First Practice Management

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CQC Inspection Reports of NHS GP Practices Published in April 2026

- 3 reports cited below were for NHS GPs rated Requires Improvement (with 1 inadequate key question)
- 1 report cited below was for NHS GPs rated Outstanding

Outstanding Performance (scores of 4):

	INSPECTION COMMENTS (***all scored 4 by CQC***)
EFFECTIVE	
Assessing needs	• The practice were pioneers in using the NHS-supported approach, **year of care**, to managing long-term conditions (LTC), for example for diabetes. This moved focus from a single, doctor's appointment to a personalised**, two-part care planning process.** It empowered patients to self-manage, using tailored information, preparation, and structured meaningful conversations with healthcare professionals to improve patient outcomes and reduce the NHS burden. This was particularly important as the practice were in an area of high deprivation and in the area of the branch surgery there was a high proportion of patients with chronic obstructive pulmonary disease (COPD) and asthma. The practice could demonstrate year on year that they had **increased the number of LTC reviews they carried out,** in 2023 – 1,656; in 2024 – 1,839; in 2025 – 2,145. Overall, in 3 years this was an increase of almost 30%. • The practice introduced a **housebound LTC visiting service** in 2025. The practice **recognised the gap in the district nurse provision**; whilst being aware they had a higher-than-average elderly population. The lead nurse

	designed and implemented a nurse associated home visiting LTC review model. This resulted in 143 housebound LTC reviews in 2025 and 26 so far in 2026; all provided by the practice. They **used frailty and risk stratification to identify the highest risk patients** to ensure they received interventions first. • The holistic reviews of these patients provided checks on their physical health, continuity of care, identified social concerns, safeguarding risks, environmental safety and carer strain. They gave **insight into patients' living conditions that could not be gained in clinical settings.**
Supporting people to live healthier lives	• The practice introduced a **self-check in pod in reception** following a trial period of using it, gaining positive feedback from patients. This could be used independently by patients, therefore encouraging them to manage their own health. • The practice has a **loan system for BP machines for patients**, allowing them to self-monitor and actively supports patients to monitor their BP, height and weight and other non-clinical checks at the pharmacy within the same building and in the local area. • The practice is classed as a **'deep end practice'** due to the high levels of deprivation. Last year they completed a healthier lives project in **collaboration with the Deep End Network and Newcastle University**. The practice employed a link worker to build relationships with patients over the phone to support them to attend for health checks, which they normally would not engage with. In a year 368 checks were carried out, those displaying some early symptoms were referred for further preventative care. For example, 70 patients were identified with high blood pressure or cholesterol, 55 of these were referred for hypertension management and 13 weight management referrals were made. Three patients were referred for support with alcohol and substance misuse who **would not have been picked up normally**. Other local GP practices were looking to introduce a similar system based on this one.
Monitoring and improving outcomes	• The practice told us attaining screening and immunisation targets could be challenging. The practice population were in the group of patients with the highest levels of deprivation, the population were transient and some patients first language was not English. They had **used targeted calls to patients, some in specific languages with the help of interpreters or staff,** with the practice nurse to target females who required cervical screening. • They demonstrated a strong focus on quality improvement at the practice. This included a **2-cycle audit on the prescribing of antibiotics** to patients with a lower respiratory tract infection. • There was a **two-cycle audit of the pneumococcal vaccination uptake among patients with learning disabilities**. This was carried out following guidance that patients with learning disabilities were more susceptible to pneumonia and carried higher mortality rates for this. The practice saw an uptake rising from 4.9% to over 55% after targeted interventions. • The practice carried out a **gestational diabetes mellitus (GDM) two cycle audit**, aimed to assess whether patients with GDM were being appropriately clinically coded and recalled for follow up and were receiving annual blood glucose level monitoring. Initial data identified 36% of these patients were having annual testing. Following this improved recall systems, clinical coding, staff education and patient awareness of the long-term diabetes risk

	and importance of follow up were implemented. Blood glucose monitoring increased to 68% on reaudit. The improvements in recall systems improved from **78% patient coverage to 100% coverage on a further reaudit**.
CARING	
Kindness, compassion and dignity	•
Workforce wellbeing and enablement	•
RESPONSIVE	
Care provision, Integration and continuity	•
Providing Information	•
Listening to and involving people	•
Equity in access	•
Equity in experiences and outcomes	•
WELL-LED	
Shared direction and culture	• The practice recognised that environmental responsibility was directly linked to population health, particularly in communities facing deprivation and long-term conditions. As a result, **sustainability was considered routinely when services were designed.** • The practice produced **newsletters for staff quarterly**. These were put in place following staff feedback. They gave information on the practice values, freedom to speak up guardian and staff survey results and actions. • The practice population was placed in the group with the highest levels of deprivation. They had high levels of patients compared to other practices, whose first language was not English. They had a higher proportion of patients who were elderly and had long term conditions (LTC). This led to challenges in relation to demand, longer appointments and difficulties in health screening and administering immunisations. However, the practice **continually reached out to all members of their community recognising the unique needs**, experiences, and challenges they face and had done so for some years. They put in place strategies to provide services to meet the needs of their population and measured these to ensure they were delivering to patient's needs.
Capable, compassionate and inclusive leaders	• Staff were **encouraged to develop and gave us examples of this**, healthcare assistant to practice nurse, apprenticeships completed and prescribing qualifications. As a result of linking training and development with quality and innovation the practice could give examples where they had expanded or strengthened services. • **Staff retention was a high priority**; there were several members of staff who had worked at the practice for 25 plus years and many staff for over 10 years.
Workforce equality, diversity and inclusion	•

Governance, management and sustainability	• Leaders and managers strongly supported staff, and all staff we spoke with were **clear on their individual roles and responsibilities.** They told us there was a culture where they were encouraged to develop. There was a strong open culture where safety was a top priority. The provider had strong systems to record incidents and investigate complaints. Learning from incidents and complaints resulted in changes that improved care for others.
Partnerships and communities	• Leaders, managers and staff strove for excellence through collaboration and shared practice. The service has a track-record of being an excellent role model for others. They were able to offer service to other practices in the area which included, providing minor surgery, **Intrauterine Device (IUD) fitting and removal**, contraceptive implants and **pessaries for pelvic floor prolapse**. Therefore improving local healthcare outcomes. • They provided daily support to a **short-term rehabilitation centre**, **2 bail hostels**, with rapid turnover and high-risk patients with poor health, **a centre for adults with complex disabilities** and **3 care homes**, each with its own liked GP. • The practice were **veteran accredited**, where veterans are proactively identified ensuring they are signposted to appropriate support and priority pathways where needed. • The service has a track-record of being an excellent role model for others. For example, the **practice manager had been recruited to teach other practice managers in the locality**.
Learning, improvement and innovation	• There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment across the organisation and local system. For example, the **home visiting service for housebound patients**. • The practice could demonstrate where they had **strengthened capacity for succession for the future**. As a result of linking training and development with quality and innovation the practice could give examples where they had expanded or strengthened services because of this. For example, the fitting of pessaries for pelvic prolapse. • The practice manager was highly commended by the Primary Care Awards in 2025 for **recognising excellence in Health and Social Care apprenticeships.** • The practice is a training practice who have **GP trainees allocated to the practice** (fully qualified doctors allocated to the practice as part of a three-year postgraduate general practice vocational training programme), 2 of the GPs are trainers. The practice **hosts final year medical students** who are not yet qualified to practice. They **host student nurses via a local university**. • The practice were **environmentally responsible**. They had policies to include sustainability in their day-to-day systems, for example, using **CFC free inhalers**, arrangements in place for **safe recycling of batteries** and **clinical and non-clinical waste.**

Key Reasons Given for Overall "Requires Improvement" and "Inadequate" CQC Ratings for GP Surgeries (scores of 1 and 2)

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

	INSPECTION COMMENTS (*all scored 1 or 2 by CQC*)
SAFE	
Learning culture	• **Events were not always assessed** to correctly designate them as significant events and to learn from them to prevent a recurrence. **Lessons were not always shared** with staff during staff meetings or recorded in the minutes to embed it into daily practice. • We found **significant event meetings were not being held at least quarterly** as recommended, so opportunities to learn from events were missed. The practice held only 2 meetings in 2024 and none in 2025. There was no formal policy outlining how significant events should be reported, reviewed or discussed. • During the April 2025 assessment, we also found there were **inadequate systems in place to monitor and act on medicines safety alerts.** The practice told us they were disseminated in the practice but we were not assured they were being monitored. For example, the Medicines and Healthcare products Regulatory Agency (MHRA) published a drug safety update in 2014 advising the medicine combination of clopidogrel and omeprazole should not be prescribed together, as omeprazole reduces the effectiveness of clopidogrel and places the patient at an increased risk of a stroke. Searches of the clinical records system found 15 patients prescribed this combination of medicine; all of whom had not been reviewed. • We also saw evidence that a clinician had **overlooked the MHRA alert** concerning the interaction between omeprazole and citalopram, despite this being highlighted within the patient's record. • The practice submitted **3 different versions of significant event analyses**, alongside minutes of meetings recorded in a way that made it difficult to identify the incidents or any resulting learning.
Safe systems, pathways and transitions	• When we carried out the inspection in April 2025, we reviewed the practice's document management system and found **7,319 tasks not actioned**, with the oldest dating back to November 2024, which included palliative care patients. Staff attributed this backlog to severe staffing shortages and were trying to clear the backlog. We noted that staff previously responsible for coding had been reassigned, creating gaps in document management processes. These failures resulted in overdue prescriptions and medicines reviews and the practice had placed a hold on booking further reviews due to capacity constraints. • We also saw **22,500 documents remained unprocessed**, 1,593 tasks were outstanding on the clinical system, some were urgent tasks from May 2024 which had not been completed. We also saw 570 referrals were still awaiting processing and could not confirm that urgent 2-week wait referrals were not among these delays. We were told there was a 4-month backlog with all the urgent and 2-week wait referrals. Documents requiring filing had reduced from 22,500 to 439 and further to 42 in December 2025. The number of unactioned tasks had reduced from 1,593 but still high numbers with 634 unactioned tasks, including 208 high priority items. • Our review of the clinical system also identified **2,382 unactioned pathology results**, with the oldest dating back to April 2023. At our further assessment activity in September 2025, we found significant improvements had been made and all previous outstanding pathology results had been actioned.

	• There was **no prioritisation for cancer referrals** and there were delays in informing patients of the outcome of their cancer referrals investigation results, with one patient having to wait 2 weeks to be informed of their result. GPs reported concerns that during telephone medication reviews, patients frequently requested discussions about their test results. These requests arose because patients had been advised to book follow-up appointments but were unable to secure one despite repeated attempts. This issue affected a significant number of patients. • The practice had **150 patient notes pending summarisation**. A summariser was recruited and 100 notes remained outstanding in September 2025.
Safeguarding	• The practice **had a safeguarding policy, but it lacked information** about who staff could report concerns to in addition to the safeguarding lead. • Children on the safeguarding register did not have **safeguarding alerts linked to their parents**. Our review of the safeguarding register looked at 5 patient records; a record did not have household members linked leaving the patients at increased risk of harm and another record did not identify who was responsible for the child in a care facility and another patient on the safeguarding register had already been deducted from the practice. • The provider could not say **how many children were under a child protection plan** and when we reviewed one of their patients on the safeguarding register, we found there was no alert on their records and the family link was not added to their record. • The adult safeguarding list only showed 25 adults, 13 of which the **reason for being on the safeguarding register was not recorded.** Three of these entries had children who were under child protection orders but who were not recorded on the register. • We found that 77 out of 298 children aged 5 to 15 years had been placed on the mental health register **without a valid clinical reason and had not been reviewed**. In addition, 157 children with identified mental health issues had not been followed up or referred to appropriate services. • Staff also reported significant **challenges in getting GPs to complete safeguarding responsibilities**, including uploading forms via a new online portal, and expressing frustration at the lack of accountability and willingness to assist. The GP safeguarding lead, although aware of the situation and with some cases dating back to early April 2025, had not taken action. Following the April 2025 assessment, the provider responded promptly with an action plan detailing steps to address the concerns identified. • While we saw evidence of safeguarding discussions with health visitors, our review of meeting minutes showed **only 2 meetings in the past six months were held where safeguarding was discussed**, one of which was a staff information session held in July 2025. There were **no dedicated adult or child safeguarding practice meetings** recorded and safeguarding was not listed as a standing agenda item. This lack of oversight increased the risk of vulnerable patients not being identified, monitored or protected from harm. • All but one non-clinical staff had completed the required adult and child safeguarding training with **8 out of 13 clinicians compliant**. This gap in compliance means some staff may not have the necessary knowledge to identify and respond to safeguarding concerns

Involving people to manage risks	• Emergency equipment was not complete and appropriately maintained. There was **no evidence of regular audits** to ensure that emergency equipment met the required standards. For example, the **anaphylaxis kit contained two 23G needles instead of the four recommended** by the Resuscitation Council UK, many of the items used in the resuscitation of a patient in cardiac arrest were missing or out of date. • We also found out-of-date emergency medicines and there was no evidence of regular checks of emergency medicines and equipment. We also found **adrenaline was not stocked in all rooms where vaccines were administered**, which was not in line with guidance. • Not all clinical and non-clinical staff were up to date with essential training, including **anaphylaxis**, **sepsis** and **basic life support**.
Safe environments	• The recommended review date for the **Legionella risk assessment** was August 2025 but there was **no evidence of completion**. The service escalated this to the building owner only during the preparation for the CQC assessment in January 2026 and not at the next review date which was August 2025. This showed a lack of oversight of the required risk assessments for the premises used for the delivery of patient care. • Another example was the action plan recommendations from the health and safety risk assessment completed by an external provider in July 2025. It was recommended that the **copy of the fire risk assessment** should be kept by the service but was **not seen on site**. We asked the service to send a copy but this was **not sent to CQC**. • There was an **absence of a system for visitors to sign-in** which further demonstrated a lack of the provider's awareness and control in relation to fire risk within the organisation. The service informed CQC that the building was maintained by the landlord and all documents remained with the property owner until requested. Following the site visit, the service informed CQC that a visitors' book would be purchased. • The **emergency cord on the accessible toilet** / baby changing area was broken and if a patient required to use it, would not be reachable when on the toilet seat or floor. In addition, there was some **debris not removed from the cupboard** that could be used to cause harm if in the hands of an unstable patient. • The premises were not owned by the practice. The cleaning contracts in place to ensure the premises were maintained were held by the building owner. **Health and safety risk assessments** and audits were not seen during the CQC visit. The practice informed us that these records were held by the landlord and had not been provided as requested by the practice when CQC announced the site visit. The practice was unable to show if any risks identified in the assessment had been addressed. • The practice **did not have any legionella safety systems** in place. We did not find any evidence of water temperature testing and there was no evidence of water flushing of the showers inside the building. Legionella risk assessments had not been carried out. Poor management of Legionella risks in water systems can have serious health consequences, including loss of life. • There had been **no portable appliance testing (PAT) and calibration** of medical equipment since 2023. Following the April 2025 assessment, the provider responded promptly with an action plan detailing steps to address the concerns identified.

	• We found significant **gaps in fire safety training**, 13 out of 31 staff had not completed or were not up to date with their training. There was **no evidence of any health and safety training for staff**.
Safe and effective staffing	• Safe recruitment practices were not always followed. For example**, no proof of identity checks** seen in 5 staff files reviewed by CQC and only 1 staff file had evidence of **references** obtained prior to starting employment. • Staff who acted as chaperones **did not have chaperone training**. • No record of **sepsis training completion** in 4 of the staff records reviewed • Clinician resignations were attributed to unsafe working conditions. At the time of inspection, the workforce had reduced from 11 GPs to 2 GP partners supported by locum GPs. Concerns were also raised regarding **13 departures from the practice in the past year**, including administrative staff and management team. There was **no permanent practice manager** at the time of the assessment. • Only 5 urgent appointments were available each morning and each afternoon. Staff had raised concerns with the partners that having to provide extra consultations created an unsafe workload and they were regularly working the equivalent time of two sessions instead of one to provide safe care. There was **no management structure** and there was a lack of communication with staff. On one occasion, a **locum GP did not arrive for their scheduled clinic** and 5 patients were waiting. Staff weren't aware of this situation, who to report to or what to do. • Staff felt unsafe to continue working in the practice without the partners acting on the concerns raised. Staff working beyond their competencies had prescribing errors, provided inappropriate treatments, inappropriate investigation requests and inadequate assessments and documentation. For example, **some reception staff were completing clinical triage** with no formal training, putting patients at risk and increasing workload for GPs who needed to review requests to check if they were safe and appropriate. This was consistent with patient complaints that they were **told by non-clinical staff that their test results looked fine when they were not**. GPs suggested to partners that such staff required teaching, supervision and a set criterion to work to but this was not provided. Concerns were also raised that **home visits were not being documented** by some staff, with one not documented until a week after the visit, by which time the patient had deteriorated and was admitted to hospital. Staff felt the lack of supervision and support meant such errors were taking place. • Following the April 2025 inspection, 2 new salaried GPs were appointed with a view to partnership, alongside 6 locum GPs, a summariser, a pharmacist, 2 reception and administrative staff, a healthcare assistant, a prescription clerk and a dedicated GP responsible for managing Docman tasks. Two GPs had begun supervising trainees, strengthening clinical oversight, 2 salaried GPs were scheduled to join in March 2026 and a GP trainer commencing part-time. • **Training provision was inadequate**, out of date and with some staff telling us they were **largely self-taught** for key responsibilities such as Quality and Outcomes Framework (QOF) management, appointment scheduling and clinical system searches. One staff member was also **asked to complete an external course at their own expense** without reimbursement, highlighting gaps in staff development support.

Infection prevention and control	• The **light cord in one of the staff toilets was a risk of infection** - it was visibly dirty - and this was not escalated to the building owner until after the site visit completed by CQC. • Risk assessments such as **Legionella** were not completed. The Legionella risk assessment report of April/ June 2024 provided after the site visit identified 8 defects that were classed as urgent priority, 11 defects classed as high priority and 9 defects classed as moderate priority all related to water safety at the practice. However, there was no evidence that the practice took or ensured any appropriate actions were completed. **IPC audits** that had been completed did not identify all risks associated with the delivery of primary care services. For example, there was no assurance that all staff vaccination records had been obtained and reviewed, and there was limited evidence of action taken to mitigate risks identified through the IPC audits. • **Mops were stored in a way that created a risk of cross-contamination**. Similarly, cleaning cloths were left overlapping on a shelf to dry, instead of being stored separately and allowed to dry fully to minimise contamination risks. A cleaning checklist was available for only 3 clinic rooms and there was no evidence that a full infection control audit had been undertaken.
Medicines optimisation	• There was no **risk assessment recorded for not storing an emergency medicine**; Diclofenac injection (a non-steroidal anti-inflammatory drug, used to reduce pain, swelling and stiffness). Following the site visit, the service informed CQC that it was removed from the emergency drug list because of the risk of gastrointestinal bleed but no risk assessment document was shared with CQC. • There was **no sharps box in the resuscitation equipment bag** when we checked during the site visit, we referred the provider to the Resus UK guidance. • There was no **log of the serial numbers of the prescription forms**. • Patient specific directions (PSDs) used by the health care assistants at the practice were **not documented** in the patient records and the file kept by the practice for PSDs was not found during the site visit. • There were no **risk assessments completed for emergency medicines** that were not carried by the service such as naloxone and atropine. The practice **did not have antiemetics** (medicine to stop nausea and vomiting), **benzylpenicillin** (for treating bacterial meningitis), and **diclofenac** injection (for the treatment of pain in an emergency). Emergency medicines for the treatment of severe pain such as **morphine**, **pethidine** and **diamorphine** were not stocked by the practice. • During the April 2025 inspection, both clinical and non-clinical staff confirmed **waiting times for prescriptions were a concern**. Despite assurances from leadership that improvements would be made when these same concerns were raised with them 6 weeks prior by staff, the situation remained unchanged, leading to staff withdrawing from the practice citing an unsafe working environment. • The management of long-term medicines prescribing was also not safe including for patients prescribed disease-modifying antirheumatic drugs **(DMARDS)** who required monitoring due to the risk of serious side effects. Our searches of the practice clinical system identified **11 out of 64 patients prescribed methotrexate had not received the required monitoring** in the last 6 months. We reviewed a sample of 5 of these patient records and

	found all patients were overdue monitoring and none had shared care agreements. One of these patient's last test showed abnormalities and dosing instructions were unclear. Repeat medicines and alerts were inconsistently updated for 3 of these patients. • Searches identified 10 out of 21 patients prescribed **Azathioprine** that had not received the required monitoring in the last 6 months, placing them at risk of serious side effects from the medicines they were taking. • Searches for patients prescribed **ACE inhibitors** showed 181 of 1,731 patients had not received the required monitoring. We reviewed a sample of 5 of these patients and found that 4 were at increased risk due to overdue tests, including 1 elderly patient with additional comorbidities. • 48 out of 467 patients prescribed direct oral anticoagulants (**DOACs**) had never had a creatinine clearance calculated and 245 out of the 467 patients had not had one in the last year. • We found the MHRA warned in 2019 that SGLT2 diabetes medicines can cause rare but serious infections such as Fournier's gangrene and diabetic ketoacidosis, advising clinicians to ensure patients are informed about these risks when starting treatment, during reviews, or in written information and when to seek urgent medical help. Our search identified 277 patients to whom this advice should have been applied. There was **no documented evidence that 3 of the 5 patient records we reviewed had been advised** about the risks of Fournier's gangrene or DKA. • Of 112 patients prescribed **benzodiazepines**, we reviewed a sample of 5 records and found that all 5 did not have a documented warning of addiction risk in their records and 3 did not have documented wean down advice in their records. Some patients had been prescribed benzodiazepines for **20 to 40 years.** • When we reviewed the practice cold chain monitoring processes, we found that **vaccines were being inappropriately stored in sample fridges**, which were not designed to safely store vaccines. There was no evidence that **daily temperature monitoring** was taking place, creating a significant risk that temperature breaches could go undetected. We also observed **vaccines were also stored in direct contact with the sides of the fridge**, reducing airflow and affecting temperature control. • 78 of the 247 patients prescribed **gabapentinoids** (high risk medicines that require regular monitoring due to the potential for dependency and misuse) had not received a medicines review in the last 12 months. • Of all the records we sampled across the various population groups, we found at least 9 of the medicines reviews **did not contain details about the review itself** and they were also **not coded as medicine reviews**.
EFFECTIVE	
Assessing needs	• Our review of records showed that completed health check reviews for **autistic** people and people with a **learning disability** showed evidence of **incomplete care plans**. • People **did not feel involved in any assessment of their needs** and felt staff did not understand their individual needs. For example, patients reported that abnormal blood test results requiring clinical follow up were **not acted upon.** Patients had carried out home blood pressure monitoring and sent in results which were filed in the patient records, with no action taken to identify or act on any abnormal readings.

	• Triage systems were weak or ineffective, with little or no risk prioritisation with potential for people to come to harm. We saw examples of this when some patients told us **doctors did not even read their online notes** before taking up appointments. • One person submitted an online triage request for worsening symptoms but received **no clinical response**. They were told they could not bypass the triage queue, despite deterioration and that over 200 people were ahead of them. They felt their worsening condition which was **not recognised or escalated** and described staff as dismissive. **No alternative pathways, safety netting or clinical advice were provided**. • Other patients described **multiple consultations with different clinicians without receiving an accurate diagnosis**. One patient reported that their condition was assessed only by a nurse who relayed GP advice without a direct GP review. The patient was directed to accident and emergency, where clinicians confirmed the condition could have been treated in primary care. • Searches also found 85 patients as having potential missed diagnosis of chronic kidney disease (CKD) stage 3-5. Following the April 2025 assessment, the provider responded promptly with an action plan detailing steps to address the concerns. Further assessment activity in September 2025 found improvements in the numbers of patients with missed diagnoses of diabetes; however, further improvements were still required and formed part of the practice strategic action plan.
Delivering evidence-based care and treatment	• There was **no effective system for monitoring chronic disease reviews**. Some patients were significantly overdue monitoring such as blood tests; for example, one patient was overdue monitoring for 5 years. • Two patients were also prescribed **SABA inhalers without a concomitant prescription of an inhaled corticosteroid** which was against national guidelines. • 60 out of 631 patients with hypothyroidism were **overdue their monitoring for 18 months**. We reviewed a sample of 5 of the 60 patients and found that all of them were overdue monitoring. The last blood test monitoring for 3 of the patients in 2022 and 2023 showed their thyroid levels were outside the normal range and 1 of these patients was also overdue other blood test monitoring.
How staff, teams and services work together	• Prior the assessment in April 2025, we received concerns that the relationship between the partners had broken down and people described a **poor staff culture and ineffective partnership working**. Staff had no directive or clarity on their roles and as a result, there was no effective teamwork between staff and their teams and there was a high turnover of clinical and non-clinical staff which left remaining staff overstretched and unsupported. This was consistent with our findings during the April 2025 assessment where we found that teamwork across the practice was significantly impaired due to **longstanding partnership conflict**, poor communication and unclear lines of accountability. Staff described a **fractured working environment** where partners frequently contradicted one another, creating divisions rather than collaboration. • We also found the redeployment of staff into other roles left gaps in necessary resources. Staff told us the lead GP worked limited clinical sessions and was **not consistently available to support allied health professionals** when they sought guidance. This created friction and a lack of collaborative working.

	• **Locum GPs were not given adequate induction or guidance**, which contributed to errors and disjointed working. For example, we saw evidence that they were not aware of how to process safeguarding referrals as they had not been shown on induction. • One patient reported waiting **5 months to obtain information required by the Drivers and Vehicle Licensing Agency** (DVLA), only for the form to contain **insufficient detail**, resulting in the patient being asked to attend a face-to-face review.
Supporting people to live healthier lives	• Patients with **caring responsibilities were not given needed support**. The provider completed a search to identify patients who had caring responsibilities during the site visit and 215 patients were identified. There was **no evidence of any support given to them** prior to CQC visit such as health checks and **signposting** to relevant support services. • One patient reported having their weight and blood pressure **recorded incorrectly** and on one occasion, their blood pressure was entered into their record despite no measurement being taken. These inaccuracies directly affect the service's ability to support people to live healthier lives due to unreliable measurements, missed opportunities for early intervention and poorer long-term health outcomes. • We received concerns that the practice **did not consistently recognise or act on raised blood pressure readings.** Although a system existed to manage these results, it was not functioning effectively. When patients were asked to submit home blood pressure readings via their Accurx messaging system, these were often saved into the record without any follow up action and it remained unclear who was responsible for reviewing and responding to these results.
Monitoring and improving outcomes	• The service did not meet national targets for **screening and immunisations**. The service informed CQC that there was a process to recall affected patients who did not take up the offer of these health screenings and services but the impact of the recalls on the uptake was not yet known.
Consent to care and treatment	• We found a record for a patient whose **DNACPR record did not include an assessment of mental capacity**. Following the site visit, the service informed us that the highlighted patient will be reviewed and the clinicians have been reminded to do so for the future. In addition, there was a housebound patient that did not have a record of DNACPR on file but the practice was in communication with the social care provider and Multidisciplinary team to review the patient's care. • Staff were **not up to date with their mental capacity act (MCA) training**. For example, only 2 clinical and 3 non-clinical staff had completed this training out of 31 staff. • Some patients reported that during appointments with the clinicians, another individual was present in the room but their **identity and role were not explained**. Patients said they were **not asked for consent** for this person to be present.
CARING	

Kindness, compassion and dignity	• Whilst most of the negative feedback related to concerns about access and care, at least 13 of these concerns were about staff attitude to patients. Patients generally felt that the overall quality of service at the surgery had deteriorated, with some reporting being **spoken to in a condescending manner.** • Patients told us their request for a longer appointment to discuss blood and scan results was refused by reception staff. On attending their appointment, several patients told us they **felt scolded by some GPs** for not booking a longer appointment, which led the GPs to be **rude and inattentive** and annoyed that multiple items had been brought to the appointment, despite patients explaining it had taken weeks to get the appointment. • Despite the practice having a data protection policy and privacy notice, we received at least 7 complaints from patients regarding **lack of privacy at the front desk**. Patients told us they were required to discuss personal medical issues and **provide sensitive information in a loud voice through thick plastic screens at reception**, which compromised their privacy, as other patients in the waiting room could overhear. A few patients also raised concerns that they observed staff members discussing confidential patient information outside the practice, breaching confidentiality guidelines. Additional concerns were raised by patients that they observed sensitive and **personal patient information displayed on the reception desk**. • One patient told us they were unable to discuss a sensitive health issue privately because staff refused their request to use a side room. The patient reported feeling distressed by this interaction and said they left the area in tears. • Another patient described staff as **hostile towards patients**. They told us that despite arriving early for a confirmed appointment, they were told on arrival that the appointment was not on the system yet repeatedly informed they would be seen next. The patient waited over an hour without being seen and had to leave.
Treating people as individuals	• One patient diagnosed with a mental health condition described the **consistently poor experience** they had received at the practice where their needs were not taken account, **especially when in crisis**, leaving them distressed and unable to access the medication they required. This was due to poor access, as well as poor communication between clinicians and poor treatment. This resulted in patients becoming upset at the reception desk or **having to bring family members to support them at the practice**.
Responding to people's immediate needs	• One elderly patient told us their request for a home visit for an unwell relative was declined and the patient was made to visit the practice instead after a home visit was denied. • We received concerns that on several occasions, **young children requiring urgent assessment and care were turned away from the practice by the lead GP** because they were presented late in the day and staff expressed their disappointment with this. On the day of assessment, we observed one child under 5 years old was turned away from the practice when they requested a morning appointment. • The emergency department asked the GP to follow up a patient after hospital discharge, but no contact was made for two weeks. When the patient contacted the practice, they were informed that no follow up had been arranged. • Another patient reported feeling increasingly unwell and, due to the **lack of support from the practice and with their immediate health concerns overl**ooked, sought care at the emergency department. This resulted in an

	unnecessary use of urgent care services, as the patient was later advised their ongoing treatment should have been managed by the GP. They submitted a formal complaint describing poor handling of their case and the receptionist's lack of compassion. The practice's response did not acknowledge their distress and simply repeated generic advice to use the emergency services. • Other patients described longstanding difficulties accessing appropriate care, leading them to seek private treatment due to frustration with the service and others described being in distress when their mental health concerns were dismissed. • Essential clinical information was not being processed promptly, which resulted in missed or delayed follow up. For example, **a vulnerable patient requiring enteral tube feeding did not receive prescribed nutrition for 2 days** because a prescription request had not been actioned.
RESPONSIVE	
Person-centred Care	• Patients told us they were very unhappy with the care provision. For example, 1 parent reported that despite their child's persistent respiratory symptoms and repeated attendances, **the practice had not undertaken appropriate clinical investigations or established a management plan,** nor had they proactively explored or addressed the underlying cause of these ongoing symptoms. • Complaints received by CQC showed **patients were leaving the practice to register at other GP practices**. Data showed a 4% reduction in the practice's patient list size over 12 months.
Care provision, Integration and continuity	• People using the service reported poor continuity of care, stating they were frequently booked with a specific clinician such as a paediatric specialist, only to find on the day that the appointment had been switched to a different or unfamiliar doctor. They described routinely seeing different locum clinicians at each visit, leading to inconsistent assessments, lack of follow up and a sense that no one clinician maintained oversight of their care.
Providing Information	• Patients were advised to contact the practice prior to their appointment so they could arrange to have a BSL interpreter when required. However, when we looked at accessibility arrangements for individuals, we saw there was **no hearing loop in the practice at the time of assessment**. • One patient explained that a private consultant had written to the practice regarding ongoing health issues; however, when they contacted the practice, **staff were unaware of this correspondence because it had not been added to their medical record.** • A patient submitted two samples requested by a GP to rule out a serious condition. Although the surgery received the results weeks prior, no contact was made to advise that both samples were inconclusive due to being submitted in incorrect containers. The patient, who had a progressive condition **was unable to obtain results by telephone and was required by the practice to queue outside before 8am to secure an appointment a week later**. The failure to review the results promptly and communicate with the patient and proactively request repeat samples created delays in care and caused significant distress. No alerts were placed on the patient's record to indicate that repeat specimens were required

Listening to and involving people	• During our assessment, patients told us they did not feel listened to and some escalated their **complaints to external bodies such as their Member of Parliament (MP) and the integrated care board.** • The practice reported 50 submitted complaints since January 2024, while CQC received 78 concerns from people. We found the record incomplete and potentially inaccurate, as at least 17 complaints, some dating back to August 2024 lacked documented actions, and patients told us that their written complaints to the practice in December 2024 were eventually closed due to no reply. We also saw **complaints were not managed in line with the practice's policy**. Their complaints policy stated that complaints would be acknowledged within 3 working days; however, we found a significant length of time was left between submission and acknowledgement; for example, 1 complaint submitted January 2024 was not acknowledged until February 2025 and the GPs spoke to the patient in March and a child's complaint raised in January 2025 was not acknowledged by the practice. • **Complaints did not lead to improvement**. The provider failed to implement the promised double checking process for clinical letters and our assessment in April 2025 showed there was still no evidence of action as patients continued to face delays in referrals and hospital correspondence due to ongoing backlogs.
Equity in access	• We received concerns that their **e-consult was closed early every day, sometimes within half an hour of opening**, due to clinical staffing issues, leaving patients with no alternative but to queue or call repeatedly, often unsuccessfully. This resulted in patients having to contact NHS 111, or attend urgent care services, putting additional strain on the administrative team who were often unable to allocate appointments to patients signposted back to the surgery. Appointments were released daily at 8am but were often fully booked within approximately 16 minutes. This was consistent with patient feedback. Many patients stated they were advised to attend the practice in person and queue from 8am, which was not feasible for everyone. This led to long queues outside the practice early in the mornings and created barriers to care for vulnerable groups and working-age adults and school aged children. • Some patients reported taking annual leave or **multiple days off work just to secure an appointment**, describing the system as not viable as a service for patients.
Equity in experience and outcomes	• There were no processes in place to prevent inequality in experience and outcomes; for example, there **was no accessibility policy and no provisions for their blind or partially sighted** patients when attending appointments. • The practice reported having 530 registered carers, including 8 young carers. In September 2025, this had reduced to 469 carers, including 10 young carers. The practice was unable to provide a clear explanation for this change or evidence of any review or validation of the data. • 1 elderly carer told us they had not been offered support and were unaware of any services for carers. This meant they did not receive the guidance or signposting needed to help them manage their caring role. Training records showed **only 2 staff had completed carer awareness training**. • They **did not involve people in decisions about their care** as patients we spoke to with long-term conditions also told us they were **not allowed to raise more than 1 issue** during their appointments but had to request another appointment when accessing the service was already an issue. Patients also felt the practice did not help them use

	services. This left staff dealing with a system that resulted in a lot of frustration for patients and a lot of abuse from patients towards the staff
WELL-LED	
Shared direction and culture	• Staff were concerned that **senior leaders were spending time on non-clinical priorities instead of seeing patients**. As a result, there was no practice vision and strategy. There was no Statement of Purpose despite this being a registration requirement and there was no succession planning taking place at the practice. We found the culture of the practice as disorganised and without strong leadership. After re-assessment in September 2025, we saw evidence of succession planning. The practice were now working diligently to develop a robust business plan looking into long term sustainability via a 1-3 year plan. They had recruited 2 salaried GP's with a view to increase the GP partnership at the practice.
Capable, compassionate and inclusive leaders	• Following the re-assessment in September 2025, the practice met with staff and the Patient Participation Group (PPG) to discuss the findings. However, **leaders did not provide an accurate account of the issues identified**. During the June and July 2025 PPG meetings, they stated the assessment had gone well with no significant concerns and attributed it to exaggerated negative feedback.
Freedom to speak up	• The practice **did not have a whistleblowing policy in place** and training records indicated substantial gaps in freedom to speak up training. Only 10 non-clinical staff and 1 clinical staff member had completed this training out of 31 employees.
Governance, management and sustainability	• During the site visit, we found that there was **no effective system to track staff training** and ensure **safe recruitment processes** were followed. For example, we reviewed 5 staff files and there were no references obtained for 4 of the staff records. In addition, there was no evidence of assurance completed by the service that the staff could work with patients who may be at risk of abuse and harm. • During our visit, the leaders were unable to show us they had a system to assure themselves of the **competency and validity of all clinical staff** working at the service. In addition, the leaders did not demonstrate oversight of **building maintenance** completed by the building owner including cleaning schedules and audits and did not follow up with the building owner to ensure all maintenance checks were completed promptly and correctly. However, the service provided evidence of correspondence with the building owner following the site visit feedback, but the concerns were not yet addressed. For example, records reviewed on site showed that **taps rarely used**, which were meant to be **flushed twice weekly** according to the water safety risk assessment, were last flushed over five weeks earlier. • During the site visit, we found that there was no effective system to **track staff training and ensure safe recruitment** processes were followed. For example, we reviewed 5 staff files and there was no evidence of risk assessments completed by the practice in relation to the **Disclosure and Barring Service (DBS)** checks where such risk assessments were appropriate to ensure that staff could work with patients who may be at risk of abuse and harm.

	• There was a **lack of oversight of building maintenance checks** completed by the landlord such as Legionella risk assessment and any action plan related to ensure the safety of staff and patients. • Some of the practice **policies were no longer current** and needed to be reviewed, such as the infection control policy and recruitment policy. • Concerns were raised that **neighbouring GP surgeries had closed their lists to new registrations** due to an influx of patients leaving the practice. As a result, patients who wished to leave the practice because of care concerns were unable to do so, limiting their ability to exercise choice and control over their healthcare. • We found that the practice was not always open or transparent with the PPG about key issues, including the rationale for the CQC assessment and the findings that emerged from it. For example, in July 2025 PPG meeting minutes, the **partners told them there were no serious or significant issues identified**, which was incorrect as they **failed to disclose a Letter of Intent to carry out enforcement action** which we had issued to the practice.
Partnerships and communities	• We found that the **Patient Participation Group (PPG) was not operating effectively** to support improvements in service delivery. The PPG members we spoke with indicated that PPG meetings were **not organised and recorded** consistently.
Learning, improvement and innovation	• The meeting minutes seen by CQC **lacked evidence that learning was consistently embedded** in daily practice and recorded for future reference. There was no evidence that Patient Participation Group (PPG) meeting minutes were shared with the patients and there was **no structure to the PPG** to ensure improvement of the service delivery.