



CQC Inspection Reports Profile Over Last 4 Weeks

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

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	• GPs told us a patient did not wish to raise a formal complaint and the patient shared they had raised a formal complaint that had not been addressed • Some of the practice staff could not recall an example of significant events; therefore, we were not assured learning was being shared amongst all relevant staff • Meeting minutes from clinical, nurse and health care assistants (HCA), reception and administration meeting minutes did not show any significant events were discussed and were not part of the agenda • Not all staff attended staff meetings, and when we asked, they were not sure how to access the meeting minutes. A staff member told us that since starting at the practice over a year ago they had not attended any staff meetings • Learning events had not been collated to enable analysis of trends and discussions at meetings. The new practice manager had recommenced the learning event system in April 2025. Records of events prior to April 2025 were not located • Not all complaints had been added to the reporting system, investigated and managed according to policy. This meant there was no awareness of how many complaints had been received, the content of complaints, learning identified and what action was required. • We reviewed 4 significant events forms. These did not contain enough information to determine exactly what had happened, what action had been taken or was required, or if learning had been shared and embedded. For example, an incident about a needlestick injury did not make it clear who had been injured, or what the advice from Occupational Health had been, and an incident about a cold chain breach did not indicate what the result of the investigation was. One significant event had not identified a possible data breach as a result of an error.
Safe systems, pathways and transitions	• There was an unacceptably high number of documents waiting to be scanned, coded and filed. As of 8 November 2024, there was in excess of 6400 documents some dating back to July 2024 • We were not assured of an effective system in place to ensure they followed up patients when they had not received an appointment because the 2-week wait referral monitoring spreadsheet provided did not document if

	the patient had received their fast-track appointment, or if they had received an outcome following an appointment. • The service did not have a system to follow up on patients after discharge from the hospital or who needed a check-up at the hospital • We found 55 test results unprocessed in the locum inbox dating back almost 3 months during our site visit • Since September 2024, the service had a regular backlog of approximately 1,700 letters from secondary care requiring review. Although the backlog had been monitored and some mitigating steps taken, the volume had remained largely unchanged (being 1784 at the time of our assessment site visit, with the oldest received by the service 23 days prior)
Safeguarding	• The practice was unable to identify any patients with a DNACPR decision in place. They told us they did complete DNACPR decisions but did not code them in a way that could identify them. • The practice did not have any safeguarding register • Patients who were in households that showed evidence of domestic violence were not flagged on the clinical system and children in such households as well as those having parents with mental health disorders, were also not flagged on the clinical system for effective monitoring and escalation where appropriate.
Involving people to manage risks	• One clinical member of staff's training records showed their adult basic life support was last completed in February 2024, and the child basic life support was last completed in October 2022. Both should be renewed annually • We received patient concerns that a clinician had missed sepsis red flags that led to hospital admission • Complaints directly sent to the practice where patients felt they were placed in harm's way due to red flag symptoms being missed • The practice could not assure themselves that emergency medicines would be easily accessible in an emergency to provide timely lifesaving treatment, as a risk assessment had not been completed • Some emergency medicines that are recommended for current practice were not kept at the practice. There was no written explanation or assessment to show why these medicines were not needed. • Effective systems were not in place for checking the expiry dates of consumables, as out of date syringes, blood bottles and needles were available in two rooms. • Most but not all reception staff had completed Care Navigation training to support nonclinical staff to signpost patients to the most appropriate clinician. There was no documented guidance in place at the time of the onsite inspection to support staff awareness on when to alert the GP regarding patients presenting symptoms.
Safe environments	• The practice manager had completed a risk assessment form for all rooms in September 2024. These did not assess or identify risks for the areas. They detailed hazards, and an overall risk rating was calculated. These had been incorrectly calculated. They had also not been accurately updated. • We asked for training information for fire wardens and were told no staff member had been trained. • We did not see evidence of a legionella risk assessment or equipment calibration records.

	• Emergency lighting in the building was working but was not up to standard. There were cables in the main patient access areas, there was a broken mirror in the patient toilet. There were carpets in the main patient waiting area, the carpet was not on the cleaning schedule. • The guttering that ran along 1 side of the building appeared to be full, causing it to overflow, which was the potential cause of damp we noted during the inspection in one of the clinical rooms • Actions from fire safety and legionella risk assessment were not completed or documented. This concern was also identified at the last assessment in November 2023. • There was no mercury spill kit or risk assessment in place for a mercury sphygmomanometer
Safe and effective staffing	• The practice had not carried out Right to Work checks for staff using a non-UK passport. • Records showed at least 8 missed diagnoses occurred and concerns around staff knowledge of undertaking wound care activities • There was only 1, not the required 2 references in all 5 files. There was no DBS on file for one staff member. Four of the 5 recruitment records we viewed had completed induction checklist on file • Our review of 10 staff records showed that there was no record of a disclosure and barring services (DBS) check or risk assessment for a receptionist. Five of the staff files did not have records of appropriate references from previous employment. • However, there was no oversight on the training achieved by the locum GP staff. • We looked at supervision arrangements concerning a recently created Physician Associate role: clinical supervision protocols had not been updated to incorporate the new role, support the post holder and ensure they worked to a safe and formally agreed scope of practice. Consequently, we saw that the provider's scope of practice allowed the post holder to treat children with minor illnesses, pregnant women with minor illnesses and some patients experiencing poor mental health. This is contrary to RCGP guidance • A system was not in place to ensure NMP staff were always up-to-date with their clinical knowledge. The service did not have a system in place to monitor the prescribing practices of NMP staff • Staff personal files did not always align with the requirements outlined in the providers policy for safe recruitment. • Significant gaps in a clinicians mandatory training completion and did not include all the training required by or completed by staff. This meant the provider did not have oversight of staff training as the system was not comprehensive
Infection prevention and control	• Some patients' complained that some clinicians did not wash their hands prior to undertaking wound care activities • Clinical waste bags were not labelled, one of the toilets did not have a mixer tap and required a warning label due to its scalding water risk and cleaning mops were stored incorrectly. • There was one clinical room where there was shelving which was covered in dust. In the same room, there was a metal stainless steel sink with cupboards above and below. The sink was not clean, there was a stain around the plug, the shelves in the cupboards were not clean

	• The lead role for infection prevention and control (IPC) had been allocated the week prior to our inspection. The practice manager carried out an IPC audit in January 2024, and they told us it had not been repeated since. The IPC policy stated it would be an annual audit. The audit stated there was a daily and weekly cleaning specification, kept in the storeroom and completed by the housekeeper. During the site visit we asked for this and were told it did not exist. The practice manager told us they had not carried out a hand hygiene audit. • The Infection Prevention and Control (IPC) Policy was out of date (expired March 2023), and it was not specific to the practice or its needs. Actions from IPC audits were completed and the last audit was completed in February 2025. The handwashing and hygiene protocol expired March 2023. • The Infection Prevention and Control (IPC) policy did not contain the information required to support staff. In particular, notifiable diseases, the appropriate reporting agency and contact details in order to report any notifiable diseases. • There were no cleaning schedules in place for the consulting rooms. • We found a sharps bin that was undated and unsigned and stored at below waist height/level.
Medicines optimisation	• Some patients told us that the practice did not listen to their concerns when they queried prescribed medicines dosages and the likelihood of adverse side effects. • Emergency medicines were locked in a cupboard inside a keypad locked room; therefore, there was a risk of delay to treatment in an emergency • There was a repeat prescription policy in place; however, this policy was out of date Despite pharmacy staff carrying out opioid reviews, there was no information regarding how they could access the Controlled Drugs Accountable Officer (CDAO) in this policy. The embedded policies within the repeat prescribing policy such as the medication change flowchart were also out of date and overdue a review since March 2022. • 10 out of 177 patients prescribed gabapentinoids had not received a review in last 12 months. 4 patients were overdue a medicine or dose review and one of these patients was not informed of their of pregnancy associated risks • There was a cold chain breach on one fridge on 1 November 2024; however, this had not been recorded as a significant event • For patients prescribed a medicine that can cause serious harm to an unborn baby if taken during pregnancy, we found that 3 out of 5 patients we looked at had not been provided with information about the potential risks. • On inspection, it was found that a staff member was taking patients' repeat prescription request forms home to work on. This could put patient privacy at risk • 39 patients were taking a medicine (bisphosphonate) used to strengthen bones and reduce the risk of fractures for more than five years. We identified that 4 out of 5 that we looked at had not been reviewed • We reviewed the records of three patients who were asthmatic, who had suffered an acute exacerbation and who had received oral steroids. None of them were followed up within 2 working days as NICE recommends; 1 out of the 3 patients was overdue an annual review; and 1 patient had not had an assessment before steroids were prescribed.

	• People with diabetes on a particular medicine were not given advice on how to identify or respond to life threatening infection that rapidly destroys deep and superficial skin tissues and complications from the condition, such as Fournier's gangrene and diabetic ketoacidosis. • The prescription policy (repeat prescription and medication protocol) shared with us by the practice was out of date (last reviewed April 2024) • Medicine reviews were coded but some patient records lacked detail to provide clarity about what was discussed. • We identified a total of 9 patients that were prescribed Clopidogrel (a medicine used to reduce the risk of a heart attack or stroke) with Proton Pump Inhibitor (a medicine used to reduce stomach acid production). We reviewed a random sample of 5 patients and found that all 5 patients were not informed of the risks, there was no evidence of any discussions had with the patients. • 25 patients were being prescribed a DMARD called Azathioprine. NICE recommends monitoring patients on Azathioprine for toxicity including monitoring full blood count and liver function tests at least every 3 months. However, when we reviewed five patient records, we noted that one patient had recently been prescribed Azathioprine in February 2025 but that their last Full Blood Count, Urea and Electrolytes and Liver function test had last been recorded in November 2023. • In patients prescribed a disease-modifying antirheumatic medicine we found the instructions on the prescription did not always include the day of the week for administration, that the condition for which the patient was taking the medicine was not always linked within the clinical record • There was no fridge temperature data logger and 3 gaps in dates for recording fridge temperatures were absent in the records reviewed • 586 patients who were prescribed as polypharmacy, with 213 identified as not having had a medication review in the last 18 months. We looked in detail at 5 patient clinical records and found that a medication review had not been coded for at least 18 months in all 5 patient records • Lack of oversight and failure to act on electronic alerts related to medications and Medicine and Healthcare products Regulatory Agency (MHRA) alerts during medication reviews and patient consultations.
EFFECTIVE	
Assessing needs	• Our remote clinical searches identified 30 people with a potentially missed diagnosis of chronic kidney disease stages 3 to 5. • Ongoing cough symptoms were inadequately assessed so this led to an emergency hospital admission a week later with a life-threatening condition • Concern over the assessment of care home residents' needs often being made by the service over the telephone.
Delivering evidence-based care and treatment	• 2 out of 329 patients diagnosed with hypothyroidism were overdue their monitoring and had not been short scripted when invited and not complied as per national guidance. We also found that 1 out of 38 patients diagnosed with chronic kidney disease (CKD) stage 4 or 5 had not received recent blood test monitoring in their records

	Identified 27 patients with hypothyroidism who had potentially not had thyroid function test monitoring for 18 months.
How staff, teams and services work together	On occasion there was a divide between reception and admin teams and this could be improved if each of the teams had insight into how the other team worked
Supporting people to live healthier lives	One patient told us they had not been informed by the practice that they had a particular disease until they moved GPs, whilst another patient told us about having surgery for a condition which had been missed at an appointment for pain
Monitoring and improving outcomes	- Concerns where blood tests were taken from patients without their consent and no effort had been made to ensure the patients had fully understood the purpose of taking their bloods - Mental Capacity Act (MCA) and DNACPR policies were up to date but there were gaps around consent documentation where they were not always documented fully as required by the forms. For example, 2 minor surgery consent forms did not have all relevant areas fully completed and were left blank. In a DNACPR form, both the GP completing the form and endorsing senior clinician's signatures were not recorded and the indefinite decision section was left blank - The cervical screening test among 25-49 years of the female patient population was 56.2% which was lower than the expected average (80.0%). The uptake of the cervical screening test was equally lower (70.8%) among patients who were 50-64 years old compared to the expected average (80.0%). - There were no clinical audits submitted before or during the site visit despite our repeated requests. The provider sent us evidence 4 weeks after the site visit. This consisted of two record reviews, we were not provided with any examples of clinical quality improvement work by the practice in the previous 15 months - Percentage of children aged 5 who had received immunisation for measles, mumps and rubella (two doses of MMR) between 2023- 24 was 84.6% which was below the World Health Organisation based target for uptake target of 95.0%. There was no strategy in place to improve uptake
Consent to care and treatment	We looked at 3 patient records to ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions were made in consultation with the patient or, where appropriate, their family/carers. However, 1 of the 3 records did not include a documented rationale for the DNACPR decision or evidence of discussion with the patient or their representative.
CARING	
Kindness, compassion and dignity	10 patients where they felt there were not treated with kindness; reported some staff members were officious, sometimes rude and obstructive. This was consistent with feedback posted online by verified NHS reviews. Complaints received by the practice also highlighted issues with different members of staff attitude towards patients
Treating people as individuals	The practice leaflet did not provide any information about how patients could access their interpretation service

Responding to people's immediate needs	• 5 patients described how their symptoms were dismissed and they experienced a deterioration which, for 3 of them involved emergency admissions into hospital. • Where people with immediate needs refuse emergency support, such as an ambulance, there was no guidance in place for staff follow.
Workforce wellbeing and enablement	• Management told us they had an open-door policy on inspection; however, this was not always reflected in staff views
RESPONSIVE	
Person-centred Care	• One patient told us they were only offered a telephone appointment for their child despite the required appointment being a face-to-face appointment. When they challenged the practice, they were informed it was due to measles risk, which the patient had already been vaccinated against but the practice would not change or tailor the request to the patient's needs.
Providing Information	• Negative reviews received 6 months prior reported frequent admin errors where they were given the incorrect forms to complete on 2 occasions, including information from the incorrect ICB after the practice sent a referral to the wrong ICB, delaying the patient's care for 3 months • The members of the PPG expressed their desires for better engagement with the practice. They told us there was no chairperson and meetings were often short notice with just 24-hours' notice and there was no mission statement, purpose, agenda or actions. • There were gaps in the confidentiality and data protection policy provided by the practice. There was a confidentiality and data protection statement, but crucial information relating to named leads in these areas was not included. For example, the policy mentioned an information governance lead, data protection officer (DPO) and Caldicott guardian but did not name who the leads were which was usually senior staff in the practice.
Listening to and involving people	• Not all staff were made aware of improvements made following complaints investigations, nor could they share examples of any recent complaints and this was for 4 staff we spoke to. • The practice had a complaints policy; however, the information regarding the new complaints lead who reported to the practice manager was not reflected in this policy
Equity in access	• 25% of patients thought it was not at all easy to get through to the practice. 18% thought it was very good making an appointment and 15% of patients thought it was very poor making an appointment. • Some patients experience of making an appointment was negative due to being told go to go accident and emergency due to the practice reaching capacity • The practice was closed for 1 hour each day to facilitate staff training. Patients had access to the online form during this time; however, urgent medical needs that could not wait an hour would be signposted to accident and emergency.
WELL-LED	
Shared direction and culture	• Out of 7 members of staff we spoke to, only 3 could confidently say what the shared vision or direction was while others did not know

	• Leaders told us that (since the COVID-19 pandemic) other priorities and major changes in the key staff team meant the service had not actively reviewed its vision and strategy. The service's business plan was outdated by 5 years • Staff told us they had access to policies and procedures but commented that there was no time allocated on induction to read these. The practice manager told us they were in the process of reviewing these. Staff told us that since the assessment was announced the practice had been busy putting policies in place and carrying out risk assessments.
Capable, compassionate and inclusive leaders	• Some staff members felt unsupported with some describing they were made to feel worthless and others felt secluded. • Some patients told us they observed some staff reluctant to raise a query with management due to fear of being shouted at because this had happened in the past.
Freedom to speak up	• There was a freedom to speak up policy and there was a Freedom to Speak up Guardian and staff told us they were aware of them. However, most of the staff provided a guardian that was inconsistent with the designated guardian assigned to the practice. For example, most of the staff told us their Freedom to speak up guardian was a practice manager at a neighbouring practice; however, the designated guardian was based at the ICB
Workforce equality, diversity and inclusion	• Some staff felt the senior management team did not take action to intervene and support staff when they heard non-clinical staff being screamed and shouted at by aggressive patients which created an awkward atmosphere for staff
Governance, management and sustainability	• The practice had an organisation structure chart; however, it was not up to date as it omitted one member of the ARRS clinicians. Gaps were also found in governance systems such as sharing and learning culture, medicines management, significant events, legionella assessments, complaints and listening to people. • Managers did not meet with staff regularly to complete appraisals and performance reviews. • The provider had failed to identify several issues we identified during inspection, for example, management of prescriptions, safe environment and infection prevention and control. The provider responded to some of the concerns raised immediately following inspection; however, this action was only taken after our intervention • The business continuity plan (for use in any emergency that could disrupt service delivery) was out of date, not tailored to the service and had missing information. • There was no system to monitor staff training and to prompt staff to complete any required training, and other training for safe service delivery, when it was due. • There remained a reliance on the lead GP as the clinical lead responsible for the all the service's regulated activities, without any long-term substantive deputising arrangements in place • The provider's clinical supervision protocols had not been updated to reflect the recent addition of a physician associate role • There was no effective system in place to maintain oversight of audits and monitor any improvements based on audit conclusions

	The practice manager told us no minutes were kept for the clinical meetings because they did not have the capacity to supply a staff minute-taker.
Partnerships and communities	- The members of the PPG expressed their desires for better engagement with the practice. They told us there was no chairperson and meetings were short notice with just 24-hour's notice and there was no mission statement, purpose, agenda or actions. - The practice did not have a Patient Participation Group (PPG). The practice manager told us there had not been one for a few years.
Learning, improvement and innovation	- Policies were custom made for the practice rather than off the shelf and a new provider was installed a year ago and the provider was now rolling out new functions. All policies were moved to the new provider, including training records, patient safety alerts, significant events and complaints records. The provider told us this provider which has audit trails was being used by their practice only and not the wider Primary care network (PCN) practices. - There was an audit on Short-Acting Beta-2 Agonist (SABA) inhalers used in the treatment of asthmatic symptoms, but the evidence was not provided on site and after the site visit. The diabetes audit put forward lacked detail and did not specify the impact on the patient population and no detailed follow up work to improve outcomes. - We asked the Registered Manager about areas of innovation within the practice. They mentioned an idea but said it had not progressed as it involved a lot of work.

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS <i>(all scored 4 by CQC)</i>
EFFECTIVE	
Assessing needs	The practice proactively used population health management tools to improve treatment for those patients whose health needs had changed, and their care needs evolved. Specifically, the practice had highlighted a growing cohort of patients who had become moderately frail. In response, the practice had commenced a multidisciplinary frailty service to try and improve the provision of care and support to this cohort of patients before they reach crisis point and needing reactive emergency care.

Supporting people to live healthier lives	In the last 12 months the practice had arranged a programme of awareness events, open forums and themed educational sessions to raise awareness of health conditions and promote good health in practice patients and the wider communities. For example, in March 2025 a GP led discussion on the menopause, perimenopause and general female health.
CARING	
Kindness, compassion and dignity	88% of responses found the reception and administrative team helpful, which was higher when compared to the local average (83%) and national average (83%). 96% of patients who responded indicated that during their last appointment, the healthcare professional was very good or fairly good at treating them with care and concern. This was higher when compared to both the local average (87%) and the national average (86%). This was also a 7% increase on the results for 2024.
Workforce wellbeing and enablement	- We saw high levels of staff retention with over 40% of practice staff employed for over 10 years - The practice had established support networks for staff to use if they were struggling, to enable support immediately and the impact on the care they deliver to people remained positive. This also included a comprehensive support package and gradual retirement options, allowing staff to transition into retirement flexibly and smoothly.
RESPONSIVE	
Care provision, Integration and continuity	Formation of an outreach service for the local Gypsy, Roma, Traveller community. The aim of this service was to increase levels of engagement with preventative care and long-term condition management.
Providing Information	The practice had started running group consultations for groups like carers and those living with chronic pain. Clinicians explained these sessions enabled people with the same conditions to share personal experiences, helping them feel less alone.
Listening to and involving people	- The practice embraced the opportunity to work with NHS Digital and the wider PCN through a six-month workstream, which culminated in the PPG, practice staff and wider members of the working group, demonstrating the use and benefits of the NHS App to the wider population. NHS Digital held promotional events held at influenza clinics, a library, community centres, a hospital and in practices within the PCN. The learning was also promoted by the local bus company with advertising on the vehicles and training sessions were held in the practice to train the clinical and administrative staff in the use of the NHS App. - Learning from complaints, compliments and other feedback was evident and staff were able to identify changes made as a result of patient feedback. This included new telephony functions to reduce long waits at peak times, additional staff to improve response times and a restructured website.
Equity in access	74% of patients who responded 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%) - We reviewed data which highlighted the practices appointment system had a positive impact on avoided non-elective (NEL) hospital activity. Specifically, the practice rate for non-elective hospital activity was 51% which was lower than the county average (94%) and the wider ICB average (78%).

Equity in experiences and outcomes	67% of patients who responded usually get to see or speak to their preferred healthcare professional when they would like to. This was significantly higher when compared to the local average (46%) and national average (40%). 88% of patients who responded described their overall experience of the practice as good. This was significantly higher when compared to both the local average (76%) and the national average (75%). This was also an 11% increase on the results for 2024.
WELL-LED	
Shared direction and culture	- The provider put forward a business case to purchase an ear irrigation machine to the ICB to provide the service to local people and to people within the PCN locality, saving the NHS and hospitals costs. In addition, through their PCN, the service initiated an NHS travel vaccination clinic for registered patients with vaccinations being administered by practice nurses and oversight of the service led by one of the GP partners, and latterly administered by the practice pharmacist. - The direction of the practice was based on a collection of 3 values, referred to within the practice as the 3 Cs: 'Caring', 'Committed' and 'Capable'. The practice values were underpinned by 4 separate elements: 'Community Focused', 'Collaborative', 'Cutting-edge' and 'Cultivating' which all formed the practice's purpose: "To make a positive difference through everything we do – for patients and for one another". Staff told us leaders within the practice led by example, and all staff understood the importance of upholding the values of the organisation.
Capable, compassionate and inclusive leaders	Staff told us that leaders cared about their wellbeing and provided mindfulness sessions for their mental health, had yoga sessions at the practice, and provided a table tennis table for staff to play to de-stress and improve mental wellbeing. During in house training sessions the practice hosted an external yoga instructor for staff and the PCN mental health practitioner offered a 30-minute mindfulness session at the start of all training sessions.
Workforce equality, diversity and inclusion	Monthly Protected Learning Time (PLT) alternated between both sites to promote an inclusive '2 sites, 1 team' culture. Staff told us whilst important updates were shared at these sessions, each month there were team-building events arranged to strengthen relationships and further improve inclusion and communication across the staff group.
Governance, management and sustainability	- The service had recently appointed a nurse and had provided funding for the nurse to enrol in a university course to gain other practice nursing skills, such as management of long-term conditions. - We were informed that since 2022 the service donated medical equipment to under privileged countries. The service explained, "it is a significant concern when out-of-date consumables and medical equipment contribute to waste, impacting the environment." Equipment donated included, out-of-date swabs, dressings, gloves blood pressure machines and stethoscopes, blood glucose monitors and test strips for monitoring diabetes. - The practice was aware of the projected increase in the local population and was working with partner agencies to address future challenges. For example, the creation of 2 additional clinical rooms
Partnerships and communities	The practice had a dynamic and active PPG. The PPG influenced changes and improved services for patients at the practice by offering to test and feedback on proposed new services and revised services. This included reviews from a patient's perspective of the appointment system. There were 11 'core' members who met on a monthly

	basis. These meetings were attended by a designated GP and a leader from the management team. The members described the strong relationship between the practice and PPG, and how the practice encouraged, respected and valued their involvement. They advised the relationship was proactive and used to discuss issues of importance to patients and share these with the practice team. The meetings provided an environment for discussions and agreements about the practice and services provided and members were encouraged to contribute their views and suggestions. We also received feedback from system partners who, despite not being employed by the practice, reported feeling involved and part of the team.
Learning, improvement and innovation	• Staff in back-office functions we spoke with said how excited they were with future developments in the practice including the use of Artificial Intelligence and digitalisation – advising this was a move they were embracing as a tool to make their roles even more effective and improve the patient experience. This aligned to 1 of the practice's elements which formed the values – 'Cutting Edge'. • The practice invited PPG members to join quality improvement working groups to bring ensure the patients perspective was central to every decision.