CQC Inspection Reports of NHS GP Practices Published in June 2026

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

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
EFFECTIVE	
Assessing needs	• The practice operated a **triage-first access model**, and to support this had redesigned the clinical workflow to ensure that every patient request could be assessed safely, effectively and consistently. When assessing requests from patients, clinicians utilised a dashboard which clearly flagged information including frailty score, triage contacts within the last 12 months, GP appointments within the last 12 months and patient summary and pre-existing health problems. Further information such as pathology and cytology results could also be easily accessed from the dashboard. This enabled clinicians to carry out a thorough assessment of the patient, consider all relevant factors and improve patient responsiveness and access outcomes.

	• The provider had effective systems to **identify people with previously undiagnosed conditions**. The practice had undertaken a range of quality improvement activities aimed to enable proactive, detailed assessment of patients. This included prevention of cardiovascular disease by improving access to lipid lowering therapies, increasing the detection of high blood pressure and an automated hypertension protocol.
How staff, teams and services work together	• We saw examples of proactive joint working including: ○ **Grief and loss counselling**: The practice had identified a gap for counselling and the need for accessible, community-based grief and loss support. This was addressed by utilising funds from the practice budget with work with a The Cellar Trust (a local organisation specialising in bereavement support) to provide regular counselling clinics at the practice. The service provides support to approximately 15-30 patients each month and has been fully utilised since inception. ○ **First Contact Mental Health Service**: The practice had identified a recurring group of patients contacting the practice with mental health concerns who did not meet the threshold for the mental health practitioner or secondary mental health services, but whose needs could not be met during a standard GP consultation. In response to this, the practice worked in collaboration with Mind Foundation to develop a first-contact mental health service. The practice utilised funding to allow patients access to a 16 hour per week telephone clinic, providing structured mental health assessment, support and signposting. This has resulted in 32 patients per week, having access to front line support and signposting. ○ **Ultrasound guided injections**: The practice had developed an in-house ultrasound guided injection service within the musculoskeletal (MSK) pathway. This involved funding specialist training for a senior MSK clinician, investment in equipment and sourcing experienced external clinical support from an established local MSK service to help safely embed the model. This enabled them to provide patients with a timelier service, closer to home and avoided the need for them to be referred to a hospital setting for the procedure, therefore reducing pressure on hospital waiting times. • The practice had undertaken a review and redesign of the internal clinical communication system and created a one-click communications hub within the clinical system. This enabled clinicians to access protocolised workflows to arrange internal appointments, signpost patients externally, request investigations, send structured internal communications and submit cases to the weekly complex patient multidisciplinary meeting.
Supporting people to live healthier lives	• We saw evidence of numerous quality improvement projects undertaken by the practice which aimed to reduce health inequalities for the local population. This included:

	○ **Raising awareness of diabetes**: Recognising that Type 2 diabetes is highly prevalent in the locality and contributes significantly to cardiovascular disease, avoidable illness and reduced quality of life, the practice had undertaken a targeted outreach and engagement focusing on higher-risk patients with pre-diabetes. This was aimed at patients who had not taken up the offer of referral to the National Diabetes Prevention Programme (NDPP) and higher-risk patients who would most benefit from intervention. Through a combination of patient surveys and hosting an in-house diabetes prevention awareness day at the practice, the practice was able to identify barriers to engagement with NDPP and work to address these. For example, improvements to in-house communication strategies to include personalised diabetes risk numbers, clear explanation of the benefits of prevention and direct links to success stories and programme information. The practice shared information with the NDPP provider regarding timings of programme sessions, which some patients found difficult to attend and suggestions for improving how the programme is promoted. ○ **Increasing the detection of high blood pressure**: Implementation of a system-based hypertension detection and management programme aligned with NICE guidance to address undiagnosed hypertension within a high-risk population. This project was rolled out in phases commencing early 2025, steps taken included expanding NHS health checks to improve preventative engagement, dedicated staff members for requesting home readings and informing patients why these were important, proactive follow up and implementation of standardised standard operating procedures for blood test, urine and Electrocardiogram (ECG). This enabled the long-term conditions team to arrange tests without clinical input, ensuring everything was ready for the next stage. This work resulted in the hypertension register increasing by 10%, with the number of patients reaching their target blood pressure rising by 4% as of January 2026.
Monitoring and improving outcomes	• Leaders at the practice had recognised the need to increase uptake of vaccination and screening and in May 2025 had implemented a number of projects to address this including: ○ **Make every contact count** - a new practice wide approach to screening and vaccination: By utilising bespoke digital infrastructure, any staff member (both clinical and non-clinical) could easily identify outstanding preventative care needs and take steps to address these by sending invites containing a booking link by text message, accessing a verbal script to discuss benefits of screening or accurately recording a decision to decline. ○ Non-clinical staff who had never been involved with patients regarding vaccination and screening were supported to **proactively engage using behavioural nudge theory scripts** aimed to explain the process to patient and reduce barriers to uptake.

	○ A **structured drive to increase uptake of cervical screening**: In May 2025 the practice also expanded nurse capacity, introduced a structured recall system based on the patient's month of birth and introduced repeated invitations and behavioural prompts to improve engagement and uptake. ○ **A structured approach to improving childhood immunisation rates**: The practice identified that many children were missing or delaying routine vaccinations due to vaccine hesitancy and the lack of a reliable, auditable recall system. In response to this, a full record review was undertaken of all children born since January 2022, introducing a structured recall process and formally documenting each contact attempt to enable full tracking. As a result of this work the practice had noted an increased uptake of 32% for 6-in-1 vaccines, 161% increase for measles, mumps and rubella (MMR)/measles, mumps, rubella and varicella (MMRV) vaccines and a 28% increase for meningococcal group B (MenB). ○ **Patient engagement and outreach** - pregnancy and childhood vaccinations in deprived communities: Leaders at the practice had also identified low uptake of pregnancy vaccinations within the population. In response to this they had approached a local charity to discuss ways to address this. In conjunction with the charity, the practice engaged with pregnant women through community events, support groups and targeted outreach to increase awareness and uptake of pertussis, Respiratory Syncytial Virus (RSV) and influenza vaccines in pregnancy. Between August 2025 and February 2026, the practice engaged with 209 individuals including pregnant women and their partners via community events and personalised telephone contacts. This led to 40% of women taking up the offer of vaccination.
WELL-LED	
Shared direction and culture	• All of the staff we spoke with showed a clear desire to provide the best care and treatment to their practice population. Leaders at the practice had implemented new systems and processes to ensure all members of the practice team had input into this and spoke highly of staff motivation. All staff we spoke with and received feedback from demonstrated a genuine commitment to providing the best care and treatment to patients.
Capable, compassionate and inclusive leaders	• We saw the leadership team worked with other practices in the primary care network and were engaged in the development of primary care services within the local area. • During our site visit, we met with the leadership team who demonstrated a genuine commitment to improving health outcomes for the practice population. • We saw evidence of how transformation of systems and process had focused on a whole practice approach which empowered all staff teams to support health improvements for the practice population.

	• We reviewed data to support how non-clinical staff had actively participated in quality improvement projects such as opportunistic vaccination and screening invitations. • There was evidence of quality improvement activity which clearly considered the needs of all staff. For example, improvements to the internal clinical communication system, **implementation of RAPP button (report a positive or a problem)** to enable real time feedback from the non-clinical team and participation in the Healthy Practice Programme. • Leaders had **introduced an Associate Partner Scheme to support salaried GPs** working at the practice to develop into leadership roles. This included attendance at board meetings, involvement in discussions about practice strategy, operational pressures and organisational decision-making. This was aimed to support salaried GPs with transition into a partnership role.
Governance, management and sustainability	• We saw evidence of how the provider had taken a proportionate approach to managing risks that allowed new and innovative ideas to be tested within the service. For example, the **practice had utilised clinical systems to aid proactive identification of long-term conditions** such as high blood pressure. In addition, the practice had undertaken a total transformation of the appointment system in response to patient feedback. This utilised the clinical system to ensure relevant health information was accessible to clinicians to support the assessment process. • The practice had developed the [practice name] Roundup, a system to **ensure all staff were informed of new primary care guidance, safety alerts and operational changes**. This was circulated electronically to staff and also included a commentary from the practice leadership team explaining how the practice was responding to any new guidance.
Partnerships and communities	• The practice understood their duty to collaborate and work in partnership, so services work seamlessly for people. They shared information and learning with partners and collaborate for improvement. For example, clinicians at the practice **created a structured GP placement for paramedics** using existing training capacity to develop them safely into more effective primary care clinicians. This model combined a 6-week GP placement with close supervision, gradual case-mix expansion, fortnightly teaching, a standardised workbook and a safe prescribing formulary developed in-house with Yorkshire Ambulance Service. • In addition, the practice had **good relationships with research partners** including Bradford Institute for Health Research, the National Institute for Health and Care Research (NIHR) Agile Research Delivery Team and West Yorkshire Integrated Care Board (ICB) and had supported patients to take part in studies. Between April and September 2025, the practice was commended as one of the highest recruiting practices in West Yorkshire for NIHR portfolio research.

Learning, improvement and innovation	• They actively contribute to safe, effective practice and research. For example, the practice worked with the Primary Care Network to **create a PCN-wide training model so that education could be shared across practices**. This aimed to reduce pressure on capacity, particularly for smaller practices and practices with only 1 designated trainer. As part of the training model, the provider hosted around 6 training sessions a year, with the remaining 6 sessions being hosted across the rest of the PCN. • At the time of our inspection the practice had been shortlisted as 1 of 3 national finalists for the 2026 **SystmOne National GP Excellence Awards –** Operational Efficiency Award and was confirmed as the winner following our site visit. • Leaders at the practice were aware of the threats caused by **climate change** and acknowledged the practice's responsibility to take steps to reduce environmental impact. Feedback obtained from staff via the 'Healthy Practice' programme had also confirmed staff were eager to work towards becoming a greener practice if given the opportunity. Therefore, the practice took a whole-organisation approach to environmental sustainability across both clinical and non-clinical workstreams. Focusing on greener inhaler prescribing, more energy-efficient lighting, lower-energy heating controls, and reducing single-use plastic waste from soaps and cleaning consumables. • **Greener prescribing was embedded into routine clinical workflow** to support prescribing, clinical education and opportunistic shared decision-making at reviews. The practice monitored this via audit activity.

(See next page for "Requires Improvement" and "Inadequate" CQC Ratings)

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

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

	INSPECTION COMMENTS (*all scored 1 or 2 by CQC*)
SAFE	
Learning culture	• We observed recurring themes from significant events with no action being taken. For example, it had been reported in June 2025 that more than 1,000 diary dates required action. Diary dates are reminders

	in a computer system, for appointments such as x-rays, blood tests or scans. These remind the provider to action. Leaders had not actioned this and at the time of our inspection, had no plan to do so. • The significant event (SEA) policy had been updated since our previous assessment. It stated the likelihood of the incident recurring would be recorded, but this had not been recorded for any of the significant events we examined. SEAs were recorded on different templates with different levels of detail. • We saw 4 recent SEAs had been raised following prescribing errors by the same GP. There was no effective learning from these SEAs, and no evidence the issues were monitored. One of the SEA forms we were provided with, regarding a prescribing error, had not been entered onto the practice's formal system for recording and managing SEAs. This meant there was no effective way of monitoring the number, seriousness and actions from SEAs. SEAs were discussed in meetings, but minutes were very brief and did not contain enough information to inform staff of what had been discussed. We saw some discussions around SEAs that had not been recorded on the practice's SEA recording system. The provider told us all SEAs should be recorded on this system and there was no other record of SEAs kept. • Our assessment of November 2024 found there had been 4 prescribing errors by this same GP within a recent 5 week period. Not all of these had been formally recorded as SEAs. Safeguards had not been put in place to minimise the chance of these errors recurring. A further assessment in March 2025 found the provider had updated their SEA policy but it was not being followed; SEAs had been identified but not formally recorded. At this assessment we found improvements had still not been made by the provider, and they had not identified repeated prescribing errors as a theme which required action to prevent future errors being made. **(All points in this section: score 1 – inadequate)**
Safe systems, pathways and transitions	• We observed a lack of consistent communication between primary and secondary care. Clinical leaders told us that amongst the 1,000 patients with an overdue diary date, they were unaware who's care was being managed by secondary care services. (score 1 – inadequate) • Referrals and test results were not always managed in a timely way; this was due to staffing levels and a lack of effective processes. Clinical and non-clinical leaders provided us with a different overview of how test results were managed. Patients told us that they had to chase results, and we saw examples of patients who were told to contact the surgery. When they did, reception staff did not always know the reason for this, causing a delay in care. • The provider had a backlog of approximately 198 patients' paper records in a cupboard awaiting digitisation. They did not know how long they had been there, but a team member told us none had been digitised since they started to attend the practice in August 2025. Although they told us another provider

	was contracted to carry out this task, and they would be digitised when there were enough to be processed, they did not know how many were required or when this would be. • Test results were not always managed in a timely way. We checked outstanding test results on the afternoon of 10 April 2026. Test results, including those that were outside the normal range, had not been looked at since 7 April 2026, when all results had been actioned. The provider told us they usually carried out appropriate actions immediately, but they had not had the chance due to them working alone while the salaried GP was on annual leave. They had not arranged cover for the salaried GP while they were on leave. They said they would prioritise the urgent test results and they would clear them that afternoon or night. There were 69 results outstanding that had not been looked at, and 31 were noted as outside the normal range. Approximately 20 of these were from 8 April 2026. The provider explained that the pathology laboratory telephoned a practice if a result needed urgent action. Following the assessment the provider told us, “Myself and my GP colleague, on a daily basis, look and action on all the lab reports”. Our observations during the assessment found this statement to be incorrect. • The provider and the practice manager told us that reception staff had and followed a triage sheet to ensure patients were offered the most suitable care option. We asked to see this but none of the 3 members of the reception team knew where it was kept. Also, 1 could not recall if they had ever seen it. Not having an effective triage system meant that the provider could not be assured patients with the most urgent needs were seen in a timely manner by the most appropriate person. • On the day of our unannounced assessment there was no GP at the practice until approximately 8.35am. Their first face to face appointment was 9.30am. The provider told us there were times in the morning where no clinician was available. They told us that if a patient needed them before they arrived, the patient would be informed that a clinician would telephone them back. At our next site visit, the following working day, the provider told us they had decided to change their working hours and always be in by 8am.Following the inspection the provider told us that on the day of our inspection a GP assistant was on site from 8am and the practice nurse was on site from 8.30am. They told us they were available remotely to provide clinical support when required **(All points in this section: score 1 – inadequate)**
Safeguarding	• During our inspection we saw in excess of 500 people who had been triaged by an external provider. It was unclear if this provider had checked any safeguarding concerns during this process. We saw examples of patients who were at risk of harming themselves due to mental health being triaged with a potential wait of 4 weeks for an appointment**. (score 2 – Req Imp)** • The safeguarding policies for adults and children had been updated since our previous assessment. However, the safeguarding adults policy named the deputy lead as a GP who had not worked at the practice for several months. The safeguarding children policy named the admin lead as a staff member

	who had not been at the practice for several months. The provider told us the current salaried GP was the deputy for adults and children. The practice nurse and practice manager told us the practice nurse was the deputy for adults and children. We spoke to a staff member who was unsure who the leads were but stated they would know where to find the policies to find out. However, the policies were inaccurate. It is important that staff know who the leads are so concerns can be escalated urgently as appropriate. **(Both points above score 1 – inadequate.**
Involving people to manage risks	• Emergency equipment was available and maintained. Staff could recognise a deteriorating patient and knew of action to take. • Patients were not always advised on risks related to their condition and actions to take if their condition deteriorated. We saw examples of online triage forms which did not safety net patients appropriately. For example, a patient completing a consultation around mental health was not provided with information to enable them to contact crisis teams. **(Both points above score 1 – inadequate.**
Safe environments	• The provider had not undertaken legionella monitoring, did not have a written fire evacuation plan, and had not carried out fire drills or checks of emergency lighting. We identified environmental hazards, including a portable heater in use, the absence of a carbon monoxide detector, and rear fire door that was not compliant with fire safety regulations. The service had not completed a privacy impact assessment for the use for CCTV. We found out of date consumables in the surgery room including syringes. There was a damp patch and mould observed on a wall in the reception area, which had previously been reported to the leadership team, but no action had been taken to have the issue fixed. • We reviewed training documents which demonstrated clinicians were not up to date with some elements of training relating to safe environments. We reviewed an incident where a member of staff had been in the building and no one was aware. This was a risk in the event of a fire. Staff raised concerns with regard to lone working. We were made aware of incidents where staff had been the only person in the building.
Safe and effective staffing	• Supervisors told us they were unsure of the roles of staff they were monitoring. We saw instances where staff were working unattended in the building leading to circumstances which meant patients did not have access to a chaperone if they requested one. We noted that reception staff were expected to work alone, despite incidents of abuse from patients. Since our inspection we have been advised the practice had implemented a policy whereby 2 members of staff will be on reception at all times. • Staff told us that they felt staffing levels were unsafe. We saw safe recruitment processes for permanent staff. However, some locum GP's who had previously worked in the practice had not provided recruitment documentation before commencing shifts. We did not see evidence that DBS checks and references had been provided ahead of the first shift, and had been requested retrospectively.

	• We checked the personnel files for the 4 staff employed since our previous assessment. None of the 4 files contained all the required information. The practice had reviewed its recruitment policy, but this did not contain enough detail to inform the manager what information they required for newly recruited staff. The need for a full employment history was not noted in the policy. The practice's safeguarding policies included a section on safer recruitment, including the need to obtain 2 references, 1 of which should be from the most recent employer. This was not followed. • The practice manager told us that all Disclosure and Barring Service (DBS) certificates were held in the staff personnel files. There was no DBS certificate in the file for 1 member of the administrative team. The practice manager, who had been employed since 01/01/2026, had a DBS certificate from February 2022. • Training was not well-managed. Records held by the provider showed that the practice manager had only completed 1 training course. Some staff had not been trained in safeguarding. One staff member, who had been employed for 7 months, had completed 9 of their 19 training courses during the weekend prior to our 2nd site visit. On the day of our 1st unannounced site visit they had not completed training, identified by the provider to be mandatory, such as in safeguarding, information governance, and fire safety. The practice manager told us that there would be a new training plan in place from the month of our assessment. An action plan put in place by the provider following our November 2024 assessment stated they would ensure all staff, "especially new hires", received training. receive one-to-one supervision, training, and performance reviews, especially new hires. The evidence seen on this assessment showed that the action plan had not been followed. **(All points in this section: score 1 – inadequate)**
Medicines optimisation	• Not all staff involved people in reviews of their medicines and helped them understand how to manage their medicines safely. People knew what to do and who to contact if their condition did not improve or they experienced any unexpected symptoms. However, due to current staff capacity this could mean a long wait. We saw examples of patients waiting up to 4 weeks to be contacted. • We reviewed 5 records for patients who had a medication review coded in the last 3 months. All 5 records had a medication review coded but none had involved the patient or had any records made to show that patient's notes had been reviewed. We also looked at patient records for people who were being prescribed numerous medicines (polypharmacy). Polypharmacy is the concurrent use of multiple medications (often defined as 5 or more) by a single individual. Three out of the 5 patients we looked at in detail had not had their medicines reviewed since 2021. The other 2 patients had not had their medicines reviewed since 2022. This meant we could not be assured medicines were being prescribed safely.

	• We reviewed prescribing processes, it was unclear how leaders wanted this to work. We were provided conflicting information regarding how many re-issues were within the process. It was unclear which partner had taken responsibility for prescribing, the previous lead had left the practice. • We saw that several significant events (SEAs) had been raised due to prescribing errors by 1 GP. We saw 4 of these were between January and March 2026. Meeting minutes we reviewed indicated that there had been other prescribing errors by this GP that had not been raised as SEAs. Some of the errors involved controlled medicines, including opioids. There are risks of serious harm to patients when controlled medicines are mis-prescribed, and the prescribing is associated with overuse, misuse or addiction. Misuse of opioids can be life-threatening. Other than the GP being reminded to carefully review doses, dates, and a patient's history before prescribing, no action had been taken to minimise the risk of this happening again. Although several errors had been identified, there was no proactive check to ensure other prescribing errors had not occurred. The prescribing errors we found had the potential to significantly impact on the health of the patients involved. Our assessment of November 2024 had found similar issues and at this assessment no improvement was seen. • 18 patients had been prescribed bisphosphonate, used for treating bone related conditions, for 5 years or more. We checked 5 of these patients in detail. All 5 required a review, including a bone density test, to check if it was appropriate and safe to continue being prescribed the medicine. **(All points in this section: score 1 – inadequate)**
EFFECTIVE	
Assessing needs	• Staffing challenges meant that clinicians did not have time to assess the needs of patients beyond the presenting complaint. This demonstrated a lack of holistic care. This meant that potentially undiagnosed conditions would be missed. Staff were under pressure due to the number of patients waiting to be seen. There was a lack of continuity of care, for example one clinician had documented a plan for a patient, which included a return appointment if symptoms did not improve. This was not actioned and this patient had to wait 4 weeks to be seen again. • We noted some documentation did not include patient preferences. We saw evidence that medication reviews were coded but had not taken place. Leaders told us this was due to a computer system issue. We will review medication reviews at our next inspection. The triage system for patients that was in place at the time of our inspection did not provide assurance that protected characteristics were considered. • People's needs were not always assessed using the appropriate range of assessment tools. Tools were not always used correctly or appropriately. For example, medication reviews. We also saw triage forms which incomplete information. People were not signposted appropriately whilst waiting for an appointment. **(All points in this section: score 1 – inadequate)**

Delivering evidence-based care and treatment	• Systems were not in place to ensure staff were up to date with evidence-based guidance and legislation. We saw examples of reviews of patients being overdue in terms of recognised best practice and expected standards. In some cases this was up to 4 years. Prescribing best practice was not followed.
How staff, teams and services work together	• The service was inconsistent with how care was planned and co-ordinated. Communication with an external patient triage provider was not sufficient to keep patients safe, or ensure care was provided in a timely and effective manner. We reviewed evidence which indicated the practice did not utilise local services effectively; for example, a walk-in contraceptive clinic that patients could have been signposted to, but were not. **(All points in this section: score 1 – inadequate)** •
Supporting people to live healthier lives	• Patients were not always involved in reviewing their health, and those who had been were not being reviewed as frequently as they should have been. We reviewed evidence which indicated the system that recalled patients was not effective. There was not a consistent approach to ensuring patients were supported and encouraged to maintain their own health. Due to patient demand, clinicians were not always able to utilise health promotion opportunities. •
Monitoring and improving outcomes	• The service did not routinely monitor people's care and treatment to continuously improve it. They did not ensure that outcomes were positive and consistent, or that they met both clinical expectations and the expectations of people themselves. The monitoring of patients was not effective. We noted that numerous groups of patients were consistently overdue for reviews, such as those awaiting prostate specific antigen (PSA) monitoring this is used to detect or monitor risk of prostate health, it is crucial to patients with or who are at higher risk of prostate cancer. Clinical leaders told us this was due to administration issues. It is unclear which patients we reviewed were overdue within the practice, or whom were treated by secondary care. Clinical leaders were not documenting this in patient notes. We also note patients requiring blood pressure monitoring for contraception were not reviewed in a timely manner. • From the clinical notes we reviewed, we found that people were not receiving reviews in line with current guidance. This had been raised by staff to leaders with no improvement plan identified. • Patients who were awaiting re-call for diagnostics such as x-rays were noted to be in a backlogged system. Clinicians had attempted to raise this with partners but had been ignored. Some patients had been waiting in excess of 5 years. **(All points in this section: score 1 – inadequate)**
Consent to care and treatment	• The service did not always tell people about their rights around consent and did not always respect their rights when delivering care and treatment. We reviewed records of consultations whereby it was not

	clear from the records if patients had been offered a chaperone. We also saw evidence which indicated staff lone working when running clinics where chaperones should have been offered and could not be.
CARING	
Kindness, compassion and dignity	• Staff told us that shorter appointments that were being offered to patients did not give staff the opportunity to offer their preferred level of compassion and communication to patients to provide a holistic approach to care. Staff told us that they tried their best in difficult circumstances to deliver good care. National GP Patient Survey data showed that 64% of respondents would describe their overall experience of this GP practice as good. This was lower than the national average of 75%. • We received 108 submissions of feedback from patients. This was positive toward clinicians, nursing staff and receptionists. We also received numerous examples from patients who told us one clinician was rude and impersonal. Patients report feeling rushed during consultations with this clinician. They also told us where possible they preferred to see another doctor. **(All points in this section: score 1 – inadequate).**
Treating people as individuals	• The practice leadership were aware of issues with the patient recall system within the practice. We saw that an example of a missed recall included a patient with a learning disability. Consideration had not been given to this person's individual needs when arranging for a further appointment to take place. Information from our clinical searches showed that care and treatment such as medication reviews, did not always account for people's individual needs.We were not assured that patients individual needs and communication preferences were being considered as part of the patient triage process one the form had been completed. • A representative from the PPG told us that the practice had been keeping its head above water for years, and that this had impacted patient care. Patients were aware that numerous staff members leaving had a negative effect, as the practice could not recruit new doctors with the same experience.
Workforce wellbeing and enablement	• There were significant areas of poor working culture. Staff told us they felt discouraged from providing feedback and suggestions about the ways in which to improve the service for people, and some described being afraid to do so. There was little wellbeing support for staff. Staff told us they felt discouraged, and afraid for patient safety. Staff felt an immense amount of responsibility for patients and the care they received. Staff did not get support from practice leadership if they were struggling at work. There was a feeling of low morale within the practice, and staff told us they struggled to think about what the future of the practice looked like. • The practice leadership did not encourage or promote a healthy work-life balance for their staff. In response to concerns about capacity of appointments, the practice leadership had suggested that GPs

	should work more hours and overrun on clinics where short appointments were offered. Staff told us that they would often complete excess work at home. **(All points in this section: score 1 – inadequate)**
RESPONSIVE	
Listening to and involving people	• Patients told us that complaints were responded to using **AI tools**. We saw evidence of this. Patients did have the option to speak with a member of management if they were not happy with the outcome of the complaint. We were not assured that appropriate clinical oversight was given to complaints. Patients told us, complaints had been answered with a generic response. Sometimes produced by an AI programme. There was no evidence that clinical leaders reviewed complaints, and developed training or further supervision where required. Leaders were unaware of or dismissive of what people who used the service thought of their care and support. Patient views were not always taken into consideration. **(Score 1)**
Equity in access	• Our assessment of November 2024 found people could access appointments but usually had to wait a long time to see the lead GP after they arrived, with it not being unusual for patients to be seen over an hour late due to the length of time the lead GP spent with people. The March 2025 assessment found there were still delays. At this assessment we looked at the provider's appointments for the previous 3 weeks. Only 1 clinic started at the correct time. We analysed 87 appointments, and 49% of patients were seen 30 minutes or more after their given appointment time. 23% of patients were seen 45 minutes or more after their given appointment time. The action plan the provider put in place following our November 2024 assessment. This stated they would implement and enforce a system to ensure appointments ran on time. Evidence seen on this assessment showed this system had not been successful. **(Score: 1)**
WELL-LED	
Shared direction and culture	• The service did not have a shared vision, strategy and culture based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. They did not understand the challenges and the needs of people and their communities. Leaders had not done a review of a newly implemented patient triage system despite staff raising legitimate concerns about it. They failed to act when staff raised concerns around patient safety. Conflict between senior clinical leaders had led to a toxic culture where staff felt frightened to speak. Staff reported feeling bullied and manipulated into working in situations they did not feel comfortable in doing so. • The practice did not have a sustainable plan to repair these issues at the time of our site visit, despite these issues being raised at previous assessments. The negative culture had been noted by staff, leaders, PPG members and an MP.

	• Following our previous assessment the provider, with the help of the Integrated Care Board (ICB) and another organisation, put an action plan in place. This served to document improvements needed for the practice, and to monitor improvements as they were made. At this assessment the provider told us this was no longer in use, and it had not been updated since approximately October 2025. They did not have a formal improvement plan and instead had some dedicated administration sessions which they said they used to monitor improvements but did not note anything down. At this assessment we found the provider was still in breach of the same Regulations and minimal improvements were seen. • We asked the provider about meetings held at the practice. They told us there was a monthly practice meeting and a separate monthly clinical governance meeting. We found this was incorrect. When we asked for minutes, we were told that clinical governance meetings had not been held since November 2025. • Our previous assessments found there was no succession plan in place for the practice. At this assessment the provider told us the salaried GP would take over the practice if the provider left or was taken ill. Although they told us there was a documented succession plan, this was not supplied. **(All points in this section: score 1 – inadequate)**
Capable, compassionate and inclusive leaders	• The service did not have inclusive leaders at senior clinical level who understood the context in which they delivered care, treatment and support, or who embodied the culture and values of their workforce and organisation. Leaders did not have the skills, knowledge, experience and credibility to lead effectively, and they did not do so with integrity, openness and honesty. Ongoing conflict between clinical leaders had impacted clinical care. Staff told us they did not know which leaders processes or instructions to follow. • Staff told us non-clinical management were approachable and responded to any concerns raised. However, staff told us clinical leaders would not respond to concerns if they raised them with them. • There was no effective succession planning at the time of our assessment, we asked leaders to explain intentions for the next twelve months, we were not provided any evidence of a plan the conflict between clinical partners had impacted the whole practice. One partner had spoken of potentially merging with other practices in the local area this was in infancy stages. The practice was actively trying to recruit GPs. **(All points in this section: score 1 – inadequate)**
Freedom to speak up	• People did not feel they could speak up and that their voice would be heard. We saw examples of staff raising concerns surrounding patient safety. These were ignored by clinical leaders. Within the partnership, there was fear amongst leaders. • The practice had established Freedom to Speak up arrangements with other practices in the primary care network. Staff were aware of how to raise concerns, however felt frightened to do so. Staff felt

	bullied. A report had been written by an external Freedom to Speak Up Guardian. They had spoken to numerous members of staff. It was not clear how leaders intended on addressing the serious issues highlighted in the report. **(All points in this section: score 1 – inadequate)**
Governance, management and sustainability	• There was a lack of governance oversight by the provider. We found significant issues with the management of significant events, complaints, recruitment and safe prescribing. Since the provider registered with CQC in April 2021 they have consistently been in breach of legal regulations relating good governance or safe care and treatment. • There was some confusion around what meetings took place, with the Provider and another clinician telling us about monthly clinical governance meetings taking place separately from the monthly practice meetings. These had not been held for 5 months. • We found the provider had 2 active websites which could cause confusion for patients. They both appeared in search engines, and both included the Provider's current address, which they moved to in June 2023. This meant some patients may have searched for information and not be aware they were looking at a dated website. **(Score 1)**