

CQC Inspection Reports of NHS GP Practices Published in October 2026

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

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS <i>(all scored 4 by CQC)</i>
EFFECTIVE	
Assessing needs	• The provider had effective systems in place to identify people with previously undiagnosed conditions and to proactively support those who may not be engaging with healthcare services. This included the use of a dedicated ‘missingness’ programme, through which staff actively identified patients who had not attended the practice within a specified timeframe or had not participated in recommended health checks and reviews. The practice took a proactive and holistic approach to assessing people’s needs, including visiting patients in their own homes to better understand any barriers they faced, build trusting relationships, and gain a comprehensive understanding of their individual circumstances and support needs. (Score 4) • The practice made effective use of the social prescribing services available within the Primary Care Network (PCN) to support patients with a range of non-clinical needs. In addition, the practice had embedded a focused care worker who managed their own caseload and provided enhanced, personalised support to patients, helping to ensure that those with more complex needs received coordinated and ongoing care. The focussed care worker on average provided person

	centred care to around 125 households per year. Approximately 25% of those being of lower complexity, typically assessed and discharged within 3 months. A further 50% were of moderate complexity and received support for between 3 and 9 months. The remaining 25% were people with higher complexity of need, receiving support for 9 months or longer. (Score 4)
Supporting people to live healthier lives	- The practice demonstrated a strong commitment to meeting the needs of the LGBTQ+ community through a focused and inclusive approach to care. This included providing dedicated services for transgender patients, ensuring they had access to appropriate, person-centred support tailored to their individual needs. The service also holds the Gold accreditation in Pride in Practice. The service also provided a dedicated Recovery Support Group, 'Recovery', which runs fortnightly for patients requiring support with alcohol and substance misuse, as well as those seeking to maintain sobriety. The group offered a supportive and non-judgemental environment where individuals could access guidance, peer support, and ongoing encouragement to help them achieve and sustain positive outcomes. (Score 4) The practice also delivered a Low Carb Group, which provided patients with lifestyle and dietary support to help them make informed choices about their health and wellbeing, data showed that 83.3% of attendees successfully lost weight after the 6 week group, and 100% of attendees intended on carrying on the lifestyle. The group offered education, guidance, and encouragement to support healthier eating habits and lifestyle changes, particularly for those seeking to manage their weight or improve long-term health conditions. Where people needed more one to one support they could be referred to the focused care worker where an individualised care plan is developed, this could be in relation multiple lifestyle factors including reducing alcohol consumption and smoking cessation. (Score 4)
How staff, teams and services work together	We found evidence that regular meetings were held across the service, including clinical, nursing, non-clinical, partner, safeguarding, quality, and safety meetings. These forums promoted effective engagement across the wider team and provided staff at all levels with opportunities to share their views and contribute to service development. The practice maintained strong and productive relationships with key stakeholders and partner practices within its Primary Care Network (PCN). It closely monitored secondary care data, proactively identifying gaps in local provision for example they had identified a link between patients voluntarily discharging themselves from hospital and high mortality rates. As a result, they actively made contact with people on discharge to understand individual circumstance and how together with other health and social care partners they could support people to access and attend health care. (Score 4)
CARING	
Kindness, compassion and dignity	92% of respondents to the survey felt the healthcare professional at their last appointment was good at treating them with care and concern, compared to a national average of 86%. (Score for this category: 3, but score for Caring overall key question: 4)
Workforce wellbeing and enablement	- We saw evidence of initiatives aimed at creating positive working relationships and staff engagement, including regular team-building days and practice events, such as Employee Appreciation Day. The practice developed role-specific appreciation initiatives to ensure staff at all levels felt valued and recognised, including national receptionists' day and nurses' appreciation day. (Score 4) - Staff told us they felt encouraged and supported to develop within their current roles and were provided with opportunities for career progression within the practice. They also described a culture in which they felt empowered with ideas and

	suggestions for service improvement were actively welcomed. For example, the nursing team identified a need for additional support for men's health and were empowered to propose and help develop initiatives to address this need , demonstrating the practice's commitment to innovation and responsive service development. (Score 4)
Treating people as individuals	- Reasonable adjustments were embedded throughout the service and supported by comprehensive alerts on patient records that highlighted individual needs. These included communication preferences, requirements for adjustments to appointments or contact methods, mobility and environmental needs, and cognitive or clinical considerations. Effective systems were in place to help staff identify, anticipate, and respond to these needs, ensuring care was accessible, personalised, and responsive at every stage of the patient journey. Patients' communication needs were routinely recognised and accommodated, enabling them to participate fully in decisions regarding their care and treatment. This included access to British Sign Language (BSL) interpreters and translation services, as well as extended appointment times where necessary to support patients with communication needs, or complex conditions. (Score 4) - We saw evidence of a range of support tools and resources designed to promote people's independence and improve access to services. For example, all staff had received training in autism and learning disabilities, providing them with the knowledge and skills to support individuals who may experience difficulties with accessing healthcare services. Staff were also provided with enhanced chaperone training, further strengthening their ability to offer personalised, compassionate, and appropriate support to patients. (Score 4)
Responding to people's immediate needs	- There was a robust system for appointment triage that ensured people with immediate needs had access to services, with clearly documents process for staff to follow should they need to escalate any concerns for a patient's welfare. Staff we spoke with knew the process for referral to emergency support, including mental health crisis teams. In response to the significant levels of social deprivation and recognising the complex social and healthcare of the local population, the practice employed a focused care worker to provide additional support to patients. The practice employed whole time equivalent (WTE) GP workforce, with 2.22 WTE GPs per 3,500 patients. A full-time GP Assistant was also in post who supported clinicians by streamlining administrative tasks, allowing more time for direct patient care. This additional capacity enabled the practice to effectively manage the needs of its patient population, maintain timely access to care, and ensure patients' needs were consistently met. This combined with the additional support the focused care worker offered people meant they were able to respond holistically to people's needs. (Score 4) - Staff told us that when patients experienced a bereavement, their usual GP would contact them to offer support and condolences. This was often followed by a consultation arranged at a time and location that met the needs and preferences of the bereaved individual or family. Where appropriate, patients were also provided with information and guidance on accessing bereavement counselling, support groups, and other relevant services to help them during their period of grief. (Score 4)
RESPONSIVE	
Equity in access	The service provided support to help people access and use digital services, including online access to records and the NHS App. Staff encouraged people to contact the practice if they required assistance with accessing or navigating these services. Treatment rooms were available on the ground floor, and an automatic door had been fitted at the entrance to help ensure the service was accessible to people with mobility needs. (Score for this individually: 3 but overall score for Effective key question: 4)

Equity in experiences and outcomes	Staff followed processes to ensure people could register at the service, including those in vulnerable circumstances such as homeless people and Travellers. Staff used systems to capture and review feedback from people who used the service. The practice was also accredited as an Armed Forces Veteran Friendly practice, demonstrating its commitment to meeting the needs of military veterans. (Score for this individually: 3 but overall score for Effective key question: 4)
WELL-LED	
Shared direction and culture	The practice operated as a not-for-profit community interest practice, with a clear focus on identifying local population needs and delivering care to those who required it most. Staff had contributed to the development of the practice's vision and strategy, helping to create a shared sense of purpose and ownership across the organisation. The strategy had been developed in collaboration with stakeholders and was regularly reviewed and discussed with staff and patients through the Patient Participation Group (PPG) to ensure it remained relevant and responsive to evolving needs. (Score 4)
Capable, compassionate and inclusive leaders	Leaders were clearly committed to meeting the needs of the most vulnerable in their cohort of patients. Leaders were proactive in reviewing data, seeking out partner agencies and organisations that would support them in promoting the best outcomes, services and amenities for people who used the practice, such as 'Child Mortality in Temporary Accommodation'. The 'GM Deprivation – GPST Training Programme' formed a robust framework to ensure equal opportunities and drive to promote and recruit people to work with patients facing health inequalities as a result of deprivation. Leaders also demonstrated a willingness and ability to share best practice and learn from others by opening up training to other practices within the PCN. There were leads within the practice for infection control, safeguarding, dementia, focussed care and chronic disease and staff knew who they were. These leads provided expert guidance and support to ensure care was tailored to individual patients' needs. (Score 4)
Governance, management and sustainability	The practice identified that some patients faced barriers to engaging with preventative healthcare services and, in response, implemented a targeted recall process to improve uptake and ensure patients received timely and appropriate care. They did this by allocating a designated member of the administration team managed weekly recalls for cervical screening and childhood immunisations. Using a live EMIS-generated list of patients who were due or overdue, they proactively contacted patients to encourage attendance, followed up non-responders and those who had not attended appointments, and recorded all outcomes in clinical records. This ongoing process helped identify and support eligible patients to access important preventative healthcare services and address any barriers to engagement. (Score 4)
Partnerships and communities	Staff had made adjustments to improve coordination of their service with community healthcare services. The practice was run by Hope Citadel Healthcare CIC, which was actively in partnership with Focussed Care, The Deep End and The Shared Health Foundation. Each of these partnerships uniquely focussed on the health and well-being of the direct population of the practice, supporting the most vulnerable patients and those in poverty and deprivation. This also enabled a training development scheme for GP registrars to train and retain GPs who specialise in these population groups, creating a more person centred and successful provision of care. (Score 4)

Learning, improvement and innovation	• The practice team demonstrated a proactive and innovative approach to service delivery and was actively involved in local pilot initiatives aimed at improving outcomes for patients within the community. For example, the ‘Low Carb Diabetes Group’ and the ‘Missingness’ initiative. The practice had implemented a focused care model, recognising the complex needs of its population and adopting a holistic approach to care. This model integrated patients’ physical health needs with their emotional, psychological, social, and economic circumstances, enabling staff to address the wider factors affecting health and wellbeing. (Score 4) • The practice had established a deprivation training scheme to support the recruitment, development, and retention of staff, ensuring they were equipped with the skills, knowledge, and experience needed to effectively meet the needs of the local population and work within an area of significant deprivation. As a result, patients were supported in a more personalised and coordinated way, helping to improve engagement with healthcare services and achieve better overall outcomes. (Score 4)
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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	We reviewed a complaint where a person was given a bowel disease screening test containing identifiable information about other people using the service, including the reason for their testing. In response to the complaint, the service told us they revised its process to ensure people were given screening tests during their appointments. However, the service was unable to evidence the updated process or the learning identified had been communicated to staff and embedded in practice. The service had also not considered this incident as a significant event and Duty of Candour had not been followed to inform those involved. (Score: 1)
Safe systems, pathways and transitions	- The service still did not ensure that test results were reviewed without delay. During our onsite visit we identified 9 test results assigned to a staff member who was absent from work, 5 of which were identified as abnormal. The service had not identified this as a risk or ensured the results would be monitored and reviewed to prevent delays in care and treatment. They only became aware of these results after we raised this with them and encouraged them to ensure they were reviewed. (Score: 1) External meeting minutes reviewed from quarterly palliative care multidisciplinary team (MDT) meetings held at the service did not record attendance, meaning it was not possible to determine who was present for key discussions. Staff told us that, although these meetings were held at the service, a clinician from the service did not always attend. This limited the service's involvement and oversight of discussions relating to people's care. (Score: 1)
Safeguarding	Staff were still not always clear about the internal escalation process for safeguarding concerns. Staff were also unable to consistently describe how to make safeguarding referrals or identify the appropriate external agencies to contact. Staff told us they would raise concerns with their line manager and would rely on them to escalate concerns to the safeguarding lead and make any necessary referrals. (Score: 1) - At the previous assessment in September 2025, it was identified that the provider's safeguarding policy contained outdated guidance regarding training requirements, and that some staff had not attended a safeguarding training event

	and were therefore not trained to an appropriate level. At this assessment, the policy guidance remained inconsistent with current published guidance on safeguarding training requirements within GP practices. In addition, the provider was unable to provide evidence that staff who had previously not completed the required safeguarding training had since done so. (Score 2)
Involving people to manage risks	• Arrangements for responding to medical emergencies were not effective. The service had still not fully assessed or mitigated risks associated with emergency medicines, including the risk that some medicines may not be accessible when required. During our onsite visit, arrangements did not provide assurance that all emergency medicines would be immediately accessible should a medical emergency occur. In addition, the service was unable to demonstrate effective oversight of emergency medicines stored between the emergency trolley and dispensary, including which medicines were held in each location. Documentation identifying the location of emergency equipment and medicines remained unclear, creating a risk of delays in an emergency response. Medicines held for emergency use were not stored in line with national guidance, as they were not kept in a tamper-proof manner. As a result, the service was unable to demonstrate the safe management of these medicines, provide evidence of when they had last been used, or ensure they were protected from loss, misuse or unauthorised access. (Score: 1)
Safe environments	• Arrangements for health and safety including fire safety, were not effective. Actions identified through risk assessments had not been completed, and the service was unable to evidence compliance dates had been met. Staff were unable to clearly describe the respective roles and responsibilities of the service and the council, as owner of the building, which reduced clarity in the management of health and safety risks. The service was also unable to evidence essential safety checks had been completed, including the electrical wiring certificate and annual fire panel service. Risks identified through the fire risk assessment, as requiring action by the end of March 2026 and May 2026, had not been completed or scheduled. These included servicing of fire safety systems, emergency lighting, fire extinguishers and the gas boiler, as well as repairs to fire safety equipment and completion of a fire door survey. (Score: 1) • An external Legionella risk assessment carried out in March 2026 had identified several actions, some of which were classified as high-risk actions requiring completion within 3 months. At the time of our assessment none of these actions had been addressed. (Score 2) • The service had undertaken health and safety risk assessments, including those around fire safety and legionella risks. The findings of some assessments indicated that actions were required to reduce the risks identified. Some of those risks had been assessed as high and required immediate action, but not all of those risks had been addressed. Some actions were described by managers as difficult to achieve due to the age and condition of the building as they were logistically challenging and required financial investment. (Score: 1) • We saw that a few clinical rooms had no lockable doors. Some of these rooms contained clinical refrigerators, medicines and sharps. This compromised effective medicines' management and put staff and patients at risk. • The practice's fire risk assessment was out of date and had not been reviewed. As a result of a recent fire evacuation drill, it was discovered that the fire alarm system was not audible of the first-floor administrative area of the premises. The provider told us that this was due to be fixed as a matter of urgency. Out of 26 staff, 5 staff were not up to date with mandatory fire training. Electrical appliance testing was also overdue for all items on the practice's inventory. (Score 2)

	• The service had a business continuity plan which outlined how the service should continue to operate in the event of a disruption, but a hard copy was not kept offsite which would have provided contingency in such an event. • We saw that an NHS Smartcard (a physical, chip-based ID token used by healthcare staff to securely access clinical records and national systems like the Electronic Prescription Service) was left unsecured in a clinical storage trolley in an unlocked room. This posed a risk of unauthorised data access and identity confusion. (Score 2)
Safe and effective staffing	• The service still had not ensured staff records contained all necessary information to demonstrate that safe recruitment processes were followed. We reviewed 5 staff records and found they were incomplete or information was not always available to demonstrate that appropriate employment checks had been undertaken. Specifically, we found information was missing relating to the interview process, Disclosure and Barring Service (DBS) checks, proof of identity, professional registration checks and information relating to staff members' physical and mental health. Additionally, where health questionnaires identified conditions that could affect a staff member's ability to carry out their role, no risk assessments had been undertaken to identify appropriate reasonable adjustments. Where information was incomplete or unavailable, the service had not risk assessed the impact of this. (Score: 1) • The service had not ensured staff acting as chaperones had received a current Disclosure and Barring Service (DBS) checks. We were told clinical staff were responsible for chaperoning duties, however we found some of these staff members did not have a DBS or risk assessment in place, as required by the service's own policy. (Score: 1) • Not all staff who worked alone had completed necessary training to support them in that role. The service told us that to mitigate the risk of lone-working, staff received face to face basic life support training to ensure they could respond appropriately should a medical emergency occur. However, training records showed this had not been completed by all relevant staff. This had not been identified by the service. (Score: 1) • The provider was unable to evidence the level of training undertaken in some areas, such as mental capacity act and preventing radicalisation. Furthermore, the previous assessment in September 2025 had identified that there was no clear system in place to record or have oversight of role-specific training. We reviewed 2 training records and found that neither contained evidence of role-specific training which demonstrated this concern had not been appropriately addressed. (Score 2) • The provider could not locate some appraisal documentation at the time of our assessment. We saw evidence of clinical supervision processes including consultation reviews and prescribing audits for non-medical prescribers. (Score 2) • We observed that a record of DBS numbers were retained by the practice for the majority of staff, however, the records did not indicate whether the DBS check had revealed anything of note or whether it was clear. There was a new member of staff recently recruited who had started working at the practice, but whose DBS check had not been requested, nor had a risk assessment been completed to adjudge if it was appropriate to work without one. (Score 2) • Leaders stated supervision for non-medical prescribers was in place, however this was informal and not documented. More formalised supervision had been planned but had not yet been implemented. (Score 2) • Some training was not relevant to some staff members and so they did not complete it, but it was not possible to know if this was overdue because it was not relevant or whether it was relevant but not completed. It was also not easy to determine how overdue the training was. A manager was in the process of attempting to rationalise training lists

	and compile a manageable matrix. They had started with training such as life support and safeguarding, but other key mandatory training had not yet been included in the matrix. (Score 2) • The service could not demonstrate that it followed safe recruitment procedures when employing staff, which were in line with national legislation. This included identity checks, review of qualifications, obtaining of professional references and a criminal records check. Some staff had a disclosure and barring check, but some did not, and there was no risk assessment undertaken to explain the absence of such checks. There was no consistent process for renewing staff DBS checks, and some staff members had not had one obtained for more than 4 years. (Score: 1) • There was an induction/competency checklist for all of the staff files that we reviewed. These had not been completed or signed off in full in any of the examples that we reviewed. There were no records of clinical supervision documented. There was no system to ensure that appraisals and one-to-ones were carried out regularly. In one instance we saw that a clinician had been onboarded and had signed their employment contract and were on the rota before disclosure and barring checks and references had been secured, or induction commenced. (Score: 1) • There were no recruitment files available for any GPs. When we spoke to the provider about this, we were told that they keep their own files in their possession. This created the potential to impact on the oversight of safe staffing because it conflicted with data accountability. (Score: 1) • At the time of the inspection records showed that not all staff were up to date with training deemed by the provider as mandatory. Although the service monitored training compliance and carried out regular checks, several mandatory training requirements had not been completed within expected timescales. These included Basic Life Support, Health and Safety, Manual Handling and Mental Capacity Act training for some staff members. This meant the service could not provide full assurance that all staff had received the training necessary to carry out their roles safely and effectively. [SS2.1] Whilst we did not identify evidence of direct patient impact during the assessment, these gaps increased the risk that staff may not always have the knowledge and skills required to carry out their roles safely. (Score 2)
Infection prevention and control	• During our onsite visit, we observed that some cleaning equipment, including wet mops, were being hung up and stored in the COSHH cupboard. We observed moisture damage to the walls and flooring in the cupboard and disposable mop heads were being reused despite being intended for single use. Cleaning products, including bleach sprays, continued to be stored within a kitchen area. This indicated that systems for the safe storage and management of hazardous substances were not being consistently followed. Cleaning records displayed within service toilets, intended to document when areas were checked and cleaned and by whom, had not been completed. The service was therefore unable to demonstrate that routine cleaning and monitoring of these areas was taking place. We raised this with the service who had not identified these concerns. Service leaders told us they were in the process of changing to a new external cleaning provider; however, they were unable to demonstrate how they were monitoring or addressing ongoing concerns while waiting. (Score: 1) • The IPC lead had been newly appointed and had not yet received training for the role. Although the service completed an IPC audit in March 2026 with support from the Integrated Care Board (ICB) IPC Lead Nurse, the audit had not identified all areas of concern including concerns we observed during assessment. At the time of inspection, not all actions identified through the service's IPC improvement work had been completed. Outstanding actions included

	removing obstructions to hand hygiene facilities, implementing cleaning schedules for infrequently used equipment, and obtaining staff immunisation records relevant to their roles. (Score: 1) • The service had still not ensured clinical waste was stored securely in line with NHS England and the Health and Safety Executive (HSE) standards. For example, the lock on the external door providing access to the clinical waste bins was broken which meant the area was not secure. Additionally, the bins in the storage area were also unlocked. • An IPC audit completed in April 2026 identified areas for improvement, and an action plan had been developed. However, the provider was unable to provide evidence of progress against the action plan or demonstrate that all actions had been completed. For example, 1 action was to display hand hygiene posters in all clinical rooms. During our assessment, we did not see hand hygiene posters displayed in either of the 2 clinical rooms we looked at. We also observed high-level dust in 1 clinical room, which did not support effective IPC measures. (Score 2) • We saw that a few bins did not have any type of lid and some with lids were not foot-operated in line with best practice for non-touch techniques. (Score 2) • The provider had acknowledged that the fabric of the chairs in the waiting area was beginning to disintegrate and posed a risk of infection. (Score 2) • The service's infection prevention and control lead told us they conducted regular risk assessments and audits to ensure compliance and took action where necessary to mitigate any identified risks. However, there was no timescale for completion and no indication of the severity of the risks attached to these audit findings. There was no indication of who was responsible or most appropriate for completing the action. Most staff had completed relevant training in infection prevention and control, with a few gaps. There was no protected time for the infection prevention and control lead, above their usual clinical duties and clinical administration time, to afford time to the role, which increased pressure. (Score 2)
Medicines optimisation	• The service had not ensured people impacted by Medicines and Healthcare products Regulatory Agency alerts were informed of the risks. For example, out of the 4 people prescribed SGLT2 inhibitors, a medicine used to treat diabetes, heart failure and chronic kidney disease, none had been informed of the associated risks. Whilst the service had taken action to inform people already prescribed this medicine following our last assessment, it had failed to ensure people recently prescribed this medicine were informed of the associated risks. (Score: 1) • Out of 37 people who were prescribed ACE inhibitors or Angiotensin II receptor blockers, which help manage blood pressure and protect kidney and heart function, we reviewed 5 records. Of those 5, we identified 1 person who had not received necessary interventions following abnormal pathology results. This exposed the person to the risk of harm which could include symptoms such as muscle weakness and cardiac arrest. (Score: 1) • The service had still not ensured people experiencing polypharmacy (defined as being prescribed more than 10 medicines) received a medicine review in line with national guidance. We reviewed 3 out of 155 people identified as experiencing polypharmacy and found that none had received a review in the last 24 months. (Score: 1) • During our onsite visit, we observed areas of the practice to be in a poor state of repair. There were damp patches on some walls, there was peeling paint and plaster, chipped paintwork, wallpaper on some walls, fabric window coverings that were not wipeable and there was carpet flooring in some clinical areas. The environment was not conducive to good infection prevention and control. (Score 2)

	• We reviewed records for patients with diabetes whose most recent blood sugar levels indicated poor diabetic control. We identified 154 patients and reviewed a sample of 5 records. Concerns were identified in 4 out of 5 records reviewed. The records did not demonstrate that appropriate monitoring was always in place and there was limited evidence of the service attempting to address this. We found examples of overdue urine albumin creatinine ratio (ACR) testing, blood pressure readings requiring follow up that had not been reviewed, and patients who were overdue diabetes reviews but continued to receive prescriptions. (Score 1) • We also reviewed records for patients with hypothyroidism who were overdue thyroid function monitoring. We identified 37 patients and reviewed a sample of 5 records. Concerns were identified in 5 out of 5 records reviewed. Patients continued to receive prescriptions despite overdue monitoring, and the records did not demonstrate that effective action had always been taken to address this. Records showed repeat dispensing arrangements had been initiated or continued despite monitoring requirements not being met, increasing the risk that patients could continue to receive treatment without appropriate review. (Score 1) • We reviewed medication reviews completed by the service and identified concerns in 2 out of 5 records reviewed. The records did not always provide assurance that medication reviews were completed in a timely manner. One patient had a medicine added to their repeat prescription without evidence that a planned review had taken place and another did not have recommended monitoring completed in line with guidance. (Score 1) • We also reviewed patients who had been prescribed high numbers of asthma reliever inhalers. We identified 23 patients and reviewed a sample of 5 records. Concerns were identified in 5 out of 5 records reviewed. Our specialist pharmacist concluded that the oversight and management of medicines usage did not ensure patients received safe care and treatment. We found examples where patients had not received timely asthma reviews, planned follow-up appointments had not taken place and opportunities to review treatment following worsening symptoms had been missed. (Score 1) • Our review of records relating to Medicines and Healthcare products Regulatory Agency (MHRA) safety alerts identified concerns regarding the management of medicines subject to national safety requirements. We identified 48 patients and reviewed a sample of 5 records. Concerns were identified in 4 out of 5 records reviewed. Records did not always demonstrate that patient safety alerts had been managed effectively. (Score 1)
EFFECTIVE	
Delivering evidence-based care and treatment	• 16 people were identified as being prescribed 2 or more courses of rescue steroids. We reviewed 5 of these records. Of those, 2 people had experienced an asthma exacerbation and had still not received a follow-up with a clinician in line with NICE guidance, and 1 person had still not received a required asthma review. • Out of the 21 people identified with a potential missed diagnosis of chronic kidney disease (CKD) stages 3, 4 or 5, we reviewed 5 records. Of these, we identified 2 people who were still not receiving appropriate monitoring in line with NICE guidance. • Out of the 32 people diagnosed with diabetes whose latest HbA1c was elevated, we reviewed 5 records. Of these, 2 people were still not receiving appropriate monitoring in line with guidance. • The service had still not ensured people diagnosed with hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone, received appropriate monitoring in line with national guidance. We reviewed

	records of people with hypothyroidism who had not received thyroid function tests (TFTs) for 18 months. TFTs are blood tests used to monitor thyroid hormone levels and help ensure treatment remains effective and appropriately managed. Of the 5 records we reviewed, 2 people had not received appropriate monitoring. We conducted an enhanced search which identified that, in the preceding 12 months, a further 8 people had not received the necessary monitoring of their thyroid stimulating hormone (TSH) levels in line with NICE guidance. (Score: 1) Findings from our clinical searches demonstrated that evidence-based guidance was not consistently followed. Concerns identified during the assessment included weaknesses in the management of some patients with asthma and gaps in the management of medicines subject to national safety requirements. For example, our review of patients prescribed high numbers of asthma reliever inhalers identified records where patients had not always received care and treatment consistent with recommended asthma management guidance. In addition, records relating to medicines subject to national safety requirements did not always demonstrate that appropriate reviews, safety arrangements and risk management processes had been completed in line with current guidance. (Score 2)
Monitoring and improving outcomes	- Staff had not always ensured patients received the reviews, monitoring and follow-up required to support safe and effective care. A review of patient records identified patients who continued to receive treatment despite overdue reviews and monitoring requirements. We also found occasions where follow-up actions had not been completed when concerns had been identified and opportunities to reduce risks of harm had been missed. The concerns identified were recurring across multiple areas reviewed and demonstrated ineffective systems for overseeing and monitoring patient care. Although the service undertook audits and monitoring activities, these had not been effective in identifying the concerns found during our assessment or ensuring that patients received appropriate reviews, monitoring and follow-up in a timely manner. (Score: 1) Records did not consistently demonstrate that risks had been recognised, acted upon or escalated appropriately when patients became overdue monitoring or review requirements. This meant the service could not be assured that patients requiring additional oversight, intervention or follow up were being identified and managed in a timely manner. (Score: 1)
WELL-LED	
Shared direction and culture	The service had not shared the warning notices in a timely way with relevant staff to support improvements. This had prevented staff from working together to ensure compliance and meant some improvements introduced by staff had been implemented after the compliance date had expired. (Score: 1) - The service had still not implemented a culture that supported and promoted learning among staff. Staff told us they did not receive regular communication, updates, or information relating to learning from significant events. Meeting agendas we reviewed did not have significant events as a standing agenda item which demonstrated it was not routinely discussed among staff. Staff told us during the inspection that they did not consistently receive updates regarding incidents or situations where learning or actions had been identified. (Score: 1) In the absence of a policy, it was difficult for staff and leaders to actively promote equality and diversity and work to identify the causes of any workforce inequalities.
Workforce equality, diversity and inclusion	The service still did not have effective systems to engage and involve staff. For example, no staff surveys had been carried out to obtain feedback. (Score: 1)

	• The service still lacked effective systems to ensure inclusion for staff in the service. Three out of 5 staff records we reviewed did not evidence discussions had taken place regarding staff physical or mental health and wellbeing, including whether any reasonable adjustments were required. In the remaining 2 records, staff employed since our previous inspection had disclosed health conditions that required risk assessments; however, these had not been completed, and no adjustments had been implemented. (Score: 1) •
Governance, management and sustainability	• The service still did not have effective oversight of internal processes to ensure compliance with its own policies and national legislation. For example, we identified concerns relating to recruitment processes, staff induction, staff immunisation records, supervision arrangements and the management of significant events and complaints. Systems and processes were not operating effectively to ensure these areas were consistently implemented, monitored and reviewed. (Score: 1) • The service did not have effective systems of oversight to ensure test results were monitored during staff absences. At the time of the inspection, the service was unable to provide a policy or protocol to support staff in managing test results when key members of staff were absent from work. We identified abnormal test results assigned to a clinician who was absent from work, which had not been identified by the service. (Score: 1) • The service had still not ensured policies contained the necessary information to give appropriate guidance to staff. For example, the service's infection prevention and control (IPC) policy contained inaccurate or irrelevant information, as it referenced contact links from an NHS trust and named the incorrect IPC lead. (Score: 1) • We identified gaps in the effective oversight of processes including staff training, recruitment, infection prevention and control, and premises-related health and safety risk management. Several issues identified during the previous assessment had not been appropriately addressed or actioned. Following our feedback after this assessment, the provider had taken steps to address some of these concerns. However, further work was needed to resolve all the issues, and to ensure improvements were fully implemented and embedded within the service. (Score: 1) • Some aspects of risk assessments were noted to require immediate action or within one month, but some of these had not been completed. This was in part due to limitations in what could be achieved given the age and condition of the building and environmental challenges. Managers also reported that they did not have enough space to deliver the service they aspired to deliver. They had sought funding to make some improvements to the environment, but found some aspects that required attention were not achievable or would require significant investment and cause disruption to service delivery. (Score: 1) • Staff could access all required policies and procedures, however the system for reviewing and revising such policies was not clear. The practice recruitment policy did not presently reflect guidance and legislation, but the practice were working to make this compliant. (Score: 1) • Staff we spoke with were clear on their individual roles and responsibilities. However, where there was clarity - and policy supporting this, some systems failed due to individuals not following policy and process. For example, where there were safeguarding concerns about a patient, a lack of overarching governance and oversight meant that there were delays in reporting, decision making and documenting outcomes and actions, which was not in line with the provider's own safeguarding policy. (Score: 1)

	• Policies and standard operating procedures were difficult to find. We saw evidence that many could only be retrieved from performing a lengthy search of digital folders. The provider told us that some staff struggled with information technology and were not able to perform the search for the document easily themselves. Policies were not kept together in a centralised place. There was no version control, and policies did not always contain the most up to date guidance. (Score: 1) • Staff needed to make improvements as to how they took confidentiality and information security seriously. We found an unsecured NHS Smartcard during a tour of the building. We asked to review the provider's confidentiality policy, but this was not retrievable or available. A review of significant events indicated that leaders had not submitted a statutory notification to the Care Quality Commission, regarding the death of a patient, as required. (Score: 1) • Concerns identified through clinical searches affected multiple areas of care and treatment, including medicines monitoring, medication reviews, management of patient safety requirements and follow-up arrangements. These concerns had not been identified, escalated or addressed effectively through the service's existing governance systems. The concerns identified were recurring across multiple clinical searches and demonstrated a lack of effective oversight of clinical risk. Patients continued to receive treatment despite overdue monitoring requirements and missed reviews, and follow-up actions were not always completed when concerns had been identified. Systems intended to monitor patient safety, medicines management and clinical performance were not operating effectively to identify these risks and ensure timely action was taken. (Score: 1)
Partnerships and communities	• At the previous assessment in September 2025, we found that the Patient Participation Group (PPG) had not formally met since 2023. The provider told us at the time that they planned to reconvene meetings in the new year. However, at this assessment we found that PPG members had not been contacted by the provider and meetings had not resumed. Feedback from the PPG continued to echo the frustrations and challenges highlighted by the provider regarding the space limitations of the premises. (Score 2)
Learning, improvement and innovation	• Action plans submitted to CQC following the previous inspection did not contain necessary information to demonstrate how the service planned to improve the standard of services provided. For example, action plans submitted were incomplete, and without identified compliance dates. This meant the service could not demonstrate, that identified concerns had been effectively addressed or that learning had led to measurable improvements in practice. (Score: 1)