First Practice Management

CQC Inspection Reports of NHS GP Practices Published in September 2026

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

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (*all scored 4 by CQC*)
CARING	
Kindness, compassion and dignity	• The practice was seen as a central hub for the local community; using additional space in the adjoining community hospital (no longer used clinically) to **set up a social day unit for those experiencing isolation or loneliness.** The unit, which is run solely by the practice with the support of volunteers from the patient population, opened in October 2022. Having initially opened for 1 session it now runs 3 sessions a week. The group grew from 8 attendees to 24 regular attendees within the first year. With the increase in popularity, specific groups have grown, with a **men's group, women's group, bereavement group and mothers'/baby group.** We reviewed evidence which demonstrated positive outcomes for mothers, who prior to this group would have had to travel long distances to seek breast feeding support. • In addition to the social aspect of the hub; there was a **proactive 'clinical and social risk-identification' aspect to it**. Leaders told us they wanted to provide a 'holistic, responsive service'. Feedback from attendees noted that **'it kept them going' and that it was 'their lifeline'.** We also reviewed evidence which highlighted the importance of

	the bereavement group in supporting family members in times of grief. Two of the volunteers at unit had joined after visiting following a bereavement.

Treating People as Individuals	• The practice provide support to vulnerable patient groups, such as **veterans**. Staff were able to show us how they **worked with external agencies and the practice was proudly a Safe surgery**, offering services to people in the community even if they didn't have all the standard documentation for identification. This meant people's nationality or immigration status did not affect their right to register with the practice. Leaders told us this was done to ensure inclusivity for the local population; 'everyone in the community deserves quality healthcare', regardless of whether they had identification or proof of address. This was in line with the practice's homeless persons policy. • Patient communication needs were met to enable them to be fully involved in their care. For example, staff had set up a **bespoke clinic for patients who lived in local sheltered accommodation so that they could come together with their carer**, to help them feel suitably supported and calm. This was done on a yearly basis and the practice received positive feedback on this being set up. • The practice ran an **extended clinic for learning disability patients to complete annual health checks**; this was run for a small group of patients; with patients knowing what to expect and targeted outcomes in a relaxed atmosphere. Patients had a full health check and any necessary vaccinations from a consistent staff member therefore ensuring continuity of care and better patient interaction. Of the patients eligible, 92% have had this health check undertaken in the last year. • The practice also ran, alongside the social day unit, a parent and child group. Parents, carers and grandparents could meet in a social setting with their young ones, and support could be offered both formally and informally from each other or from the practices' health and wellbeing co-ordinator. They also ran a **baby massage session** to support bonding and infant wellbeing. The group currently runs 3 days a week and since it began 53 parents and children and 65 adults in total had been supported. This is another example of the practice **actively addressing the potential for social isolation and housebound people due to the small, isolated population**. For housebound people the social day unit has transport that can bring those people for activities.
Independence, choice and control	• The 'social day unit' run by the practice offered a range of activities for those who attended; everything from **chair yoga and fit4all to crafts and games.** These activities were run by trained volunteers. Lunch was provided, organised by practice staff. On the day of our assessment, we saw that it was woman's day at the unit and a range of activities were planned with a special lunch prepared to be served in the boardroom. Staff and attendees, we spoke with highlighted how much they enjoyed and appreciated the unit being run. • The practice co-ordinated **weekly Integrated Community Ageing Team (ICAT) home visits.** This demonstrated proactive care planning and supported keeping patients independent and giving them a choice in their care **beyond standard GP appointments.** Discussions were held during these visits (alongside blood tests, checks and other holistic assessments) with patients and their families regarding plans, next of kin (NOK) contact details, DNACPR and preferred place of care. Frailty assessments, ICAT visits and GP reviews resulted in 90 patients holding an active care plan. Searches on records were run monthly by the practice to ensure everything was up to date. All plans were reviewed at least annually.

WELL-LED	
Shared direction and culture	• We spoke with members of the PPG (Patient Participation Group) who told us how they were involved in shaping the future direction of the practice and had a strong voice in scoping the direction of the provider going forward. Examples that we heard about included the **PPG participating in the development of workload agreements for staff and supporting the practice manager with fund raising for the social hub.** • Staff and leaders actively monitored and anticipated current and future risks to delivering the strategy, including relevant local factors. The **practice leaders had reviewed the demographics and social makeup of the patient population and went to lengths to recruit patients to research trials to help combat specific ailments**, including respiratory disease. There was an ongoing trial which 17 practice patients were part of.
Capable, compassionate and inclusive leaders	• Staff told us leaders in the practice were approachable and responded to any concerns raised. Staff told us leaders modelled the values of the practice. For example, **the lead GP would complete out of hours visits to families of patients receiving palliative care in the local community to provide reassurance**; exemplifying the family feel to the practice, and the value they placed on support and kindness. • We saw the leadership team worked with other practices under the provider (Cumbria Health) proactively and in pursuit of patient care and were engaged in the development of support services within the local area. We saw evidence of leaders cross-skilling to support staff where required. For example, **the practice manager had undertaken appropriate training for the dispensary and would support with the administrative team answering patient calls.** Leaders were willing to listen to feedback from all staff members. • We saw evidence of leadership meetings that discussed a range of topics including **developing a standardised audit cycle and shared template to improve consistency and evidence for clinical leads both for the practice and the wider Cumbria Health teams.** Improvement plans were constantly looking to modernise access to general practice and align services more closely with patient needs through a data-driven approach. Leaders at the practice felt invested in this approach and the work they did was evidence of that approach. • Leaders have access to high-quality resources, support and development in their role, linked with the provider. We saw **examples of staff being offered leadership courses and digital/AI training for leaders.** With the aims of increasing staff flexibility within roles, being able to cover for each other and reflecting on how digitisation can be put into effective use to benefit of patients.

Partnerships and communities	• The provider **worked with local hospitals to try and offer treatments in the practice as much as possible before having to refer on.** They did this recognising the location of the practice, the patient profile and local transport links. Patients, many of whom were elderly, lived around 28 miles from the local hospital. We heard from leaders' examples where this had been done for cancer patients. **Clinicians at the practice recognised there wasn't a local urgent suspected cancer referral pathway. They worked with hospital teams, oncology and the ICB to raise this and support a targeted pathway to be developed.** This will ensure all future patients that present with similar symptoms who meet the criteria for this pathway can access co-ordinated specialist assessments and investigations. This has been established and accessible for patients across Cumbria.

	• **The practice also worked with a third sector autism service called Triple A (Autism in Action) to help codesign services for autistic people**; to improve access for these patients and for their experiences. This linked in with the practice proactively using available rooms on site and other reasonable adjustments. This engagement reflected the support and advice the practice offered to people with a learning disability and to patients living with autism. There are currently 14 learning disability patients registered with the practice and 21 patients registered with a clinical diagnosis of autism.
Learning, improvement and innovation	• Leaders and staff proactively drove contributions and engagement with effective practice and research to improve care quality. A recent example of this was the **employment of a new practice nurse who was specialised in wound care. This had been an area the practice had identified to address following feedback and leaders worked to address this.** • Practice leaders were able to provide examples of improvements that had been made as a direct result of feedback or incidents. An example of this work included where the clinicians reviewed all patients at the practice who were on **private prescriptions for weight loss medication including mounjaro; cross checking against whether patients were taking oral contraceptives or on Hormone Replace Therapy (HRT) for those going through menopause**. Action would be taken if this was the case (in the form of an HRT review being booked). As an additional safety net, a letter was sent out to all patients of childbearing age to warn them about the risks (even if not prescribed contraception/HRT). **A practice protocol was set up**, discussed in the Cumbria Health clinical leads meeting and the protocol was being rolled out across the providers linked practices. The implications of taking weight loss drugs and being on oral contraceptives or HRT are clinically clear in that they that they can reduce their effectiveness due to reduced absorption. • Leaders empower staff to share ideas and make changes. Staying on top of innovations and progressing new innovations is seen as integral to all staff roles. We saw **examples of this where clinicians advocated for specific EMIS searches to be added to standard audit protocols particularly in regard to cancer patients. This increased flexibility in making sure no patients were missed**, so they could be appropriately supported and plans put in place. This included further consultation and co-operation with secondary care providers.

	assessment documents, protocols and other support for staff and this had been shared within the Primary Care Network (PCN).
	• Leaders and staff proactively fostered a wide range of external networks, including by participating in research. They used these to identify and share improvements and innovations. The practice leaders actively engaged with NCIC (North Cumbria Integrated Care) and other networks in terms of research; constantly striving for better care, integrated systems and cooperation. The practice was a research practice and clinical leads worked closely with colleagues in NCIC to invite and enrol patients on innovative clinical studies. Examples of where patients from the practice participated in studies included **17 respiratory patients signing up to a study looking at 'digital social intervention in patients with moderate to severe asthma' and 5 patients joining a women's health study looking at menopause management.** • The practice has been **working with the local Integrated Care Community (ICC) to look to set up a 'staying steady falls clinic' to begin to address a gap in provision** for patients in Cumbria. The practice had developed

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.*

First Practice Management

	INSPECTION COMMENTS (*all scored 1 or 2 by CQC*)
SAFE	
Learning culture	• During this assessment the provider showed us **the system that they had put in place to deal with SEAs, however, this was not effective and robust**. In the time since the last assessment there had been 2 SEAs documented and discussed, but only 1 had been appropriately documented and disseminated to staff. (Score 1) • **Significant incidents were not routinely or consistently documented**, or discussed with all staff to promote an open and transparent learning environment. There was limited evidence that lessons learned from concerns, incidents, complaints, and patient feedback were shared with staff or embedded within practice. Arrangements to communicate learning across the organisation were ineffective and did not support service improvement. (Score 1) • Feedback and complaints were collected and responded to, but the provider **could not demonstrate that themes and trends were routinely analysed, translated into action plans** or used to achieve sustained improvements. (Score 1)
Safe systems, pathways and transitions	• Although processes existed to monitor referrals, these were not applied consistently, increasing the risk that delays or gaps in care would not be identified promptly. The provider worked with other health and social care organisations to support patient care; however, there was **limited assurance that communication and information sharing arrangements were consistently effective**. We found little evidence that patient pathways were routinely reviewed to identify risks, monitor outcomes or drive improvements where concerns had been identified. Oversight of systems, pathways and transitions were ineffective. Leaders had not routinely monitored the effectiveness of these processes or used available information to identify themes, address risks and improve the coordination of care. Although we did not identify evidence of widespread harm, the provider could not demonstrate that systems consistently supported safe transitions and continuity of care. (Score 2)

Safeguarding	• **Not all staff had received safeguarding training appropriate to their role**, and leaders could not provide assurance that safeguarding concerns were consistently recognised, recorded, escalated, and acted on appropriately, as there was insufficient documented evidence to demonstrate this. Safeguarding meetings were not consistently attended, and safeguarding was not routinely discussed with the wider practice team, limiting opportunities to share information, review risk and promote learning. Safeguarding policies and procedures were available, however, governance arrangements to monitor compliance and ensure their effective implementation

	were not consistently followed. **We did not see evidence that safeguarding activity was routinely reviewed to identify themes, monitor trends or share learning to improve practice.** The provider had not established effective failsafe systems to oversee safeguarding activity and could not provide assurance that people were consistently protected from the risk of abuse or neglect. (Score 1)
Involving people to manage risks	• Emergency equipment, such as oxygen, was available although we found that while the equipment was in working order **there was a lack of recorded evidence that this had been regularly checked**. The Resuscitation Council UK recommend that emergency equipment is checked at least weekly. Whilst some emergency equipment such as personal protective equipment (PPE), and equipment to administer medicines was available in the practice there was no single system in place to ensure these were immediately accessible in the event of an emergency, such as in the waiting room or car park. For example, the practice **had not provided a dedicated emergency bag or trolley containing all the necessary equipment and medicines** required for immediate use. A risk assessment for the provision of emergency equipment had not been completed.
Safe environments	• **Ligature risks had not been adequately identified, assessed or mitigated** within consultation and treatment rooms. Window blind cords presented an avoidable ligature risk. Following our visit, the service advised they had written an action plan to replace or modify blinds to minimise risk. (Score 1) • During our site visit we identified gaps in the management of fire safety, for example, there were **no fire alarms in the building**, however one smoke detector was seen. In addition, there was no evidence that regular fire drills had been undertaken or documented. Following the concerns we raised during our visit, the Provider commissioned an external fire risk assessment. This identified several high and medium priority actions indicating the provider's existing fire risk assessment arrangements had not been sufficient to identify and mitigate all relevant fire safety risks. (Score 1) • We also identified environmental concerns regarding the security of prescription stationery. During the assessment **prescription stationery was observed unsecured in a printer within the nurse's room**. Staff we spoke with were unable to clearly explain the arrangements for securing prescription stationery. (Score 1)

	• There were significant concerns regarding fire safety and electrical safety. The provider was **unable to demonstrate that remedial works identified through fire safety and electrical inspections had been completed**, and systems to monitor ongoing compliance were ineffective. Required fire safety arrangements, including routine testing, record keeping, staff training, and the management of fire protection measures, were not implemented in accordance with legal requirements or the provider's own policy. (Score 1) • Equipment was not consistently maintained, serviced or stored safely. We found **expired clinical equipment and medicines, inadequate storage arrangements, and insufficient assurance** that equipment used in patient care remained safe and fit for purpose. (Score 1) • Records showed that **fire alarm checks had been completed monthly rather than weekly and the fire risk assessment had last been undertaken in 2022 and had not been reviewed.** There were no other records to show if fire extinguisher or emergency lights had been checked and no records of a fire drill. Four of the ten staff had

	completed health and safety training which included fire training, two of the staff were not enrolled on the training to enable them to complete this. **Not all fire extinguishers were safely secured.** (Score 1) • The examination bed in the nurses' room had not been working for 4 weeks, we were told an engineer had assessed this and they were waiting for a replacement part. The bed was set at its lowest position and could not be raised/lowered to aid access for patients and the staff. (Score 1)
Safe and effective staffing	• The service had implemented a recruitment policy. The policy was robust but was not being followed correctly. **Some new starters to the service since the last assessment in December 2025 had started roles before all recruitment checks had been completed.** There was a long standing (prior to December 2025 assessment) member of staff that the provider had failed to complete a Right to Work check for. (Score 1) • Although the Chaperone Policy deemed that staff who chaperoned were not to be left alone with the person they chaperoned, **staff we spoke with told us they were left alone.** Leaders told us staff who chaperoned were given a copy of the chaperone policy at induction which they discussed and signed. Staff we spoke with who chaperoned told us they had not received training. (Score 2) • Recruitment records contained significant gaps, and the provider was **unable to produce recruitment documentation for GPs working within the practice**. In addition, there were no effective systems to monitor the ongoing professional registration of clinical staff. **Leaders relied on the assumption that clinicians maintained their own registration with the General Medical Council (GMC) or Nursing and Midwifery Council (NMC)**, rather than operating formal assurance processes. (Score 1)

	• The training overview did not include nurse role specific training and there was no oversight of this by the provider. We found there was a **lack of evidence nurse training was up to date for example, staff undertaking childhood vaccines had not completed the required refresher training.** This was immediately addressed, training was provided, a risk assessment was completed and appropriate action to safeguard patients was taken. There was no evidence the provider had ensured clinical staff were working within their agreed areas of competence. For example, there was **no documented evidence scope of practice had been agreed with the nurses to ensure they only undertook tasks they were trained and competent to perform** and competency assessments were not undertaken. (Score 1)
Infection prevention and control	• The provider had completed hand washing audits and IPC audits but there was missing information on both audits. When looking at the hand washing audit **it was not clearly documented who was being assessed. It was not obvious that the provider managed the risk of infectio**n as there was little evidence of risk assessments being completed and no record that actions had been taken to mitigate risks, stop the spread of infection or sharing of concerns with appropriate agencies promptly. (Score 2) • The practice had a designated infection, prevention and control lead, but **not all staff had undertaken relevant IPC training.** (Score 2) • It was highlighted the provider's IPC audits included damaged lino **flooring visibly peeling away in the nurse's room** and **carpeted flooring was present in all clinical rooms**. This was acknowledged by the provider however no actions were taken or risk mitigations put in place at the time of the visit. The service has since provided us with

	an action plan to act on the risks identified to replace the flooring in the nurse's room. During the assessment staff told us the previous steam cleaning of the carpet flooring had been carried out approximately two years ago. (Score 2)

	• Clinical equipment was not consistently cleaned, with visible accumulations of dust observed on equipment used within consultation rooms. The provider had not ensured that all areas were maintained in a clean condition appropriate for the delivery of clinical care. The storage and management of clinical equipment and consumables did not support effective infection prevention and control. **Clinical equipment and supplies were stored alongside food preparation areas within a staff kitchen**, increasing the risk of contamination. Cleaning equipment was poorly maintained and stored inappropriately, and expired infection control products, personal protective equipment and clinical consumables remained available for use. In addition, privacy curtains, although visibly clean, had not been appropriately dated to demonstrate routine replacement or cleaning in line with recognised standards. We also found that **the cold chain was not managed in accordance with the provider's own policy**, reducing assurance that vaccines and temperature-sensitive medicines were stored safely and effectively. The condition of the premises further compromised effective infection prevention and control. **Damaged and cracked surfaces, together with stained fabric seating used within patient areas, could not be effectively cleaned or decontaminated**. Governance arrangements to oversee infection prevention and control were ineffective. The designated lead lacked role-specific training. Due to a lack of routine audits or risk assessments, leaders could not demonstrate effective infection control oversight. Whilst policies and procedures were in place, these were not consistently followed in practice. (Score 1) • We observed the **plastic shelves on the equipment trolley in the area in the GP room used for minor surgery were cracked** and this may impact on the effectiveness of the cleaning. • The practice had IPC policies and procedures to support safe practice; however, these had not been fully implemented. For example, **the waste control policy stated each bag of clinical waste should be labeled but this was not being completed to ensure traceability and enable safe handling and completion of annual IPC assessments had not been undertaken prior to June 2026. The policy had not been fully completed to identify the IPC lead and minor surgery room.** • Some people (34 of 200) prescribed medicines (ACE inhibitors) for high blood pressure, heart failure and kidney disease had **not received the required 6 monthly monitoring of their bloods**. Some people (45 of 60) prescribed an oral anticoagulant (DOACs) had not had their kidney function checked by undertaking creatine clearance calculations at least annually. Some people (2 of 4) prescribed anti rheumatic medicines (DMARDs) had not had the required 12 weekly monitoring and 1 of these had not had the required monitoring for 6 months.
Medicines optimisation	• As part of this assessment a CQC GP Specialist Advisor (GP SpA) conducted a series of remote clinical searches of patient records. **Patients taking high risk medications that required regular monitoring were not always called or recalled** where required in line with guidance. The process in place for call/recall/identifying these patients was not robust. (Score 1)

	• Records showed us that **some patients did not receive information that needed to be shared with them** once they had been started on a medication that had a Medicines and Healthcare products Regulatory Agency (MHRA) alert attached to it. This put patients at risk of harm. (Score 1) • The GP SpA advised that **medicine reviews reviewed during the inspection were inconstant**. (Score 1) • There were still some concerns with regards to the way prescription stationary was being stored. This was not in line with their own prescription security policy or in line with national NHS guidance. For example, **we found some prescription pads in an office draw and there was no record of serial numbers stored anywhere.** This could increase the risk of misuse or prescription fraud. (Score 1) • The provider could not demonstrate an effective process for reviewing and implementing MHRA medicines safety alerts or provide assurance that all relevant actions had been completed. Clinical searches were undertaken by the provider; however, **findings had not always been translated into timely action to reduce risk** and improve patient care. (Score 1) • We also identified concerns regarding the storage and management of medicines. **Vaccine refrigerators were overstocked, expired vaccines and an out-of-date anaphylaxis kit were present**, and the cold chain was not consistently managed in accordance with the provider's own policy. These findings reduced assurance that medicines requiring temperature-controlled storage were consistently managed safely. (Score 1)
EFFECTIVE	
Assessing needs	• Clinical searches undertaken during the assessment **identified patients with long-term conditions who had not received timely reviews following abnormal clinical findings.** This included patients with raised diabetes indicator results, hypothyroidism and asthma, where appropriate assessment, review and follow-up had not been completed within expected timescales. We also identified opportunities where potential diagnoses had not been recognised or appropriately coded, which may have delayed further assessment, treatment and ongoing management. (Score 2)
Delivering evidence-based care and treatment	• Clinical records we reviewed demonstrated care was not always provided in line with current guidance and there was insufficient evidence that people were routinely told about current good practice that was relevant to their care, and patients were not always involved in care planning. The results of the National GP Patient Survey were below the national and local average. For example, **76% of respondents stated that during their last appointment, they felt were treated with care and concern by the healthcare professional they saw or spoke to, compared to 86% nationally and 87% locally.** (Score 2)

How staff, teams and services work together	• There were **no formal internal multidisciplinary or whole-practice meetings to support the routine sharing of information**, learning or service developments. Staff described daily clinical huddles; however, these were informal, focused primarily on immediate clinical issues and were not documented. **The practice manager did not routinely attend these meetings** and leaders could not provide assurance that important information was consistently communicated across the practice. (Score 2) • The provider demonstrated collaborative working with partner organisations where required, including participation in Gold Standards Framework (GSF) multidisciplinary meetings to support people receiving end-of-life care.

	However, there was **limited evidence of wider multidisciplinary working within the practice**, including formal safeguarding discussions, to support coordinated care, shared learning and service improvement. (Score 2)
Monitoring and improving outcomes	• Clinical searches undertaken during the assessment identified examples where monitoring and follow-up were not consistently undertaken in accordance with national guidance. Although the provider undertook their own internal clinical searches and quality improvement initiatives, **leaders could not demonstrate that findings were consistently translated into timely action** or that governance systems effectively monitored the delivery of evidence-based care across all patient groups. As a result, the provider could not provide assurance that systems to monitor outcomes and identify patients requiring review were consistently effective. (Score 2)
Consent to care and treatment	• The provider **could not demonstrate that all staff had received appropriate training in the Mental Capacity Act 2005** and consent to care and treatment. Leaders were therefore unable to provide assurance that staff had the knowledge and skills required to consistently apply the legislation and associated guidance in practice. (Score 2) • We identified concerns regarding the management of documentation relating to Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. **DNACPR documentation was not consistently maintained within patients' clinical records** in accordance with national guidance. This meant the provider could not provide assurance that important information relating to patients' wishes and clinical decisions would always be readily available to staff involved in their care. (Score 2)
CARING	
Treating people as individuals	• Some arrangements to support patients with communication and accessibility needs required further development. For example, **there was no hearing loop available, and we did not see examples of easy read information being readily available for patients**, although staff told us information could be adapted if required. (Score 2)

Responding to people's immediate needs	• Whilst many patients spoke positively about the care they received when they were able to see one of the permanent GPs, some described difficulties accessing the practice and variable experiences when receiving care from locum GPs. The National GP Patient Survey supported these findings and highlighted concerns about patients' ability to access the practice. **Only 23% of respondents found it easy to get through by phone, compared with 57% locally and nationally**. **Only 33% found it easy to contact the practice through its website, compared with 55% locally and 58% nationally**, and 31% found it easy to contact the practice using the NHS App, compared with 53% locally and 54% nationally. (Score 2)
Workforce wellbeing and enablement	• Protected time for learning and development was not consistently available, and **mandatory training had not been prioritised due to workload pressures.** Staff welfare facilities were limited, with **no dedicated area available for staff to take breaks** away from their working environment. (Score 2)
RESPONSIVE	
Person-centred Care	• Data from the National GP Patient Survey however showed that **67% of respondents felt they were involved as much as they wanted to be** in decisions about their care and treatment during their last general practice appointment, which was significantly below the national average of 92%. (Score 2)

	• In addition, **36% of respondents said the healthcare professional they saw or spoke to was good at considering their mental wellbeing** during their last appointment which was significantly below the national average of 75%. (Score 2)
Providing Information	• 70% of respondents from the National GP Patient Survey however felt the healthcare professional they saw had all the information they needed about them during their last general practice appointment which was significantly below the national average of 92%. **50% of patients reported they knew what the next step would be after contacting the practice** which was significantly below the national average of 84%. (Score 2) • Feedback from patients identified delays in receiving information about test results, referrals, medication queries and hospital correspondence. Some **patients told us they needed to contact the practice on multiple occasions to obtain updates,** while others reported information being relayed through administrative staff rather than directly by a clinician. We also identified examples where patients became aware of errors or outstanding actions through the NHS App before being contacted by the practice. These findings were reflected in the National GP Patient Survey, where 57% of respondents described their experience of contacting the practice as good, compared to the local result of 73% and the national result of 73%. In addition, 55% of respondents described their overall experience of the practice as good, compared to the local result of 78% and the national result of 77%. (Score 2)
Care provision, integration and continuity	• The National GP Patient Survey results highlighted that **49% of patients felt they had enough support from local services or organisations** in the last 12 months to help manage their long-term conditions or illnesses, which was significantly below the national average of 70%. (Score 2)

Listening to and involving people	• From 1 April 2025 to 31 March 2026, the practice had received a total of 51 complaints. These complaints were analysed and 6 were upheld, 28 partially upheld, and 17 not upheld. The highest number of complaints related to Clinical Treatment (13), Appointments (10), and Communications (10). The National GP Patient Survey data reported **50% of respondents said the healthcare professional they saw or spoke to was good at listening to them** during their last general practice appointment, which was in significantly below the national average of 86%. (Score 2) • Since the last assessment the practice had received 3 complaints. We saw some improvement, but **1 of the 3 complaints we reviewed had not been managed in line with the practice's policy.** It did not include information of how the complainant could escalate the complaint if they were dissatisfied with how the complaint had been handled. Learning from complaints was not evident and staff were not able to identify changes made because of patient feedback, including complaints. (Score 2)
Equity in access	• We reviewed patient feedback in relation to their experience of accessing the service. Our review found the practice was **not able to consistently demonstrate that patients could access care and treatment in a timely or equitable way.** Patients reported experiencing significant difficulties obtaining appointments, long waits for routine appointments, challenges accessing the practice by telephone, and limited availability of appointments that met individual needs.

	• Latest National GP Patient Survey data relating to patient access to the service demonstrated scores significantly below the national averages. For example: ○ **24% of respondents described their experience of contacting the practice as good**, which was significantly below the national average of 73%. ○ **15% of respondents found it easy to contact the practice by telephone** which was significantly below the national average of 57%. ○ **8% of respondents found it easy to contact the practice by their website**, which was significantly below the national average of 58%. ○ **11% of respondents found it easy to contact the practice by the NHS app**, which was significantly below the national average of 54%. ○ **32% of respondents felt they waited about the right amount of time** for their last general practice appointment, which was significantly below the national average of 69%. (Score 2)

	• Feedback identified significant difficulties accessing appointments, with patients reporting that the online appointment system reached capacity shortly after opening, long telephone waiting times and limited access to routine appointments. **Patients also described barriers for working people, carers and those unable to access the system at 8am.** This was reflected in the National GP Patient Survey, where only 23% of respondents found it easy to get through to the practice by phone, compared to the local result of 57% and the national result of 57%. In addition, 33% found the practice website easy to use, compared to the local result of 81% and the national result of 79%. Only 31% of patients found it easy to use the NHS App to contact the practice, compared to the local result of 60% and the national result of 60% and 34% reported a good experience of making an appointment, compared to the local result of 56% and the national result of 56%. (Score 2)
WELL-LED	
Shared direction and culture	• The provider was **unable to demonstrate that regular whole-practice meetings were held to discuss quality, safety, significant events, complaints and organisational learning.** As a result, leaders could not provide assurance that important information and learning were consistently shared across the practice. (Score 2)
Capable, compassionate and inclusive leaders	• There was a lack of oversight and leadership to ensure concerns were acted on appropriately which reduced assurance that leaders consistently promoted a culture of openness, accountability and learning. Leaders recognised some of the challenges facing the practice, including workforce pressures and increasing demand. However, they had **not implemented effective arrangements to ensure staff were consistently supported through appropriate training, structured supervision, workforce planning and clear communication**. (Score 2)
Freedom to speak up	• The provider **could not demonstrate that concerns raised by staff were consistently managed through effective governance arrangements**. Concerns were not consistently recorded as incidents or escalated to significant events in accordance with the provider's own policies and procedures, reducing assurance that issues raised by staff were appropriately investigated, acted on and used to improve the quality and safety of the service. (Score 2)
Governance, management and sustainability	• NHS Friends and Family data showed in April 2026, **30% of patients surveyed responded they would recommend the practice to family and friends.** May 2026 data showed a slight improvement to 35% of patients surveyed. June 2026 data showed another improvement to 44% of patients surveyed responding they would recommend the practice to family and friends. However, these scores remained very low, and the latest National GP Patient Survey results were significantly below both local and national averages. In addition, the vast majority of feedback from patients via CQC's 'Give Feedback on Care' process was negative about the service they received. Overall, we found the governance arrangements for the practice systems and processes required improvement and embedding to impact positively on patient experience. (Score 1)

	• There was a recruitment policy in place but this was not being followed correctly. New staff have been recruited by the provider since the last assessment. **Not all background and reference checks had been completed as per the providers own recruitment policy before the new staff were in post. The Infection Prevention Control (IPC) policy that was in place was not being followed correctly**. The lack of up-to-date IPC audits and accurate handwashing audits meant that the provider did not have a clear understanding of risks posed by staff not following the national guidelines on IPC. (Score 1) • Not all staff had received an appraisal in the last 12 months, with **1 staff member not having one since they started employment in November 2014.** (Score 1) • Some risks identified during the assessment had also been highlighted at our previous assessment of the service, including fire drills implementation and securing prescription stationery. This indicated learning had not always been embedded or sustained over time. Following the assessment, the service has submitted additional evidence including action plans and an external fire risk assessment to demonstrate how these issues would be addressed. While these actions were positive, **they were not fully embedded at the time of this assessment.** Score 1)
Learning, improvement and innovation	• Quality improvement activity lacked strategic oversight. **Leaders were unable to demonstrate that clinical audit, National GP Patient Survey results, Friends and Family Test feedback and other sources of assurance were routinely used** to evaluate performance, drive service improvement or improve patient outcomes. Where areas requiring improvement had been identified, there was insufficient evidence that actions were evaluated to determine whether they had achieved the intended outcomes. Although staff demonstrated a willingness to improve the service, governance arrangements did not support continuous learning or innovation. The absence of effective systems to identify, monitor and evaluate improvement meant leaders could not provide assurance that the quality of the service was improving over time. (Score 1)