First Practice Management

CQC Inspection Reports of NHS GP Practices Published in August 2026

- 4 reports cited below were for NHS GPs rated Requires Improvement overall
- 0 reports were published in Aug for NHS GPs rated Inadequate overall (as of time of writing on 28/8/26)
- 0 reports were published in Aug for NHS GPs rated Outstanding overall (as of time of writing on 28/8/26)

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.*

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	INSPECTION COMMENTS: *all individually scored 1 (Inadequate) or 2 (Requires Improvement) by CQC*
SAFE	
Learning culture	• The service did not have a proactive and positive culture of safety based on openness and honesty. They did not listen to concerns about safety. **Complaints and significant events were recorded but lessons were not learnt** to continually identify and embed good practice. This was shown by the **evidence of repeated breaches** for concerns known from the previous assessment. (Score 1)
Safeguarding	• Safeguarding policies were in place and known to staff, but **the policy did not reflect daily practice, for example in relation to the frequency of safeguarding training.** The practice **did not maintain a list of vulnerable people**. The service **did not code adult patients who were at risk of abuse and harm**. After the site visit, the service told us that the affected patients had now been coded on the clinical system. (Score 2)
Involving people to manage risks	• **Not all emergency equipment was available and maintained.** For example, not all items recommended by the Resuscitation Council UK, needed for resuscitation, were in place and the risk assessment presented by the service to support rationale or decision to not have them did not sufficiently consider the risks and impacts. Items not available included portable suction, oropharyngeal airway devices in different sizes, self-inflating bag with reservoir (adult child), clear face masks in different sizes, supraglottic airway device, thermometer, sphygmomanometer, pulse oximeter. (Score 1)
Safe environments	• Recommended **actions from the fire safety risk assessment completed December 2025 had not been completed**. This was also identified at the last assessment in August 2022. In addition, there was no process to ensure visitors on the premises were accounted for. (Score 2) • Whilst the service was testing its water temperature monthly, records showed the temperatures did not consistently meet the required standards, with **some hot and cold-water readings from different outlets outside the expected thresholds.** By not ensuring water temperatures were in safe ranges, people using the service were at risk of avoidable harm, including exposure to waterborne bacteria. Although the service's water policy stated out-of-range readings should be investigated, the service was unable to demonstrate actions had been taken when the recordings had happened. (Score 1)

	• The service also **could not provide maintenance records for a wheelchair available** for people to use. This meant they could not demonstrate the equipment was routinely maintained and safe for use, potentially placing people at risk of harm if defects or faults were not identified and addressed promptly. (Score 1) • Fire safety records showed that weekly fire alarm tests, as required by the service's policy, were not consistently completed or documented. Records demonstrated that **testing had only been recorded monthly or fortnightly during the previous year.** (Score 1) • Inspection findings identified several gaps in environmental and safety oversight. The fire risk assessment available **related only to shared areas of the building**, **fire marshal training had not been completed**, and the practice manager confirmed they had **not previously seen some fire safety and servicing documentation** held by the building owner. (Score 2) • There was **no practice COSHH file or evidence** of completed COSHH risk assessments. However, after the inspection the practice sent in a COSHH risk assessment for the cleaning materials used by the practice. **Prescription stationery was not consistently stored securely**, with prescription pads and printed prescriptions observed in unlocked areas. The practice updated their blank prescription policy after the inspection which stated that prescriptions would be signed in and out daily. We also found **out of date consumables in one clinical room**. We noted that there was **no reasonable adjustment risk assessment in place**. **Legionella water temperature monitoring was not being completed.** (Score 2) • An independent company carried out a fire risk assessment at the main surgery and branch surgery in December 2025. The report identified several areas of serious and immediate concern, with timescales for the completion of necessary to be completed. Although the provider had taken some action, some control measures had not been put in place. These included for some high-risk areas. **Although fire alarms were checked at each site, only 1 person at each site was trained to do this. When these people were not in work the checks were not completed**, so there were gaps in records. (Score: 1) • An independent company had carried out a health and safety risk assessment at the main surgery and branch surgery in December 2025. This risk assessment also highlighted areas where improvement was necessary, but required actions had not been taken. (Score: 1) • Some issues relating to the environment had not been recognised. There was a **tear in the flooring** in a corridor, which could become a trip hazard. Some doors were labelled "Fire door, keep locked" and these were found to be unlocked. **Defibrillator pads had an expiry date of 28 October 2025**. Weekly documented checks of the defibrillator had not noted this. (Score: 1) • Although the service did record the serial numbers of some prescriptions, this was not well organised. It was not possible to determine what prescriptions were in which printers, and **there was no prescription security** at the branch site. (Score: 1)
Safe and effective staffing	• There were not a sufficient range of clinical and non-clinical roles within the practice. For example, staff with **administrative roles were asked to cover the reception due to lack of sufficient receptionists** which created

	additional workload for the staff and increased their stress level. We found training was not up to date, learning needs and development of staff was not managed appropriately. • Several of the staff told us that there was **a shortage of staff which had impacted the wellbeing of the staff**. In addition, we found that documentation of staff prior to employment was not robust to ensure safe recruitment processes. This was a concern identified at the last assessment in August 2022. Following the site visit, the service shared recruitment documents obtained from the staff by the new practice management who had been in the process of implementing changes since September 2025. (Score: 1) • 1 staff member had **started employment without the required professional reference** in line with national legislation, and no risk assessment had been undertaken by the service to mitigate this omission. The service had instead accepted 2 references that were not related to their clinical practice. Following the onsite visit, the provider requested the reference but this could not be obtained because the employer had changed ownership and was unable to support the request. In response, the provider has since provided a completed risk assessment. The provider has since confirmed that their recruitment policy has been updated to prevent this happening again. (Score 2) • Staff training records identified significant gaps in completion rates and mandatory training compliance. Some staff had low completion rates on the training system, including clinical staff. Mandatory training in areas such as **safeguarding, infection prevention and control, information governance, legionella awareness and first aid had expired for some staff members.** Fire safety training had only been completed by one member of staff, and the provider could not demonstrate that all staff had completed autism awareness training. (Score 1) • Recruitment files did not consistently contain all information required to demonstrate staff suitability. For example, one GP file did not contain evidence of qualifications. Newly recruited administrative and reception staff had **commenced employment before all pre-employment checks had been completed**. Missing information included references, proof of identity, DBS checks and employment history documentation. One staff member had **started employment without a CV, DBS check, references or proof of identity** being available within their file at the time of inspection, although the practice did inform us this information had been requested. (Score 1)
Infection prevention and control	• The practice had only recently appointed a designated infection, prevention and control (IPC) lead. Not all staff had had relevant training. **Cleaning schedules were in place but not always followed** as indicated by the IPC audit completed in June 2026. Risk assessments and audits were completed, but recommended actions from Legionella risk assessment completed December 2025 had not been completed to mitigate risks. (Score 2) • The service was **unable to provide evidence relating to its 2025 infection prevention and control (IPC) audit** and hand hygiene audits for the past year during our onsite visit. The service confirmed it had not completed any IPC audits at its branch site. Records relating to cleaning arrangements were also not available, including cleaning schedules, cleaning company audits and Control of Substances Hazardous to Health (COSHH) risk assessments being available for staff. The cleaning equipment stored at the service and used by the cleaning company was not in line with national guidance. For example, **the availability of colour-coded equipment to be used in specific areas to reduce the risk of cross-contamination between clinical and non-clinical areas was not appropriate**

	for the service's needs. The service's annual IPC statement was overdue and dated 2025, although the Infection Control Annual Statement on its website stated this should be produced every April. The service also could not demonstrate how high-frequency touch areas were cleaned regularly, for example, the blood pressure machine in the waiting room. (Score 1) • Following the onsite visit, the provider submitted evidence of a hand hygiene audit which had been completed within the previous 6 months, along with cleaning audits for both sites carried out by the contracted cleaning company over the same period. The hand hygiene audit identified, from the sample of staff audited, that **3 staff were not bare below the elbows and 6 did not follow the correct hand hygiene process.** Following the audit, the provider confirmed staff had completed refresher training and planned to undertake a further audit, although no timescale was given for this. (Score 1) • Some concerns were identified regarding infection prevention and control governance. **Out-of-date syringes were found in a doctor's room, some sharps bins were unsigned and undated, and no infection control audits or hand hygiene audits were available for several years** prior to 2026. The IPC lead was unable to confirm recent IPC training, and there was limited evidence of ongoing competency development. The IPC policy referred to monthly checks, but supporting records were not available. (Score 2) • The **infection prevention and control (IPC) policy did not name the IPC lead** and did not contain any information about local contacts or relevant information. It mentioned an unconnected service, and the practice manager told us it **could have been adopted from another GP practice**. The policy did not stipulate how often staff should be trained. (Score 1) • An IPC audit had been completed by the IPC lead in March 2026. It **did not contain a total score**, and the majority of sections were RAG rated red or amber, indicating a high or medium risk. The IPC lead and manager explained that there was **no score as they did not know how to calculate it**, and they did not think the risk ratings were correct; they thought their audit was more aligned to hospitals than GP practices. We found several areas of concern that had not been highlighted in the audit, including several clinical rooms having hand wash basins with plugs on chains. This is an IPC risk. The audit stated there were no hand wash basins with plugs. (Score 1) • Although the practice manager told us room checks were carried out, **some supplies expired in 2022**. (Score 1) • It was difficult to access the cleaner's cupboard at the main site as a large bag of waste was behind the door. This was a general waste bag, but **clinical gloves were coming out of a rip to the side of the bag**. Clinical gloves should be disposed of in clinical waste bins. **Mops were not stored in a way to promote IPC**. They were colour coded, but the mop for isolation cleaning was stored head down touching the mop head for cleaning general areas. (Score 1) • **Waste management was not safe**. At both sites clinical waste bins were stored outside in areas accessible by the public. **They were not locked** and contained clinical waste which is a safety risk. (Score 1) • Out of 15 staff, **up to date IPC training was not recorded for 8 staff**. (Score 1)

Medicines optimisation	• Staff managed prescription stationery appropriately and securely. However, we found that the process could be better managed and improved. For example, **the log sheet did not include the date the box of blank prescription sheets was opened**, but the serial numbers of prescription sheets in each clinical room was included. • Patient group directions (PGDs) were not always current. We found **3 PGDs had expired**. The service could not explain the rationale for nurses using patient specific directions (PSDs) instead of the PGDs for Vitamin B12 injections. Following the site visit, the service provided additional information on administration of Vitamin B12 under a PSD. • We found **no evidence staff regularly checked the stock levels and expiry dates for all medicines**, including emergency medicines and vaccines. (Score 2) •
EFFECTIVE	
Assessing needs	• Feedback received from experience of care online forms from the patients was negative. It mentioned how people felt they treated rudely by the staff, that **staff culture was less than positive, and elderly patients were digitally excluded.** Care plans for people with learning disability and autism were not reviewed effectively to embed all required information about the wellbeing and health goals of the patients. For example, we found there were **incomplete sections of the templated care plans** where there was no information about the next health check date and agreed health goals This was also observed for patients with mental health needs; an example was a patient on quetiapine whose medication review was not completed after the strength of the medicine was reduced from a higher strength to a lower one in September 2025. The provider did not check if the patient had adjusted to the change. (Score 2)
Monitoring and improving outcomes	• The service **did not meet national targets for cervical screening and childhood immunisations**. The percentage of women aged 25-49 who had an adequate cervical screening test was 62.4% which was below the 80% national target. The percentage of women aged 50-64 who had an adequate cervical screening test was 75.0% which was below the 80% national target. This concern was also identified at the last assessment in August 2022.The service was below the target uptake rates (90%) in all categories of childhood immunisations. The provider was achieving childhood immunisation uptake rates of 79.1% – 83.7% for children aged 2 and 83.3% for children aged 5. The service was achieving immunisation uptake for children aged 1 (77.5%) and MMR (measles, mumps and rubella) uptake for children aged 2 (MMR category) was 81.4%. A recall system was in place to engage patients who had not responded to health interventions, providing education on the associated health benefits. However, the impact of the recall on the uptake was yet to be known. This was **also identified at the last assessment** in August 2022. (Score: 2)
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. Staff did not always understand and apply legislation relating to consent. Capacity and consent were not clearly recorded. Do not attempt cardiopulmonary resuscitation (DNACPR) decisions were not appropriate and not made in line with relevant legislation. Our review of seven DNACPR records showed that there was no process of review of the decisions made while patients were admitted

	at the hospitals to ensure it remained valid and current to the patient's needs. **We found a DNACPR that did not show the details of the patient it concerned or the clinician who authorised it.** This patient was discharged 18 May 2026 and did not have any follow up with the patient completed until 22 June 2026. (Score: 1)
CARING	
Kindness, compassion and dignity	• National GP Patient Survey 2025 data reflected **people did not find the reception and administrative team at the practice helpful.** Seventy percent of the respondents found the practice helpful compared to the local (82%) and national (83%) averages. (Score: 2)
Workforce wellbeing and enablement	• The service did not support or enable staff to deliver person-centred care. Several members of staff told us they were overwhelmed with tasks due to significant shortage of experienced staff at the practice. A number of staff told us that they did not feel supported enough by the leaders. During the site visit, we observed that there was no provision made by the leaders to support the staff during the heatwave, **there were no portable fans to ease the discomfort experienced by the staff.** (Score: 1)
WELL-LED	
Shared direction and culture	• The culture observed during the site visit and assessment process showed a lack of accountability for the tasks required to ensure safe delivery of primary care. We observed that **the practice had not clearly identified who was responsible for specific tasks at the practice** and to monitor compliance with guidance and regulations. Patient feedback expressed dissatisfaction with the culture and attitude of staff at the practice. Staff we spoke with expressed their concerns about the work **ethics and culture at the practice were not according to the practice's code of conduct.** (Score: 1) • At our assessment in January 2017 there had been 4872 patients, 3 GP partners, a salaried GP and a practice nurse. The service said they carried out a survey at the end of 2025 and patients said they would like more GPs. At the time of our assessment there were 2 GP partners, a practice nurse and a healthcare assistant. All other clinicians were locum staff. The practice population had grown to 9215 patients. The practice manager told us a salaried GP had been recruited and they would start imminently. (Score: 2) • Out of 15 staff, 8 were up to date with equality, diversity and human rights training. (Score: 2)
Capable, compassionate and inclusive leaders	• Leaders did not have the skills, knowledge, experience and credibility to lead effectively, and they did not do so with integrity, openness and honesty. Several members of staff told us that they could approach the leaders with their concerns but **the necessary support or follow-up was not provided by the leaders**, increasing the anxiety experienced by staff about performing their roles satisfactorily. (Score: 1)
Freedom to speak up	• The service attempted to foster a positive culture where people felt they could speak up and their voice would be heard. The practice had established Freedom to Speak up arrangements with the Integrated Care Board in North and West London. However **not all staff were aware of the speaking up arrangements** and staff told us more needed to be done for appropriate actions to be put in place to encourage staff to speak up. (Score: 2)
Governance, management and sustainability	• The service did not have clear responsibilities, roles, systems of accountability and good governance. **They did not act on the best information about risk, performance and outcomes, or share this securely with others** when

	appropriate. This was a concern identified at the last assessment in August 2022 and there had been no improvement. The service did not mitigate the risks identified with staff training, safe recruitment procedures, safe environment and tasks related to safe delivery of primary care. The leaders did not have oversight of administrative tasks and some clinical tasks. Clinical meetings prior to the CQC visit shared with us by the practice lacked details of agenda and discussions and any learning from complaints and significant events. This showed that **meeting minutes were not consistently recorded to embed good practice or share learning with staff.** The evidence of repeated breaches showed that the practice lacked good governance. Staff took patient confidentiality and information security seriously. (Score: 1) • The service could not demonstrate how it maintained **oversight of its water temperature monitoring** and the actioning of out of range recordings. The service did not effectively **monitor IPC risks** and had not considered its branch site when undertaking its IPC audits for the local integrated care board. There were also gaps in governance and assurance processes, including inconsistent fire safety monitoring records, incomplete cleaning and COSHH documentation, and limited recruitment oversight of a clinical reference. (Score 1) • The provider had also **failed to submit 2 statutory notifications to CQC relating to the death of a person** who uses its service in line with regulations, demonstrating that its systems for meeting regulatory requirements were not operating effectively. Both deaths had occurred in the preceding 12months and based on our discussions with the service, warranted a statutory notification to CQC. (Score 1) • Concerns were identified regarding oversight of **infection prevention and control, health and safety arrangements, prescription security, training records, incident management. Recruitment systems were also ineffective**, with processes lacking to ensure recruitment practices and personnel files met the requirements of Schedule 3 of the Health and Social Care Act 2008. (Score 1) • A recent **leak that resulted in the loss of old financial records had not been reported as an incident**. A coroner-related case had not been recorded as a significant incident, despite the incident reporting policy listing relevant events that should be considered. There was **limited evidence that significant events were consistently discussed** and learning embedded within team meetings. Clinical meeting records were incomplete or not always documented. Governance oversight of training, recruitment and risk management was not always in place. (Score 1)
Learning, improvement and innovation	• The service did not focus on continuous learning, innovation and improvement across the organisation and local system. They did not encourage creative ways of delivering equality of experience, outcome and quality of life for people. They did not actively contribute to safe, effective practice and research. The practice was **not proactive in mitigating the risks identified at the last assessment** in August 2022 and evidence seen by CQC **showed new concerns related to patient care and safety which showed the practice did not learn from the last assessment** to ensure safe care delivery on a consistent and continued basis. There was **no quality improvement plan in place** to drive improvement in services. (Score: 1)