

CQC Inspection Reports Published in March 2026

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

Outstanding Performance (scores of 4):

EFFECTIVE	INSPECTION COMMENTS (all scored 4 by CQC)
Assessing needs	<ul style="list-style-type: none"> • Patients shared examples of how cultural sensitivities were considered in practice, including the provision of female-only exercise sessions to support reductions in BMI and blood pressure. • Staff at all levels had access to the business continuity plan via an app on their personal mobile devices and were involved in its development • We were shown a range of standard clinical templates that had been adapted by the practice to maximise the capture of relevant clinical information, supporting effective care delivery and informed clinical decision-making and auditing. • The provider had effective systems to identify people with previously undiagnosed conditions. The practice proactively used population health management tools to assess needs and improve outcomes for patients. One of the GP's had completed a population health management programme with the aim of understanding population health better. For example, they focused on pre-diabetes patients, particularly those who were not engaging with education and lifestyle changes. They organised a meeting with a range of partners including public health, the National Diabetes prevention programme and a team of data analysts. Patients who were not engaging with pre-

	<p>diabetes monitoring, were selected, focussing on patients who had factors suggesting barriers to accessing healthcare. Data available identified 89 pre-diabetic patients with co-morbidities. Patients were contacted and introduced to the project.</p>
Delivering evidence-based care and treatment	<ul style="list-style-type: none"> • Systems were in place to ensure staff were kept up to date with evidence-based guidance and legislation. This included a fortnightly practice newsletter highlighting updates in clinical practice, changes within the practice, and key learning points. Daily staff huddles, along with monthly training sessions and staff meetings, reinforced these updates and provided opportunities to share learning. The practice also held regular staff quizzes, with prizes, to reinforce learning, training, and updates in information in an engaging way.
Supporting people to live healthier lives	<ul style="list-style-type: none"> • Wellbeing Hub, which delivered 14 structured wellbeing initiatives, including a weekly walking group and a weekly in-house cooking programme run from a purpose-built, approved kitchen. Between December 2024 and December 2025, the programme supported 179 patients and achieved strong clinical outcomes, with 58% of participants showing improvement in at least one clinical area, including reductions in weight (43.5%), HbA1c (31.3%), and cholesterol levels (15%). Sustained improvements were seen across multiple clinical measures for some patients. Patient-reported outcomes were also positive, with 60–90% improvements across wellbeing indicators and 73% of participants reporting overall improvement with no deterioration. The programme demonstrated wider system impact, receiving 328 referrals from other Primary Care Network practices within one year. • The practice had set up a respiratory support group and supported the practice nurse to develop advanced skills in Chronic Obstructive Pulmonary Disease (COPD) and asthma in order to improve management of these conditions. They had also purchased a FENO (Fractional Exhaled Nitric Oxide) machine (used to aid in the diagnosis of asthma) to enable patients to access this service locally and in a timely way. • The practice had worked with the Integrated Care Board’s vaccinations team to implement strategies to address patients’ hesitancy for vaccination and improve uptake which included training for all staff.
Consent to care and treatment	<ul style="list-style-type: none"> • Following an area that had been highlighted at our previous assessment, one of the GP partners led discussions at PCN level relating to completion of ReSPECT forms. They worked with a palliative care consultant to contribute to a refresh of the county-wide ReSPECT policy which resulted in simplification of clinical authorisation and the introduction of a standardised template in care settings. • The in-house Neighbourhood Nurse carried out capacity assessments and supported RESPECT (Recommended Summary Plan for Emergency Care and Treatment) form completion, enabling informed care and end-of-life decisions. • The practice had a higher-than-average LGBTQ+ population and staff had identified a need for sensitive discussions about birth gender screening. As a result, staff members attended targeted NHS training, following which the practice introduced rainbow signage, gender-neutral toilets and same-gender chaperones.

Monitoring and improving outcomes	<ul style="list-style-type: none"> The nursing team had recorded a podcast on their “Whalepod” outlining the challenges of increasing the uptake and how they planned to improve things. The vaccine champion had also completed a training session for the in-house podcast on how to help educate parents on vaccine hesitancy.
CARING	
Kindness, compassion and dignity	<ul style="list-style-type: none"> Bereaved family members received cards which offered the service’s condolences and signposted families to the dedicated web page for further support.
Workforce wellbeing and enablement	<ul style="list-style-type: none"> Staff completed annual wellbeing surveys and changes had been made following staff suggestions. These included providing a standing desk, reducing the brightness of the lighting in reception, phasing out lunch time meetings so staff had a proper lunch break and adjusting timetables to enable travel for home visits. Seasonal wellbeing weeks were organised 4 times a year, involving team building through craft activities, competitions and activities which helped staff to get to know each other better. The service had introduced a “positivitree” and rainbow into their common room to promote positive affirmations of staff towards each other (on the positivitree) and to celebrate achievements (gold coins on the rainbow). Staff told us this has been an excellent way of promoting positive feedback and to raise morale when things are difficult. These were made by members of their wellbeing committee. The positivitree affirmations were collected every so often and placed in a Wellbeing Newsletter which was circulated to all staff. We saw team building days and social events were established within the practice. Recent events included a treasure hunt around the local town and chair yoga with a view to build strength, stability, flexibility alongside mental clarity and fun within the team. Given the relocation from a small practice to a large multi-service modern building hosting 2 practices in 2022 (a significant upscale in size), staff reported opportunities to gather as a team had reduced. Leaders acted upon staff suggestions to recreate the previous small practice environment with the creation of a coffee/tea break area alongside scheduled break times. This increased the potential for team collaboration and created a sense of team, despite being in a large building. Staff feedback was positive regarding this initiative, with staff reporting it boosted their productivity, stimulated creative thinking and supported their wellbeing.
Treating people as individuals	<ul style="list-style-type: none"> The practice had identified that there were a number of military veterans in their patient population (45 patients) and had taken action to help ensure this group of patients received suitable individual support including access to appointments and referrals to dedicated NHS services such as OpCOURAGE (the veterans mental health and well-being service). We noted this was in line with the Government’s Armed Forces Covenant. The practice encouraged these patients to identify themselves through signage at the practice, military veteran information packs, information on the practice website and via questions on the ‘new patient’ form. Feedback we saw highlighted examples when the practice had gone above and beyond to support neurodivergent patients and their individual preferences. For example, prior to the relocation to the new premises, neurodivergent patients and their families could visit the new premises to acclimatise to the new, unfamiliar surroundings such as the waiting areas and treatment rooms.

	<ul style="list-style-type: none"> • Staff told us how they supported minority and marginalised groups of people for example people from the lesbian, gay, bisexual, transgender, queer or questioning, or another diverse gender identity (LGBTQIA+) population. Information to support this group of people was available on the practice website. The service had participated in a pilot project for the national opt in process for transgender and non-binary cervical screening. Following the national implementation of the service, practice staff repeated the search and re-invited those eligible who had not yet attended for cervical screening. • The service had identified 719 people registered with the service as carers which was 6.5% of the practice population. Carers were offered health checks and vaccinations and could be referred to the social prescriber or care co-ordinator for information and guidance on support available to them.
Independence, choice and control	<ul style="list-style-type: none"> • The practice had implemented a new process (and additional alerts for staff to check, discuss and amend if required) regarding parent/guardian proxy access for those patients aged between 11 and 16 in addition to those aged over 16. The aim of this was to raise awareness to this cohort of patients to ensure they were aware of changes in data sharing, whilst ensuring confidentiality was respected and patients had control and oversight over their care. The reception manager audited proxy access each month to ensure access was accurate and up to date.
RESPONSIVE	
Care provision, integration and continuity	<ul style="list-style-type: none"> • The practice had tailored its services to meet the diverse needs of its community, for example by building strong relationships with local charities, mosques, and community groups, and delivering outreach engagement and education sessions in local markets, both within and outside of normal practice opening hours, to promote the uptake of screening programmes. These partnerships also supported ongoing community outreach and engagement sessions focused on topical health issues and areas of concern for the local population. • The social prescriber had created a local NHS wellbeing hub which patients could access and provided peer support groups for bereavement support, respiratory support, menopause and chronic pain. There were also other groups such as art therapy, yoga and gardening groups. Patients were still able to attend these supportive groups after their work with the social prescriber ended to maintain the benefits achieved and continue supporting their wellbeing to avoid further issues. • We saw the practice worked in partnership with other services to meet the needs of its patient population and the wider community. For example, in addition to the standard General Medical Services (GMS) contract, the practice also provided the county-wide non-urgent community Ear, Nose and Throat (ENT) service from the practice. Approximately 4,000 patients from GP practices accessed this service each year for a range of conditions. This service was run by 2 GP partners and a salaried GP who had additional specialised ENT training. The practice shared data which demonstrated the positive impact the community ENT service had, including a significantly shorter waiting time (average of 8 weeks as opposed the national average of 18 weeks) with less than 5% of cases referred on to secondary care. • The practice had also completed a piece of work in partnership with public health to identify patients at risk of harm from “cold environments” winter warmth programme. They used a risk stratification tool to identify high

	<p>risk patients and booked them appointments with their health and wellbeing team. In conjunction with the social prescriber they discussed energy saving devices, tips to stay warm and exercise groups. Practical support was provided by the practice including providing free electric hot water bottles. They conducted this exercise annually. In 2025 they contacted 490 patients at risk to morbidities of heart failure, COPD and heart disease. There was a 17% uptake of this service.</p>
<p>Person-centred care</p>	<ul style="list-style-type: none"> • The practice team consistently demonstrated a holistic approach to care with individual patient needs at the centre of this. There was a high referral rate within the practice to the social prescriber, compared to other practices in the area. • To further support patients holistically the practice had initiated and created a Wellbeing Garden on land adjacent to the practice which was used by patients with learning disabilities and mental health needs. They had also initiated and developed hydrotherapy sessions, a wellbeing hub with various support groups and health walks to benefit their patients. These were all well attended. • Staff gave an example of how they were person centred in relation to laboratory results. They had a standard operating procedure outlining how abnormal results needed to be communicated. They did not send generic template messages. Instead, GPs contacted the patients to explain the results, even if they needed another appointment.
<p>Providing Information</p>	<ul style="list-style-type: none"> • In 2024–25, the practice focused on building trust with families to improve childhood immunisation uptake through clinician-led workshops, community discussions and one-to-one nursing support. Feedback highlighted concerns about autism, allergies, neurological conditions and online misinformation, which informed improvements to recall processes and patient messaging. Uptake improved steadily with closer clinical oversight, including a dedicated healthcare assistant contacting hesitant families, targeted recalls in community languages and nurse-led community engagement. The third DTaP dose before 8 months increased from 54% in June to 91% in December, and first MMR uptake at 12–18 months rose from 59% in July to 87% in December. Uptake for children aged 1–5 years requiring two MMR doses and a DTaP/IPV booster increased from 77% to 84%, with the practice recognising ongoing challenges such as non-attendance, mobility and entrenched hesitancy. • The practice employed a full time Bengali speaking interpreter and had access to interpreter services, including British Sign Language. Information provided by the service met the Accessible Information Standard. Patients were informed as to how to access their care records. • Flags were added to patients’ individual records and the practice phone system. This enabled reception staff to be aware of someone’s need before they answered the phone. • The practice had a very comprehensive website with information for patients including booking appointments, test results, prescriptions and self-help leaflets. It was available in over 21 languages of people who used the service including Spanish, German, Arabic and Romanian.
<p>Listening to and involving people</p>	<ul style="list-style-type: none"> • Complaints were managed in line with the practice’s policy, and patients and staff could access complaints forms via QR codes around the practice or as hard copies. Information on how to complain was also available on

	<p>the practice website and in the practice leaflet. Learning from complaints was clearly evident, with changes made as a result of patient feedback shared widely through a twice-yearly practice learning time (PLT) dedicated to complaints, in the staff newsletter, and on a “You Said, We Did” poster so patients could see the impact of their feedback. Complaints were also a standing item on the monthly practice meeting agenda, and where relevant, learning was signed off by the Patient Participation Group (PPG) to ensure changes reflected the patient perspective.</p> <ul style="list-style-type: none"> • The practice website included a section known as ‘Have your say’. This was a designated section of the website which enabled patients and their families to be involved and share feedback, ideas and opinions. There were 6 separate topics of feedback (compliments and suggestions, complaints, NHS Friends and Family Test, information about the patient participation group, the patient survey and patient opinion). We saw all 6 topics were regularly reviewed to provide oversight of patient feedback.
Equity in access	<ul style="list-style-type: none"> • Following a significant rise in telephone demand after COVID, the practice reviewed how calls were handled and made a number of changes to better meet patient needs. Call flows were redesigned based on how long callers were willing to wait, staff start times were adjusted to match peak demand, and the reception manager role was reshaped to focus on actively managing call flow. Non-patient-facing tasks were rescheduled, self-service options were expanded through the NHS App, call-backs were introduced, appointment checks and cancellations were automated, and telephone system coding was improved to reduce unanswered calls. These changes led to a 30% improvement in patients finding it easy to get through by phone (compared with 3% nationally), alongside a 13% improvement in both contact and overall experience. Missed calls reduced from 50% between July and November 2023, to 30% over the same period in 2024, and then to 8.7% in July–November 2025. Total call volume fell by 12%, from 1,392 to 1,222 calls per week, answering times improved by 76%, and abandoned calls reduced by 9%. This approach was shared through EQUIP to support quality improvement coaches and has been adopted by two further NEL practices, resulting in measurable improvements, including a 77% reduction in peak waiting times at a neighbouring practice. • One provider looked closely at how patients were accessing the service and made changes to improve this. One key change was the introduction of a Duty Doctor “Hot Triage” model, with a GP based in reception who clinically triaged all appointment requests and urgent queries. This meant patients could be assessed quickly, reception staff could work closely with a GP, and acutely unwell patients could be reviewed straight away. As a result, many issues were safely dealt with at the first point of contact, with around 466 patient queries managed each week (about 200 consults and 266 urgent contacts). This reduced pressure on routine appointments, freeing up around 296 GP appointments each week and significantly improving access, safety and responsiveness for patients. • The practice had installed a medicine vending machine outside the practice to enable patients to collect their medicines at a time to suit them 24 hours a day.

	<ul style="list-style-type: none"> • A FENO (Fractional Exhaled Nitric Oxide) machine (used to aid in the diagnosis of asthma) had recently been purchased by the practice to help address health inequality and offer the service inhouse to allow quicker diagnoses and to avoid patients having to travel. The practice had helped to establish a volunteer car service, which transported patients to social prescribing and wellbeing groups ensuring inclusivity and equity of access. • 80% of respondents found it easy to get through to the practice by phone. This was significantly higher when compared to both the local average (54%) and national average (53%). • 75% of respondents found it easy to contact the practice using the practice website. This was significantly higher when compared to both the local average (51%) and national average (51%). • Over the last 9 months the number of patients accessing urgent treatment at other services such as the local urgent treatment centres was lower than the local average for the ICB and PCN averages. For example, in October 2025 the total percentage of patients attending alternative urgent care was 1.2% compared to the PCN average of 1.7%, in November 2025 it was 1.1% compared to the PCN average of 1.7% and in December 2025 it was 1.4% compared to the PCN average of 1.9%. • The practice reception was open for patients from 7am to 8pm. Patients could attend and make appointments, get information or advice during these times.
Equity in experiences and outcomes	<ul style="list-style-type: none"> • Some initiatives were gender-specific, such as Women’s Keep Fit, Women’s Healthy Lifestyle Improvement, and Men’s Fitness sessions (both indoor and outdoor), which supported participation from patients who may otherwise feel unable to engage due to cultural or personal preferences. Other initiatives included wellbeing walks, chronic pain management groups delivered in both English and Bengali, community gardening, morning coffee and fitness sessions, guided trips, massage courses, and youth empowerment programmes. These initiatives were delivered in accessible, community-based settings and were open not only to patients registered at the practice but also to patients from neighbouring practices, supporting wider population health and reducing inequalities across the local area. Clinicians attended the sessions, enabling relaxed, non-clinical conversations that helped build trust, improve engagement, and shape support around patients lived experiences, improving how they were supported by the practice. • They worked closely with local organisations to ensure continuity of care. Homeless people could register without an address. Once registered they offered same day appointments and were always seen on the day they requested to be seen. Recognising the vulnerability of this group the practice implemented a “one stop shop”. This meant that once a patient was in the building they dealt with all their needs including carrying out blood test, vaccinations and any other service they may need access to whilst in the practice. All homeless patients were flagged in the electronic recording system so staff were aware and could offer the one stop service to them. At the time of our inspection, they had 45 homeless patients who they were supporting and tailoring services to their needs. This included some patients who were undergoing treatment from secondary care services which was co-ordinated by the practice (so all referral letter, hospital appointment details were available for them to access via the practice).

	<ul style="list-style-type: none"> • One issue identified was that asylum seekers often wait to access services when they are at crisis point and often present at accident and emergency (AE) departments. To combat this, they had developed a system in conjunction with partner organisations. The practice was part of a project working on improving the experiences of asylum seekers. Initially they attended a local hotel to register the patients. Those who did not want to register during the visit were offered an appointment at the practice where they could register later. Following this they provided organisations with paper registration forms so there were no barriers to accessing registration via the online form. Patients were also offered an Asylum Seeker Healthcheck, (some of these were initially carried out at the hotel but after feedback this was moved to the practice). • Recognising delays in patients accessing mental health services, the practice arranged for two GPs to complete mental health diplomas so they could offer additional support and manage more complex mental health patients with psychiatrist support. In response to dermatology clinic wait times they set up an in-house skin clinic training two GPs to complete diplomas in dermatology and minor surgery. Thirteen appointments per week had been added resulting in 700 patients being seen (and not having to wait for the hospital referral).
WELL-LED	
Shared direction and culture	<ul style="list-style-type: none"> • Staff were aware of the practice vision and strategy, which was displayed in the practice and on the practice website and kept under review. Staff told us they had contributed to the most recent version of the mission statement demonstrating the service valued and actively engaged staff in the direction and plans for the practice. • The practice mission statement was: “Caring for our community”. The mission statement was supported by 11 separate strands, referred to internally as the collective vision which were joined by 5 practice values: Caring, Accountable, Fair, Professional and Evolving.
Governance, management and sustainability	<ul style="list-style-type: none"> • Staff working in enhanced roles had regular clinical supervision meetings, in addition to regular debrief sessions at the end of clinics. Staff told us they valued the debrief sessions as they provided feedback on consultations which had taken place that day, and they could incorporate any suggestions immediately into their practice going forward. Leaders also worked with staff working in enhanced roles through joint clinics, and there were regular skills reviews with the health care assistant. These processes provided the opportunity for constructive and supportive dialogue between leaders and staff, and the opportunity for leaders to assure themselves staff were competent in their roles. This demonstrated the practice’s commitment to patient safety, personalised care, and continuous quality improvement. • Individual teams had their own meetings but also came together for whole practice meetings. Managers clearly recorded any actions arising from these meetings and ensured they shared these with staff. • The service routinely reviewed all deaths, and new cancer diagnoses to identify good practice as well as any learning or gaps in care. These reviews had resulted in the introduction of annual reviews for people with chronic degenerative neurological conditions, flank pain as a red flag for an urgent appointment and consider cancer if persistent musculoskeletal pain or a dropping blood iron levels.

	<ul style="list-style-type: none"> The practice used Artificial Intelligence (AI) tools in the delivery of care and treatment. A GP partner led on this workstream and governed the practice's use of different AI tools used. This was in accordance with the NHS Digital clinical risk management standards, the Digital Technology Assessment Criteria and other digital and information security standards.
Partnerships and communities	<ul style="list-style-type: none"> The service recognised the during the pandemic, the 'lockdowns' had a profound impact on people's mental health and increased social isolation. As a consequence, they wanted to give back to the community and to support people experiencing poor mental health and social isolation, by creating an environment where for people to sit and meet with others, Since 2021, the service has developed a community garden at the front of the building as a way of integrating with the local community and providing a pleasant open space for people. The garden has developed over time, and a local charity for people with acquired brain injuries works in collaboration with the practice to maintain the garden area and provide valuable rehabilitation activities for their members. Members of the community have contributed painted stones with positive messages on and a handmade bird house. The service was invited to apply for [city] in Bloom and were awarded best in category in the 2025 completion in recognition of the work done for the local community. The service also worked in collaboration with the local Wildlife Trust and had funded 5 walks a year since 2022. The service told us this helped to support isolated people in the community to engage with and develop social relationships. The PPG had encouraged the service to increase their presence on social media through daily posts. The service used this platform to promote national campaigns such as breast cancer awareness and updates on the measles, mumps and rubella (MMR) vaccines, as well as general information, for example healthy eating. The service had also developed an information leaflet on wait times for referrals and blood test results, following a suggestion from the PPG. The PPG planned to engage more with community groups to identify any areas for improvement for specific groups of people and had established links with the PPG for the wider area. The service had been instrumental in the development of The FACT service, a primary care network (PCN) level enhanced frailty service with one of the GP Partners as the clinical lead. The FACT team supported the enhanced care needs of people referred to them from across the PCN.
Learning, improvement and innovation	<ul style="list-style-type: none"> They had commissioned and implemented an AI process to improve efficiency across various teams within the practice. This process was underpinned by the relevant safeguards to ensure safety and mitigate risk, and this included the relevant clinical risk assessment to comply with commissioner requirements. There was a human element involved in reviewing quality and safety, involving regular and frequent checks and recording any issues which could be addressed directly with the provider. Analysis had shown that there was a significant improvement in efficiency, meaning that staff time usually spent on this process could be diverted to other tasks. Staff we spoke to, who used the new AI processes were complimentary of the new tools, advising the tools and processes helped them work more effectively and allowed for more time to spend with patients. Several members

of staff highlighted the **increased time they now had with patients** correlated with improved patient satisfaction scores.

- The GP Partners had an **established history of academic and research activity**, having previously worked at the local university lecturing on primary care focused research and GP partnership roles in practice. The development of a new initiative, The Deck, which started in December 2025, with **regional Health Innovation funding** and one of the doctors as clinical lead. The service will offer an **enhanced level of care in order to mitigate the impact of trauma/adverse childhood experiences** on future health and wellbeing.
- The GP Partners regularly **presented work undertaken at the practice at national and international conferences**. They had presented improvement work at national RCGP Annual Conference for the last 3 years. This included 'Using case studies and a toolkit approach for improving care for high volume users in primary care', and 'Understanding and improving continuity of care in general practice'. Both GP partners had authored a number of publications over recent years and acted as topic advisor for the latest osteoarthritis guideline produced by NICE in 2022.
- Several members of staff told us they had been **supported by the service to gain additional qualifications**. This included General Practice Nursing, supplementary prescribing and advanced clinical practitioner.
- One of the practice nurses had received the **GPN Fellow of the Year 2025** award from the GPN Foundation School. This was in recognition of their resilience, peer support, practice improvement, positive impact, and dedication to **exceptional patient care** as a General Practice Nurse.

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

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



	INSPECTION COMMENTS <i>(all scored 1 or 2 by CQC)</i>
SAFE	
Learning culture	<ul style="list-style-type: none">• People reported feeling discriminated against when they raised concerns about safety and ideas to improve, and the providers primary response was to dismiss these.• We reviewed information where staff had attempted to discuss poor practice and had been told by leaders that it was not to be discussed. The same incident had not been recorded on the significant events log that we reviewed. Representatives from the Patient Participation Group (PPG) felt the provider did not take concerns



	<p>seriously and felt that more recently aside from changes to the triage system, there had been a lack of any other changes.</p> <ul style="list-style-type: none"> • We reviewed information relating to patient safety. We found this was not being logged accurately or in a timely manner. Furthermore, we established this was not reported to NHS England in line with their Reporting Safety Incidents Policy. We identified errors within Patient Specific Directions (PSD's) that had not been identified by staff within the practice. • Staff told us they were only directly invited to [complaint investigation] meetings if the context was relevant to them. This meant that opportunities to share learning more widely across the staff team were missed. It was unclear at the time of our inspection how important information was shared. The practice manager told us staff had requested changes in communication; however, this had not been embedded. • Learning from events was not consistently completed. For example, a person experiencing chest pain presented at the service when no clinician was on site. The person was directed to attend the local hospital's emergency department. A significant event was raised, and an action was set to update the service's chest pain protocol. However, when we reviewed the protocol, it had not been updated to reflect what staff should do if this situation occurred again, nor was it displayed in the reception area for staff to access. This information was shared with the service leaders so they could make the changes they originally planned. • The service was unable to provide any meeting minutes, or evidence of discussions held with the service team or with other multidisciplinary teams where significant events and associated learning had been reviewed.
Safe systems, pathways and transitions	<ul style="list-style-type: none"> • At our last assessment in February 2025, clinicians reported that they had excessive numbers of results to review, which posed a potential risk to patient safety, due to the length of time taken to review results and, if appropriate, begin treatment. At this assessment, one of the GP partners reported that results were allocated to them for tests that they did not request. The practice attempted to improve the time in which test results were reviewed by giving clinicians administration time for the task. However, we found that a number of test results had not been checked and remained unfiled, some of which had been received by the practice 2 weeks earlier, and which could have potentially contained results requiring further investigation. • The practice reported that they did not routinely take action if a child was not brought to an appointment. We identified a child who was not brought to an appointment scheduled to review their long-term condition. From this child's clinical record it was evident the child's long-term condition was not well-managed and the current management plan was not effective. There was no evidence the missed appointment was flagged and reviewed and no plan to reschedule the appointment. • There were 232 pathology test results awaiting review, including both normal and abnormal results. The oldest result dated back to 5 September 2025. This backlog presents a risk as delays in reviewing results may lead to missed or delayed treatment, putting people's health and safety at risk.

	<ul style="list-style-type: none"> Staff told us a nurse also supported with checking incoming test results and would inform a GP of any concerns when required. However, training related to interpreting test results could not be evidenced for this nurse during the inspection.
Safeguarding	<ul style="list-style-type: none"> The practice maintained a list of vulnerable people however, systems to corroborate this with the wider multi-disciplinary team were not in place. Alerts were added to the records of people with a safeguarding concern however, alerts had not been added to the records of people living in the same household. Safeguarding policies were in place and known to staff. However, the policies made no reference to human trafficking or radicalisation. During our inspection, we asked staff about safeguarding scenarios and what actions they would take in response. Staff were unable to provide examples of what they would do in safeguarding situations and demonstrated a lack of knowledge about who to contact or how to make appropriate referrals. The service held a list of vulnerable people; however, the list was not being effectively maintained and there was no designated person to monitor this or a process to follow. The service held a risk register, but this was not being regularly reviewed. The child register was last checked in March 2023, and the adults' register in April 2023. The service was unable to provide any evidence that regular safeguarding meetings or discussions were taking place for people using the service who may be, or are, at risk.
Involving people to manage risks	<ul style="list-style-type: none"> Emergency equipment for children and young people was not always readily available. For example, paediatric pulse oximetry, oral airways for children, and paediatric pads for the defibrillator. Following our assessment, the provider sent us evidence these had been ordered. Suction was not available at either of the 3 practices. The provider showed us evidence that this had been ordered. Some staff were aware of how to recognise the rapidly deteriorating patient however, protocols were not in place for non-clinical staff to refer to. Reception staff were responsible for triaging appointment requests received by telephone, in person and through e-consults. However, these staff did not receive additional training or have triage tools to support them in this responsibility. Staff could access clinical support as needed, however a clinician was not always available onsite.
Safe environments	<ul style="list-style-type: none"> The practice is located in a premises shared with a number of other services. At our last assessment in February 2025 we found that emergency medicines were located in a clinic room not routinely used by the practice. At this assessment, the practice had moved the stock of the emergency medicines to a more accessible location. However, we noted that spare adult defibrillator pads were not available. The practice ordered spare defibrillator pads during our visit and subsequently sent evidence showing them in place. Appropriate testing of electrical equipment and electrical hard wiring were in place. However, the provider was unable to evidence that the gas boilers had been serviced. Legionella risk assessments had not been completed at 2 of the 3 practices. Water testing was in place however, running of taps and monitoring of water temperatures was not. Control of Substances Hazardous to Health (COSHH) risk assessments were available for the products used by the cleaning staff however, service wide

	<p>COSHH risk assessments were not. Blind hoops for blinds were not always secured to walls in line with national alerts.</p> <ul style="list-style-type: none"> • There was a business continuity plan in place which was monitored and reviewed. However, the plan did not include telephone contacts for essential services such as electricity, gas and water. • The service's health and safety policies were overdue for review. Staff members recorded as the service's health and safety leads were former employees and were no longer at the service. • The service did provide evidence of the emergency lighting being last checked in October 2024. However, emergency lighting should be checked monthly. • The service was not following national guidance in relation to fire safety. The last fire risk assessment was completed in March 2022, despite annual assessments being required under national fire safety guidance for healthcare premises. The service was unable to provide evidence of fire drills taking place or that weekly fire alarm testing was being carried out. Staff told us the neighbouring library, who share the building with the service, conducted these weekly, but there was no evidence of this shared responsibility or any recording system in place. • All staff employed by the service were aware of the key safe code used to access the dispensary keys. This meant there was no control over who could enter the dispensary, which created a significant risk to unauthorised access to medicines, potential misuse and theft and lack of accountability for medicine handling.
Safe and effective staffing	<ul style="list-style-type: none"> • 2 members of staff have been recruited without following local policies. Two members of staff had been recruited without a formal interview. One of these members of staff had no Disclosure and Barring Service (DBS) check in place at the time of commencing employment. This member of staff also had no references in place at the time of commencing employment. • Staff told us they were also unsure of the working patterns of management, and who was the responsible leader within the practice on any given day. We were told of an incident that took place within the practice recently, whereby staff needed a member of management and no-one was available on site to support them. A GP partner had to offer support in the middle of a clinic. • We looked at the actual number of appointments being provided on a sample of days over a 4-week period. This did not support the appointment data as shared by the provider. The provider must consider this as part of their review of capacity and demand and appointment provision. • Staff told us that staffing concerns had been compounded by a reduction in the clinical team when an advanced nurse practitioner (ANP) had left and had yet to be replaced. The provider told us they were currently looking at capacity and demand and looking at information to capture contacts and the use of digital/on-line service provision. The nursing model was also under review in consultation with the nursing team. This was to include an assessment of the current model of working across multiple sites and the speciality training of nurses. Another area of work in progress was to establish a clearer picture of the prevalence of patients with long term and

	<p>multiple health conditions and assessing acuity of patients to support decisions around the staffing establishment.</p> <ul style="list-style-type: none"> • Safe recruitment practices were not followed. For example, Disclosure and Barring Service (DBS) checks; evidence of satisfactory conduct in previous employment; complete employment histories; and satisfactory information about physical or mental health conditions relevant to the person’s ability to carry out their role. Assurance had not been acquired to confirm that staff employed by the Primary Care Network (PCN), and working in the practices, had been appropriately recruited, trained and supervised. Following our assessment, the provider sent us a memorandum of understanding between the practice and the PCN that had showed there was an agreement in place for the recruitment of staff however, there was no reference to training and supervision of staff. • There was no effective system or process in place to ensure recruitment complied with Schedule 3 of the Health and Social Care Act 2008. During our onsite visit, we reviewed 6 staff files, none of which contained the required information to confirm the suitability of persons employed for regulated activities. There was no evidence appropriate inductions, supervision or appraisals were taking place to ensure staff could carry out their duties safely and effectively. • Role-specific training was not being monitored, increasing the risk that staff may not have the necessary skills and knowledge to carry out duties safely. As a result, on review of the service’s training matrix, we noted all 10 staff members employed at the time of inspection, did not have up-to-date training. For example, 9 out of the 10 staff did not have current basic life support training.
Infection prevention and control	<ul style="list-style-type: none"> • All the IPC audits had failed to identify there were overflows in some of the sinks. • Action plans to mitigate identified risks such as carpets in clinical and non-clinical areas and some non-wipeable chairs were not in place. Following our assessment, the provider sent us action plans for 2 of the 3 practices to mitigate risks identified in the practice. However, 1 of the action plans made no reference to carpets and non-wipeable chairs, as identified in their IPC audit, and the other action plan contained no details of how risks were being mitigated. • Of the 4 staff files we reviewed we found 3 of the staff did not have a complete record of all the recommended immunisations for potential healthcare acquired infections. • The service did not ensure appropriate Control of Substances Hazardous to Health (COSHH) risk assessments were in place from their external cleaning provider, as required by national guidance. Cleaning products were stored in unlocked cupboards, and there was no evidence of completed cleaning schedules. • The service did not have an up-to-date Infection Prevention and Control (IPC) policy, nor was it reflective of current staffing as it referred to a staff member who was no longer at the service. There was no evidence of hand hygiene audits or audits of aseptic non-touch technique having been completed at the time of our onsite visit.

	<ul style="list-style-type: none"> • Staff were unable to readily identify the location of spillage kits. There was no IPC risk assessment in place, the IPC policy was overdue a review and did not reflect national guidance. The policy also did not include isolation procedures for suspected infections. • Clinical waste bags were not being labelled, as required by NHS England and Health and Safety Executive (HSE) standards.
Medicines optimisation	<ul style="list-style-type: none"> • We saw errors in the prescribing of vaccinations; this resulted in 78 patients being vaccinated by a member of staff who the provider had not assured themselves at the time was trained to administer these. We also reviewed evidence which indicated the practice had not managed the Patient Specific Directions (PSD's) accurately. PSDs are specific guidance on the administration of medicines authorising nurses and health care assistants to administer them. We informed the practice of this immediately, and reported the incident to appropriate external agencies, who told us they would follow this up. • The provider's systems to manage and respond to safety alerts and medicine recalls were not consistently effective. We identified two patients who were prescribed a medicine which posed additional risks because of the patients' age. Based on the evidence in the clinical records, the patients had not been advised of these risks. We looked at the records of 5 patients prescribed a medicine that can cause harm to a developing foetus if taken during pregnancy. Based on the evidence in the clinical records, the provider had not followed national guidance to ensure pregnancy prevention programmes were followed. • We looked at the records of patients on a medicine that needs to be overseen by a hospital consultant. Some patients did not have a record of this shared care being agreed. This medicine needs to be taken once a week, on a specified day. This information was not always included on the prescription. • Medicines prescribed in a hospital setting were not always added to patients' records. This placed patients at risk of harm as clinicians may not be aware of all the medicines a patient was taking when prescribing. • Based on the evidence we saw in clinical records, if patients did not respond to one means of communication (e.g. phone calls) practice protocols did not ensure that staff would try a different method. • On the day of our remote clinical records searches (26 January 2026), we found the electronic correspondence system used by the practice showed 213 unfiled results (122 of which were abnormal), dating back to 12 January 2026. There was risk to patient safety as this could have contained information requiring urgent action, thus causing a significant delay to further treatment or investigation. • We were unable to locate the shared care agreement for some people prescribed a medicine used in the treatment of rheumatoid arthritis and, in line with national guidance, the day of the week to take the medicine was not included on their prescription. The provider told us they had discussed the difficulty in locating shared care agreements and were liaising with secondary care providers to locate them. • We reviewed a Medicines and Healthcare products Regulatory Agency (MHRA) alert relating to women of child-bearing age who were prescribed a medicine used in the treatment of epilepsy. We found that the required safety precautions had not been followed for 1 of the 3 people prescribed this medicine.

	<ul style="list-style-type: none"> • We found that some Patient Group Directions had been authorised before they had been signed by a practice nurse. There was a system in place for tracking prescription stationery throughout the practice however, it was not effective. • Out of 8 people prescribed Disease-Modifying Anti-Rheumatic Drugs (DMARDs), such as Methotrexate, we reviewed 5 records. None of the 5 records had the specific day documented for when the medicine should be taken. This is important because Methotrexate must only be taken once a week, and not recording the specific day increases the risk of people taking it incorrectly. During our clinical searches, an enhanced search had to be run because existing coding did not reliably identify these people. • We also reviewed the service's compliance with Medicines and Healthcare products Regulatory Agency (MHRA) alerts. The specific alert reviewed related to Topiramate. This medicine must not be prescribed to women of childbearing age, unless they meet the requirements of a Pregnancy Prevention Programme. We reviewed 3 records, and 2 records contained no evidence a pregnancy prevention plan was in place and all 3 had no annual risk acknowledgement forms completed. • Out of 115 people identified as being prescribed an SGLT-2 inhibitor a class of medication used to manage type 2 diabetes, we reviewed 5 records. Everyone prescribed this type of medicine should be informed of the associated risks and education in relation to Ketoacidosis and Fournier's gangrene. All 5 records reviewed did not show evidence of people being informed of these risks. The service did not have a policy in place relating to SGLT-2 medications. • During our clinical searches, we also attempted to review medication reviews. Many people had been incorrectly coded as having received a medication review, when in fact they had not. This was due to some staff using the clinical system's coding function incorrectly. • When reviewing 5 records where a PSD should have been in place, we found 2 people had been administered an injectable medication without a valid PSD recorded. In both cases, a nurse had documented a PSD had been reviewed, when in fact no PSD existed. This represents a significant risk, as medicines were administered without the legally required authorisation.
EFFECTIVE	
Assessing needs	<ul style="list-style-type: none"> • When we assessed the practice in May 2023 and April 2024, we found patients requiring high dose steroid treatment for severe asthma exacerbations were not always followed up in line with national guidance to ensure that treatment had been effective. We found this again at this assessment. We saw that some patients with this long-term condition were receiving medicines that should have stopped being prescribed when their treatment plan changed. • We reviewed 5 patient records who had been prescribed 12 or more short-acting beta agonist (SABA) inhalers. SABA inhalers are used to quickly relieve the symptoms of asthma. We found that they did not all receive the required review of their condition and treatment. In 2 of the 5 records we looked at, the reviews had not

	<p>adequately considered the mismatch between the symptom control recorded and the amount of medicine that had been prescribed.</p> <ul style="list-style-type: none"> • Our remote clinical records searches identified 83 out of 525 patients whose last HbA1c reading was over 75mmol/L/. We reviewed 5 of these patient records and found that treatment escalation plans were not consistently documented, nor was follow up initiated when blood pressure monitoring indicated potential hypertension. • We looked at the records of reviews of people’s medicines. These were generally of poor quality, with a lack of clinical justification for some prescribing and blood tests, and medicines remaining available to patients on repeat prescription despite no longer being required.
How staff, teams and services work together	<ul style="list-style-type: none"> • At our previous assessments in May 2023, April 2024 and February 2025, we found there had been a breakdown in the partnership between the 2 GP partners which impacted staff and patients. At this assessment, we found these concerns remained and the relationship between the GP partners remained challenging. It was unclear what steps had been taken to create a successful working partnership since the last assessment. One of the GP partners continued to work alongside the business manager and 1 of the salaried GPs in attempts to provide stability to the practice. We reviewed clinical meeting minutes and found 1 partner did not always attend these meetings. We saw evidence of 1 of the GP partners being assigned a task to complete in 1 meeting despite them not physically being present. The 2 GP partners reported following different processes in various scenarios (for example, 1 GP partner stated some of the processes referred to by the other GP partner either “did not work” or “did not exist” when asked, such as the process for managing test results). One of the GP partners also claimed that they were refused prescription paper and clinical equipment, as well as being removed from being able to see significant events or complaints on the practice electronic system.
RESPONSIVE	
Care provision, integration and continuity	<ul style="list-style-type: none"> • Since our last assessment some work had been undertaken to consider if patients were attending a local walk-in centre rather than the practice due to the distance, this was ongoing and had not concluded. This was in response to high secondary care attendance figures. The practice was aware of the high attendance rates and had plans to address it. We will review this at our next assessment.
Providing Information	<ul style="list-style-type: none"> • We spoke with the Patient Participation Group (PPG) who told us since our last assessment they did not feel valued by practice management. They told us they did not feel that suggestions were valued. At the time of our assessment a meeting was scheduled. Members of the PPG told us that 3 days prior to this meeting they had not received an agenda or confirmation that the meeting was going ahead, and we are unsure if this meeting went ahead.
Listening to and involving people	<ul style="list-style-type: none"> • We reviewed some minutes from team meetings, however further minutes requested were not provided, and therefore we cannot be assured that learning from complaints was being shared with staff other than those who were directly involved. We cannot be assured that circulating minutes on TeamNet ensures staff have read, understood and would implement any changes.

	<ul style="list-style-type: none"> • We did not see evidence of complaints being recorded and addressed in a timely manner, nor did we see evidence of learning needs identified as a result. 62 complaints had been recorded since April 2025. 38 of 62 complaints remained open, some dating back to 8 April 2025. • We saw evidence of one complaint being discussed in the staff meeting minutes; however, this did not appear to be a standard agenda item. The practice advised that it held a standalone meeting for complaints, compliments and significant events. We saw 2 sets of meeting minutes from these for May and October 2025. Recording of learning points and actions was not consistent and it was not clear what steps had been taken to reduce the risk of the same issue happening again.
Equity in access	<ul style="list-style-type: none"> • We reviewed an audit of triage's carried out by reception staff and raised concerns with leadership at the time of our site visit. These related to staff not triaging effectively or accessing a GP at the time of the patient call. • The practice received significantly lower than average scores for patient satisfaction in the national GP Patient Survey for satisfaction relating to experience of contacting the practice. The percentage of respondents who responded positively to their experience of contacting the practice was lower than average at 39% (compared to 69% nationally) and 46% of respondents (compared to 67% nationally) felt they waited about the right amount of time for their last appointment. Patient satisfaction for finding it easy to get through to the practice by phone was lower than average at 25% (compared to 52% nationally). • We noted that there was no designated parking, including parking for disabled people.
WELL-LED	
Shared direction and culture	<ul style="list-style-type: none"> • Leaders were out of touch with what was happening in the service and what staff think. There were examples provided to us by staff in relation to non-clinical management of workforce bullying, harassment, discrimination towards certain staff and certain groups of people. The provider was not taking adequate action to reduce or investigate this promptly. Leaders told us there were challenges with conflict between management and staff, and they were unsure how this could be resolved. We note that whilst this is a series of allegations, leaders had not taken them seriously. • At the time of our assessment, we informed partners that staff feedback was overwhelmingly negative. There were concerns from staff about the professionalism of management, including attitudes towards staff members, breaches of staff confidentiality and allegations of foul language being used. Staff told us they felt threatened by redundancies. Since our site visit, clinical leaders have told us they intend to address this feedback. This will be reviewed at our next assessment.
Capable, compassionate and inclusive leaders	<ul style="list-style-type: none"> • We saw examples of management making significant changes to policies. For example, staff were only made aware of changes to the sickness policy after it had been implemented. This was disclosed to staff via an email informing them of a new policy on Team Net. Staff told us communication from management was ineffective. They had suggested other forms of communication to management; however, they did not feel this was working well. Leaders told us they felt staff remained unhappy with communication and they were not sure how this could be resolved.

	<ul style="list-style-type: none"> • We reviewed evidence which indicated that leaders were not following their own policies, specifically in relation to recruitment and grievances. • At our assessments in May 2023, April 2024 and February 2025, we found there was a breakdown in the relationship between the GP partners which negatively impacted staff at the practice. Staff referred to a toxic working environment. At this assessment, we found a similar situation. One of the GP partners described how they had worked collaboratively with the business manager and 1 of the salaried GPs at the practice to provide a more stable management team. However, this was implemented without the agreement or involvement of the other GP partner. The negative relationship between the partners had directly impacted staff satisfaction levels, which was referred to in a culture review completed by an independent external organisation.
Freedom to speak up	<ul style="list-style-type: none"> • We saw that at the time of our assessment staff had engaged with the freedom to speak up guardian. Following our site visit we were informed the practice had removed this person from the role. We asked for a process and rationale around this decision, given leaders knew that staff had spoken up. Practice leaders were unable to demonstrate they had considered the impact this would have on staff. We were made aware by an external stakeholder that they had suggested a different person for the role of freedom to speak up guardian. The practice then changed the name of the guardian on their policy before informing this person. At the time of writing the practice does not have a freedom to speak up guardian in place. • The Patient Participation Group told us they did not feel valued or listened to and were not informed at the time of the last CQC assessment of ratings. Members of the PPG told us they found out the rating of our last inspection via the news.
Workforce equality, diversity and inclusion	<ul style="list-style-type: none"> • At our last assessment in February 2025, we saw that a number of grievances had been raised by staff within the practice. At this assessment, some staff reported that grievances continued to be raised against fellow colleagues and that relationships in the working environment remained unsettled. The practice's review of culture found staff did not always feel respected by management or that their concerns were taken seriously. • In line with the Health and Safety (Display Screen Equipment) Regulations 1992, staff who use display screen equipment as part of their role should have workstation assessments to ensure ergonomic safety. However, 4 out of the 6 staff files we reviewed during our on-site visit contained no evidence of these assessments having been completed. This created a risk of staff working in an unsafe environment, and potential health or safety issues were not being identified or addressed.
Governance, management and sustainability	<ul style="list-style-type: none"> • Leaders were unaware of a potential risk of harm to 78 patients, who were vaccinated without the appropriate safeguards in place, until it was highlighted by CQC. This information was not shared appropriately with the required external partners. • During discussions with leaders, it was clear they were aware of the gaps in the service however, an overarching action plan was not in place to capture this or identify how changes were going to be made and the effectiveness of the changes monitored. For example, action plans to mitigate issues identified in the infection prevention and control (IPC) audit did not address all the issues. In particular, cleaning of carpets, non-wipeable seats and

	<p>overflows in sinks. Systems to identify people with previously undiagnosed conditions such as chronic kidney disease were not effective because coding had not always been correctly added to people's records to ensure they did not miss essential monitoring.</p> <ul style="list-style-type: none"> • Service wide Control of Substances Hazardous to Health (COSHH) risk assessments were not available. A complete list of staff immunisations against potential healthcare acquired infections was not available for all members of staff and risk assessments to mitigate potential risks had not been completed.
Partnerships and communities	<ul style="list-style-type: none"> • We received information from external partner agencies working with the practice, expressing concern at the inability of the partners to work together. • The provider worked with other practices within their primary care network to offer extended access, and flu and covid vaccination programmes. The provider had 1,723 unactioned tasks outstanding for mostly clinical, administration, and practice manager tasks, the oldest being dated December 2024. There were 23 tasks allocated to a clinical pharmacist practice between 10 February and 18 February 2025, who had stopped working at the practice at the beginning of February 2025. We saw there was no updated clinical coding flowchart to show where staff referred clinical pharmacy tasks to until a replacement pharmacist was found.
Learning, improvement and innovation	<ul style="list-style-type: none"> • At our last inspection in February 2025, we did not see any evidence of completed (two-cycle) audits. At this assessment, we saw one two-cycle audit had been completed. This audit showed some improvement, however the provider acknowledged further work was needed for this cohort of patients.