovascular risk optimisation for 100% of patients within the audit

	period. In addition, a bisphosphonate re-audit demonstrated monitoring and medication review compliance rising to over 90%. • Targeted inequality-focused work improved diabetes care completion for housebound patients and blood pressure control among Black patients, achieving and exceeding planned targets. **A targeted diabetes initiative** also engaged patients who had previously not attended routine care, supporting re-entry into the treatment pathway. • A **structured mortality review process** was embedded within the governance framework. Reviews confirmed that care planning was effective, with all patients who had documented preferences for their place of care dying in their preferred location.
Assessing needs	• The practice **identified a cohort of frequent attenders**, consisting of 179 patients (2% of the practice population) who had attended 13 or more acute appointments within a 12-month period. This group accounted for 3,015 appointments, equating to approximately 58 appointments per week and representing 13.3% of total clinical capacity. This demonstrated that a small proportion of patients were utilising a disproportionate level of resources. In response, the practice implemented a structured and proactive approach, including the use of continuity of care flags, protected continuity appointment slots, and partnership working with the social prescribing team to provide more coordinated and personalised care. These interventions aimed to address underlying needs and reduce avoidable demand. Post intervention showed a 22% reduction in acute appointments over a 3-month period. Further population analysis also identified that 8% of registered patients had 3 or more long-term conditions.
CARING	
Kindness, compassion and dignity	• Specific **examples of how social prescribers had helped patients were provided during our visit**. These included, two elderly patients with caring responsibilities who had been supported with dementia and end of life care; a young adult experiencing anxiety and self-harm who had been supported to become more independent and less socially isolated; a single-parent who needed support with balancing their home and work commitments; and a patient who required support following a relationship breakdown. In all of these examples, positive outcomes were noted. • Although **chaperone training** was not mandatory for all staff, it had been completed by those staff who required it and we saw that there were **posters on display** (both in reception and in treatment rooms) advertising that chaperones were available. • The practice had actively committed to promoting dignity, having signed up to the **'Dignity in Care' initiative**. 2 staff members had completed additional training and were appointed as dignity champions, enabling them to lead, promote and embed best practice across the service. This reinforced a strong, organisation wide culture of respect, inclusion and person-centred care. • The practice demonstrated a compassionate and proactive approach to supporting patients following bereavement. This included the introduction of a **dedicated Baby Loss Support Letter**, providing timely, empathetic and sensitive communication following loss. The letter offered emotional reassurance, practical

	guidance, and clear signposting to bereavement services, while reinforcing the availability of ongoing support from the practice. Embedded into clinical and administrative workflows and supported by staff training, this ensured consistent and sensitive use, reflecting a strong commitment to personalised, trauma informed care.
Workforce wellbeing and enablement	• The service actively sought and responded to staff feedback. Annual staff surveys were undertaken, and tangible improvements had been implemented as a direct result. These included adjustments to clinic times, flexible changes to staff working hours, the introduction of standing desks, and the **creation of a staff book club** to encourage engagement and social connection. Regular newsletters and access to mental health support further reinforced the organisation's proactive approach. • A **menopause policy** was in place, demonstrating a commitment to inclusivity and practical support. This was **complemented by a "comfort box"** located within staff facilities, providing menstrual and menopause related supplies. The service also **recognised the needs of neurodiverse staff**, enabling the use of headphones to listen to music during work to support concentration, reduce stress, and enhance the working environment. • Initiatives such as **'Wellbeing Wednesdays'** had been introduced to promote positivity and reinforce organisational values. These provided structured, themed communications aligned with the NHS People Promise, combining awareness, recognition and practical resources for staff. A visible wellbeing and positivity board further celebrated achievements and encouraged staff engagement.
Treating people as individuals	• We saw evidence of support tools and advice to aid people's independence and support. For example, 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 had a sensory box available** if patients struggled with the sensory environment of the practice.
RESPONSIVE	
Care provision, Integration and continuity	• The service worked beyond traditional primary care boundaries to provide integrated support for patients with wider social needs. This included **establishing and leading a monthly Health Hub**, a drop-in community service where patients could access health, housing, financial, wellbeing and digital support in one place without needing a referral. This reduced barriers to access and helped patients receive more holistic support, while strengthening partnership working across primary care, the local authority and voluntary sector organisations. • The service carried out **ongoing assessment of its population using data on demographics, demand and patient feedback** to understand the needs of its diverse and growing community. It used this information to design how services were delivered, including offering multiple ways for patients to access care, such as online, by phone or in person, so people could choose the option that suited them best. Access was prioritised for vulnerable patients, and systems were in place to support continuity with preferred clinicians where possible, ensuring care was safe, fair and responsive. • The service also **delivered annual Teddy Bear GP Clinics in partnership with local schools to support early health education and reduce anxiety around healthcare environments**. Through interactive and engaging

	sessions, children were introduced to the GP setting in a safe and supportive way, helping to build confidence and improve understanding of health and well-being from an early age.
Person-centred care	• At the time of assessment, **all of the 20 patients on the dementia register had care plans in place.** All patients on the end-of-life register had been reviewed, with **care plans updated on both EMIS and the UCP system**, ensuring real-time access for urgent, out-of-hours and secondary care services. This supported consistent recognition of patients' wishes across services. • The service **maintained a register of over 220 carers, overseen by a named senior lead, with a dedicated Carers Champion providing a single point of contact.** Newly identified carers received tailored information and access to a structured programme of workshops delivered in partnership with local services, supporting carers to manage their role and well-being. Flexible appointment arrangements further reduced the burden on carers. • A **Priority Patient Scheme ensured daily same-day appointment capacity for vulnerable groups**, including those with complex or urgent needs. Patients were identified proactively through clinical systems, ensuring timely access and reducing the risk of unmet need. • A review of **DNACPR records confirmed decisions were appropriately applied and documented**. National GP Patient Survey results showed that 90% of respondents felt involved in decisions about their care. Clinical records and patient feedback demonstrated that patients were supported to understand their conditions and were actively involved in care planning. • The service **pioneered and implemented an Autism Friendly Practice model**, becoming the first practice in the borough to achieve formal accreditation. It introduced a range of tailored adjustments, including named GPs, longer appointments, environmental changes, flexible access and clear communication, supported by staff training and digital systems to ensure individual needs were consistently recognised. This work was co-designed with autistic people, improved access and experience, and was subsequently adopted across the primary care network and borough, gaining national recognition as an example of best practice.
Providing Information	• The service enhanced accessibility further through the development of **an Autism Friendly GP Practice model**, ensuring that patients with autism could access information and care in an environment adapted to their communication and sensory needs. • The service used digital platforms to extend access to health information, maintaining an active social media presence and introducing a **clinician-led video series delivering structured, evidence-based education**. This supported patients to access reliable information outside of appointments and in formats aligned with their preferences. • The service adopted a targeted and intelligence-led approach to communicating with families about childhood immunisations. Population health tools were used to identify patients requiring contact, and communication was coordinated through a dedicated administrative role responsible for call and recall systems and follow-up. This was

	complemented by **themed community events** designed to provide information in a more accessible and engaging format for families who may not respond to traditional methods. • The service also delivered a sustained programme of **free patient education**, including workshops, antenatal classes and well-being sessions, covering topics informed by patient need and clinical priorities. These were delivered in a range of formats, including online and face-to-face sessions, supporting patients to better understand and manage their health. • A **Digital Inclusion Programme ensured that patients who experienced barriers to accessing digital information were actively supported**. This included large-scale engagement events, access to devices, peer support and one-to-one assistance, enabling patients to develop the skills and confidence to use online services and access health information independently.
Equity in access	• The building was open from 8.00am to 6.00pm Monday, Tuesday, Thursday and Friday and 8.00am to 7.30pm on Wednesday. **Extended access clinics were also available** for patients across 3 other local sites from 4.00pm to 8:00pm Monday to Friday and 8.30am to 1.00pm on Saturdays, Sundays and Bank holidays. • The surgery operated a **mixture of urgent and pre-bookable appointments** and an effective monitoring system was in place, which the practice manager or the reception manager oversaw, to ensure **both pre-bookable and same-day appointments were consistently available**, waiting times for non-urgent appointments did not exceed 2 weeks and continuity of care was maintained whenever possible. Home visits were also available at the discretion of a GP for those patients who could not attend the surgery, thereby **ensuring their continuity of care**. • On the day of our visit, we spoke to patients who had been able to secure same day appointments and in feedback to the CQC, patients were complimentary about access to the surgery. One patient stated, "appointments are easily booked as and when required" and another described **how efficiently reception staff responded** to phone calls and emails and **actively followed** up on things. • In December 2025, the service introduced a **redesigned access model**, following a review of patient access, telephony demand, and feedback. The model simplified access routes, reduced reliance on early-morning telephone contact, and strengthened continuity of care, while maintaining clinical safety during winter pressures. Since implementation, the service achieved significant improvements despite a 9% increase in list size. Total telephone calls reduced by 29%, calls per 1,000 patients reduced by 35%, and 8 to 9 am call volumes fell by 40%. Call answering performance also improved, with calls answered within 10 minutes increasing by 21%. A patient survey conducted in February 2026 showed high satisfaction, with 91% of patients finding the system easy to use and 92% satisfied with the timeliness of care. Continuity of care improved substantially, with over 80% of patients able to see their preferred GP when requested. • In response to the 2025 national GP Patient Survey, the **provider introduced a digital improvement programme** aimed in part at **increasing NHS app engagement** as a route for patients to manage appointments and access services. Actions included launching a patient-facing campaign, appointing a digital champion to support

	onboarding, and providing service-based electronic devices to help patients set up the NHS app. As a result, NHS app registrations increased by 11% between January 2025 and January 2026. Monthly NHS app logins rose from 9,243 in January 2025 to 18,321 in January 2026, representing a 98% increase in usage.
Equity in experiences and outcomes	• The service developed a structured programme of equality-focused initiatives, each aligned to a clearly identified need and evaluated for impact. This included targeted support for patients experiencing digital exclusion. A sustained **Digital Inclusion Programme** combined community engagement events, device loan schemes, peer support and one-to-one assistance. This enabled patients to access online services and improved confidence in using digital healthcare, reducing barriers created by increasing reliance on digital access. • The service addressed inequalities affecting children and families through a range of targeted interventions. The service's **Sports Academy** was developed in response to high levels of childhood obesity in the local population, particularly among lower-income and ethnically diverse families and has supported over 200 children since its launch in 2024. The programme was co-designed with local families and delivered free weekly sessions, resulting in improved physical activity levels and 23% of participating children returning to a healthy weight range. Free antenatal classes, funded by the service, removed financial barriers to pregnancy support, improving confidence and preparedness for expectant parents. • The service also addressed inequalities in access and engagement for vulnerable and underserved groups. **A drop-in Health Hub provided integrated support for patients facing housing, financial and well-being challenges,** removing appointment barriers and enabling over 450 residents to access coordinated support. Targeted outreach to underserved communities, including a dedicated event for the local Latino American community, improved understanding of NHS access and reduced barriers linked to language and system awareness. • **Equality in experience was supported through inclusive care practices**. For example, **preferred names** and **pronouns** were consistently recorded and used for transgender patients, ensuring respectful and affirming interactions across all staff. • The impact of this sustained and targeted approach was demonstrated through large-scale engagement, with over 5,000 residents reached, more than 2,300 health checks delivered and over 900 referrals made to support services. Independent validation from Healthwatch confirmed consistently high levels of positive patient experience and **recognised the service as an exemplar in addressing health inequalities**. The service was also invited to share its approach at system-level forums, reflecting recognition beyond the organisation. • Additionally, the service delivered an annual "**Santa Comes to [borough]" community initiative over four consecutive years**, working in partnership with its Patient Participation Group and local volunteers to support families during the festive period. The initiative provided free gifts and inclusive festive experiences for children and families, including events at the practice, community outreach via a travelling Santa sleigh, and visits to local hospitals. This strengthened community engagement, reduced social isolation, and ensured that families facing financial or social challenges were able to participate in seasonal celebrations.

WELL-LED	
Shared direction and culture	• Leaders promoted a **positive, compassionate and listening culture**. Staff reported high levels of support, fairness and well-being, and felt able to raise concerns and contribute to service development. The service demonstrated a well-developed understanding of equality, diversity and human rights, with inclusive leadership behaviours and development pathways that reflected the diversity of the community served. • The **strategy was monitored through governance processes**, with progress reviewed and risks to delivery identified and acted upon. Strategic priorities were reflected in improvements to access, integrated working, anticipatory care and workforce development, and in population-level outcomes such as lower emergency attendance and admission rates compared with local averages. • Communication and engagement across the team were highly effective. There were multiple, well-established forums for sharing information and learning, including **dedicated practice updates for staff**, regular team meetings, whole team learning events, and **structured Quality and Safety meetings**. The practice used a **centralised platform to ensure full transparency** and accessibility, where all key documents, audits, learning from events, and complaints were shared openly, embedding a culture of continuous learning and collective accountability.
Capable, compassionate and inclusive leaders	• Oversight and support for staff were well established. Non-medical prescribers and advanced practitioners worked within a **structured supervision model that exceeded standard expectations**, with both named educational supervisors and daily on-site clinical supervision available. A consistent daily clinical safety model ensured immediate access to senior clinical support, reinforcing safe decision-making and staff confidence. • Leaders prioritised staff well-being and actively sought and responded to staff feedback. The 2026 staff survey showed high levels of perceived support, with no staff reporting that they felt unsupported. Leaders used this feedback to make tangible improvements, including introducing **protected working time and dedicated space for administrative staff to improve focus, accuracy and well-being.** High levels of long-term staff retention further demonstrated a positive and supportive working culture.
Workforce equality, diversity and inclusion	• Leaders undertook reviews of staff pay, incorporating **analysis of the gender pay gap and age-related disparities** to ensure fairness, transparency, and equity across the workforce. Learning and development opportunities were actively encouraged, contributing to a motivated and engaged workforce.
Governance, management and sustainability	• A structured governance framework ensured risks were identified, escalated and managed at the appropriate level. Weekly senior management team and senior leadership team meetings reviewed operational performance and emerging risks, while monthly clinical governance meetings focused on audit outcomes, safety concerns and quality improvement. Learning was shared through whole-practice meetings, and all meetings were minuted with clear actions. A **live risk register was maintained, with risks categorised by likelihood and impact**, assigned named owners and tracked to completion, with relevant findings shared across the wider system.

	• Systems to support learning and improvement were embedded. **Significant events and complaints were reviewed routinely**, with themes used to drive service changes and shared learning across the team. This supported an open and continuous learning culture. • **Operational oversight was strengthened through a bespoke end-of-day supervisor report**, completed daily to capture activity, feedback, complaints and risks. These reports were reviewed by senior leaders each day and collectively at weekly meetings, creating a real-time intelligence cycle that ensured issues were identified and addressed promptly between formal governance meetings. • Governance processes demonstrably led to measurable improvement. **Analysis of performance data identified access pressures and digital underutilisation, directly informing service redesign** and improvement programmes. Clinical audit cycles were embedded, with re-audit demonstrating sustained improvement in prescribing safety and ongoing monitoring planned. External feedback described the service's medicines optimisation processes as particularly strong. • The service demonstrated forward planning through a focus on workforce sustainability, including structured development pathways and training programmes to support future workforce capacity. **Business continuity arrangements were robust and tested under real conditions**; following significant premises damage due to flooding, services continued without disruption and the practice was fully operational within 48 hours. External stakeholders, including the Integrated Care Board, provided positive feedback about the service and raised no concerns. • During the factual accuracy process, the provider submitted additional evidence relating to governance and organisational structure, which supported an uplift in the score from 3 to 4. Taken together, the service's clearly defined organisational structure, well-established leadership tiers and explicit role responsibilities created a governance framework that was consistently understood and applied across the team. Real-time oversight mechanisms, including daily reporting and structured escalation routes, enabled leaders to identify risk promptly and maintain safe, resilient and continuously improving care. This demonstrated an outstanding standard of governance, management and sustainability. • In March 2026, the practice introduced an **enhanced system to strengthen oversight of patient recalls and improve long-term condition management**. This system ensured recalls were fully visible, actively monitored, and consistently managed, leading to improved safety and continuity of care. It also supported a more efficient and patient-centred approach by reducing unnecessary appointments and combining care into fewer, more meaningful interactions, improving both patient experience and clinical outcome.
Partnerships and communities	• Partnership working also extended into prevention and early intervention. In 2024, the service delivered a weekly, **fully funded Sports Academy for local children**, working with professional coaches, youth services and local families. The programme was co-designed with input from 30 families and included structured health huddles focused on nutrition, hydration, sleep, confidence and mental wellbeing. A clinician referral pathway was

	embedded to enable direct referral of children experiencing high BMI, anxiety, low confidence or social isolation into additional youth support. • Since launching, over 200 children engaged with the Sports Academy. Evaluation demonstrated positive and sustained impact, with 23% of children identified with a high BMI returning to a healthy range, 76% reporting increased physical activity outside the sessions, and 95% feeling more confident in sport and physical activity. Family satisfaction was high at 98%. The programme also received external recognition, being **shortlisted for the 2025 GP Awards in the Advancing Health Equity category** and was recognised at the 2025 Personalised Care Awards. • The service strengthened access and equity through a wide range of community-based initiatives aimed at reducing barriers, improving health literacy and promoting prevention. **Large-scale Health and Wellbeing Fairs brought together NHS, council and voluntary sector partners in a single accessible setting**, enabling residents to access vaccinations, health checks, screening sign-ups and social prescribing support. Attendance was high, satisfaction exceeded 95%, and the events contributed to measurable system benefit, including reduced physiotherapy waiting times. • Inclusive community engagement further addressed social isolation and financial pressures. Annual festive outreach events supported families and children, **while Teddy Bear GP Clinics promoted early-years engagement and reduced anxiety around healthcare.** Ongoing weekly and quarterly wellbeing activities, including walking groups, yoga, social groups, acupuncture, Health Hubs and educational sessions, offered regular opportunities for preventative engagement outside traditional appointments. • Following achievement of **Level 4 maturity across all domains within the Modern General Practice framework** (August 2023), the practice was recognised as a **peer support and exemplar site**, supporting other practices through the national model, sharing practical, learning tailored to the needs of individual practices, demographics, and populations.
Learning, improvement and innovation	• Learning and innovation were further supported through participation in targeted prostate cancer early-detection research. **Using primary care records, the service identified men aged 45-69 at higher risk and evaluated two invitation models for PSA-based targeted prostate health checks**. Findings showed higher engagement with a direct, local test-first approach and highlighted data-quality limitations, including under-recording of family history, as well as lower prior screening rates and higher deprivation among Black men. These insights informed improvements to engagement strategies, early-detection pathways and equity-focused service design. • External feedback reinforced this learning culture. **A local councillor described the service as a valued and visible presence within the community**, highlighting inclusive, community-focused care that extended beyond traditional general practice. They noted strong access arrangements, consistently high clinical outcomes, leadership in borough-wide vaccination delivery and innovative community outreach that built trust and familiarity with local residents.

	• Leadership oversight supported continuous improvement. Assurance systems were reviewed regularly, with clinical audit and quality improvement activity demonstrating positive impact on service quality. Clinical supervision was well managed and consistently documented. **A well-established patient participation group met regularly, reported feeling listened to, and contributed ideas to service development.** • Quality improvement activity included structured protocols focused on access and appointment systems, with **staff encouraged to propose and test new ways of working**. The leadership team also worked closely with GP practices within the primary care network and the integrated care board, supporting shared learning and coordinated improvement across the system. • The service received sustained external recognition at local, regional and national level for patient care, partnership working, equity and workforce well-being. This **included winning the 2025 London-wide LMC Award for Non-Clinical Team of the Year** and the **NHS Parliamentary Award for Excellence in Primary and Community Care** (2023), as well as **multiple General Practice Awards**, including winning GP Team of the Year in 2017, 2020 and 2023 and being highly commended for GP of the Year in 2018. The service was also highly commended at the 2025 Personalised Care Awards and shortlisted in multiple categories at the National General Practice Awards, including GP Team of the Year, Public Health and Prevention, Advancing Health Equity and Workforce Well-being. Additional recognition included winning Reception Team of the Year (2023) and Best in General Practice at the Business of Healthcare Awards (2022).

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	• **Not all safety events were discussed or noted in meeting minutes**. There was **no recorded follow up of actions** to ensure that changes had been made and were effective. We saw evidence of disagreement between service leaders as to which events should be managed through the service process, which led to differences in engagement with investigation and difficult discussions in meetings. (Score 2) • Leaders could not demonstrate complete oversight regarding the management of patient safety alerts. For example, we identified 5 patients on a combination of prescribed medicines, who may have been affected by an MHRA alert. **We could not find any record that these patients had been informed of the risks** relating to prescribing outside national guidelines. (Score 2) • The service's track record on complaints had le**d people wishing to raise their concerns to do so through other avenues,** such as with the patient participation group, the Care Quality Commission (CQC) or the local Integrated Care Board (ICB). This was because they were not assured by the practice complaints processes, that they would be listened to and acted upon. There was a lack of insight into how to effectively investigate and learn from complaints. The provider reported a sharp increase in complaints immediately following publication of the CQC inspection report; however, in recent months, complaint numbers reduced. However, overall, we found complaints

First Practice Management

	did not always inform quality improvement. They did not always fully establish the facts that led to the complaint or give a clear rationale of findings. (Score 1) • **The culture within the practice acted as a barrier to staff raising concerns**, with a longstanding perception among some that issues would not be acted upon. The significant event process was also viewed by some staff (particularly non-clinical colleagues) as burdensome and ineffective. This perception was reinforced by limited involvement in reviewing events or receiving feedback on wider learning at a practice level, with feedback typically only provided when individuals were directly involved. Additionally, the process tended to focus on addressing past errors rather than identifying system improvements to prevent recurrence. As a result, significant events were often perceived negatively, contributing to a sense of blame rather than a culture of shared learning and continuous improvement. (Score 1)
Safe systems, pathways and transitions	• While multidisciplinary meetings were arranged, they were not consistently attended by external healthcare professionals. Although these professionals were encouraged to share updates when unable to attend, this did not routinely happen. (Score 2)
Safeguarding	• Training records we checked showed 2 members of staff had not completed safeguarding training appropriate to their roles. There was **no record of completed Mental Capacity Act online training for 3 members of clinical staff** which should be renewed every 3 years. (Score 1) • Staff we spoke with told us the service had a Was Not Brought (WNB) protocol and that they would always follow up on children and vulnerable adults who missed or did not attend at prearranged appointments. However, the GP Partner told us they had **not yet carried out an annual audit of children who were not brought to appointments**, or an audit of attendances at accident and emergency services to identify any patterns which may indicate neglect. (Score 1)
Involving people to manage risks	• We looked at the records of 3 patients experiencing an exacerbation of one long-term condition. **Documentation of follow-up arrangements to re-review patients was inconsistent.** The provider could not consistently demonstrate through the records that patients had been managed and monitored in line with national guidance. (Score 2) • On the day of the site visit, **managers could not show evidence of staff members completed basic life support training.** There was no record of completed sepsis training for 3 members of staff. (Score 2) • Emergency equipment was available and appropriately maintained. However, it was stored in an area that could only be accessed by passing through clinical rooms. This arrangement raised concerns about patient privacy and dignity, as staff may need to interrupt appointments; particularly during intimate examinations; to access the emergency trolley in a medical emergency. (Score 2)
Safe environments	• During the inspection we reviewed the practice risk register but found this **was not routinely used to document risks relating to health and safety.** The risk register **did not include action plans** for managing all identified risks. (Score 2)

Safe and effective staffing	• Non-clinical staff allocated patients to staff in advanced clinical roles based on a list of conditions. The list differentiated some conditions by severity and underlying cause, which would require clinical knowledge. This could lead to **patients being inappropriately triaged** to staff in advanced clinical roles rather to than GPs. (Score 1) • A review of staff records undertaken during the inspection identified that appropriate Disclosure and Barring Service **(DBS) checks were not consistently completed for all staff members**, in accordance with safer recruitment practices. • The service had a recruitment policy, but recruitment checks were not consistently followed. Some recruitment information was unavailable. For example, of 6 staff files reviewed, **3 clinical staff did not have recorded employment references**. We checked 6 staff files. Two contained DBS certificates dated 2015 and 2020. The remaining four staff files did not contain DBS certificates but only a record that a basic DBS check was carried out. • Systems to oversee staff training were not effective. Although training software was in place, managers had not established effective systems to monitor staff completion of mandatory training. Of 6 staff files reviewed, the training records of **two clinical staff and one non-clinical staff member were incomplete**. Safeguarding training was not fully compliant with intercollegiate guidance, and there was no record of completed fire safety training for 2 members of staff. (Score 1) • Records of staff vaccinations were incomplete and not maintained in line with Green Book guidance. **Hepatitis B immunisation history had not been collected for three staff** at risk of blood exposure. There was also insufficient recording of which staff were up to date with their **routine immunisations**, for example, tetanus, diphtheria, polio and MMR. Where staff declined immunisation, **risk assessments had not been completed**. (Score 1) • Leaders had not consistently prioritised staff development and appraisal. **Six staff had not received an annual appraisal**, and this had not been clearly identified by managers. (Score 1) • There was insufficient evidence that staff had received training to support people with autism or learning disabilities. **Three of five staff files reviewed did not include records of this training**. (score 1)
Infection prevention and control	• The service had assessed the risk of infection, and had taken actions to manage it, however **staff who completed the assessment were unable to explain why one risk identified had not been acted upon**. The service collected information about staff immunity on recruitment. We looked at the records of 3 staff members. Two of these had information that showed immunity in line with national guidance. The third staff record had some information, but the process was not sufficiently well-documented to demonstrate that national guidance was followed. (Score 2) • At the time of our inspection, the GP Partner was acting as the IPC lead but explained that the role would shortly be taken over by the PCN senior nurse as the service had no permanent practice nurse. When we checked staff files, we found **some staff had not completed mandatory IPC training relevant to their roles**. (Score 1)

	• **Staff could not show us a cleaning schedule** and there was no system of checking which cleaning tasks had been completed by the cleaning contractor and that they had been done at the recommended frequency. (Score 1) • **Managers could not show us evidence of a waste consignment agreement**. There was no Control of Substances Hazardous to Health (COSHH) risk assessment available. Staff could not show us any data sheets for substances stored on the practice premises. Staff we spoke with were **not aware they had to have a COSHH risk assessment.** (Score 1)
Medicines optimisation	• Medicines (including controlled drugs were stored securely and at appropriate temperatures, but the provider's **system to verify the correct storage temperature of vaccines was not consistently effective**. (2) • The provider had completed a risk assessment and identified the need to store the Automated External Defibrillator where it could be accessed rapidly. The risk assessment did not consider the risk of potential delays in access to other emergency equipment and medicines, in line with the most recent guidance. (2) • Most people had received the monitoring required. In patients that had not, we **did not see evidence of a consistent documented approach to follow up** to ensure these patients received the monitoring required. (2) • Patients prescribed a disease-modifying antirheumatic drug (DMARDS) had not always received appropriate monitoring. A clinical search identified 20 patients taking the high-risk medicine methotrexate (a medicine used to suppress the immune system). We reviewed 3 patients prescribed methotrexate and found all 3 patients had not had required monitoring in the last 6 months. The practice escalation protocol to follow up non-responders was ineffective. All 3 did not have up to date blood tests in the record. One of the patients was under secondary care for monitoring. It was unclear as to whether alternative methods of communication were tried, and medication quantities adjusted to prevent potential harm. (Score 1) • There were 71 patients taking ACE inhibitors (a medicine used to treat high blood pressure) identified by a clinical search who had not had required monitoring (nearly 10%). We looked at 5 patients and found although monitoring was up to date, **3 out of 5 patients had not been responding to requests to come in for monitoring tests**. The practice escalation protocol had not ensured that non-responding patients were followed up. There was no note recording what the next steps were for patients who were not compliant. (Score 1) • We found **one emergency medicine was out of date** which had not been picked up by staff.
EFFECTIVE	
Assessing needs	• We looked at the records of 3 patients experiencing an exacerbation of one long-term condition. 2 of 3 the records reviewed **records did not have enough detail to show that staff made a sufficient assessment** of the patient before prescribing, and there was no rationale for this divergence from national guidelines in the notes of these patients at the time. • We saw that two patients with one condition **did not have an active code for that condition on their patient record**. The provider told us that this was intentional coding in response to patients not responding to follow up with the practice for a long period. This may present a potential risk to patients, particularly if care is transferred

	between providers or information is viewed through shared care records, as it may reduce visibility of an active long-term condition. It may also affect recall processes and limit opportunities for providers to encourage patients to re-engage with monitoring and review. (2) • From our review of patients with long-term health conditions **patients with potential diagnoses of diabetes were being missed for appropriate review and follow up**. The management of these patients was not always in line with national guidelines. We found one patient had not had appropriate follow up when their last two readings confirmed a diagnosis of diabetes. Patients were therefore at risk of diabetic complications. (Score 2)
Delivering evidence-based care and treatment	• We looked at the records of patients experiencing an exacerbation of one long-term condition. Patients were not followed up in line with national guidance to assess the effectiveness of treatment. Where clinical management differed from national guidance, we **did not see a documented rationale for this in the patient records**. Patients received an annual review of their condition. However, we saw a record where it was not possible to evidence that the review was effective, as it did not accurately record the exacerbations the person had experienced. The provider told us that this was a documentation error. • There was **no consistent system to follow up on people who did not respond to routine requests** to have monitoring or review, or who were not requesting required medicines. (2) • Information had not been placed on patient records to ensure that it was safe to continue to prescribe and that the patient received timely care and treatment. Staff had not always followed escalation protocols which set out the process, or action to be taken if patients did not respond to appointment invites or failed to attend appointments. (score 2)
Monitoring and improving outcomes	• The practice **had not met national targets for immunisations or cervical screening**. The latest published immunisation data covers the period 01/04/2023 to 31/03/2024. The provider told us that shortly before this the service had changed to a new patient record system, and coding inconsistencies affected the data used for the national analysis. The practice sent us more recent data that showed that immunisations uptake had improved but remained below national targets. The practice data cannot be directly compared to the data used for reporting by CQC as it has not been nationally validated. • The practice told us that there was a period where staff changes meant **cervical screening could only be carried out using appointments at weekends and at the local hub service**. The practice had an action plan in place to improve uptake and showed us unverified data that suggested improvement, although this data cannot be compared directly to the data used by CQC for reporting. (2)
Consent to care and treatment	• We observed **2 patients did not have a DNACPR form** documented in their records. It was not clear whether decisions about CPR would be reviewed at the appropriate interval. (Score 2)
CARING	
Workforce wellbeing and enablement	• We found there remained a clear **divide between staff who supported the provider and those who did not**. Staff continued to report the situation in the practice as a turbulent and unstable time for them. They spoke of constant

	change, poor communication and uncertainty on current policies and procedures. The culture in their workplace remained stressful and staff morale was low. Some staff described the atmosphere as 'toxic', **with concerns about psychological safety.** There were gaps in communication channels, particularly for non-clinical staff and the pharmacy team. This was hampering productive working relationships. A new suite of personnel policies had been developed and introduced to support a better working environment. However, these had not had a significant impact on the working environment. (Score 1)
RESPONSIVE	
Listening to and involving people	• Although administrative changes had been made to improve the tracking and monitoring of complaints, they had not improved the quality of the complaint responses provided. In the examples we reviewed we found the provider did not always provide a chronology of events or other important information to evidence their findings. They did not come to robust evidence-based conclusions or give a clear rationale for their findings. There was evidence of significant delays in responding to some complaints. The provider did not demonstrate they had learned or improved because of complaints. (Score 1) • The Patient Participation Group (PPG) expressed significant concerns about the way the practice listened and learnt from the feedback provided by themselves as a group, as well as individual patients. They told us there were common themes to the feedback they had given to the practice, but they remained unconvinced that the provider listened or responded to these matters. The PPG told us they felt there was a lack of respect from the provider about the work they had done and the feedback they provided. The relationship between the provider and the PPG did not always lead to productive change. However, both sides told us they were still willing to engage and were hopeful that positive change could be achieved in the future. (Score 1)
Equity in access	•
WELL-LED	
Capable, compassionate and inclusive leaders	• As in previous inspections, we saw evidence of a culture where **leaders did not work as a team and where differing views relating to ways of working were not handled effectively** between the leaders, leading to open disputes in meetings which were not resolved. Staff told us that this represented an open culture and this did not significantly impact on morale or ability to complete tasks. (Score 1)
Freedom to speak up	• 3 members of staff we spoke with **did not know who the Freedom to Speak Up guardian was** (FTSU). Information about the freedom guardian was available as a poster in staff areas but contact information was not included in the Staff Handbook. (Score 2)
Governance, management and sustainability	• As part of the assessment, we were sent examples of minutes of clinical meetings, practice meetings and patient participation group meetings. Most of the meeting **minutes we reviewed did not have actions agreed** in the meeting clearly identified and there was **no consistent, documented, follow-up of actions previously agreed**. **Not all clinical staff were invited** to clinical meetings or received the minutes. (Score 1)

	• Staff had **not always followed practice policies in relation to infection control, recruitment checks and staff training.** Managers had not met with all staff annually to complete appraisals and performance reviews. Systems for responding to medicines safety alerts and documenting DNACPR decisions required improvement. (Score 1) • Regular searches of the clinical record system were being run to identify patient needs and ensure these were being met. However, our review of clinical records showed that this was not always effective. Consistency in the monitoring of people's medicines was needed to make sure blood tests were carried out prior to a review or prescription being issued. • **Staff expressed frustrations with the continual changes being made to policies and procedures and poor communications around this**. There was a lack of an effective strategy to tackle the cultural issues within the practice, which was risking the ability of the practice to continue to improve. There was a limited forum for non-clinical staff to influence change. Learning, improvement and embedding of good practice was ineffective, as the practice did not routinely learn from complaints and significant events. Clinical audit processes were at an early stage.
Learning, improvement and innovation	• In 2021 we found that there were disagreements between the partners about incidents that were identified and discussed, and that there was **limited collaboration between partners on events that affected the practice, such as significant events and complaints**. We found the same at this assessment. (1)