The Roehampton Surgery

Quality Report

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Date of inspection visit: 12 January 2017
Date of publication: 05/06/2017

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 7

Detailed findings from this inspection

Our inspection team 8

Background to The Roehampton Surgery 8

Why we carried out this inspection 8

How we carried out this inspection 8

Detailed findings 10

Action we have told the provider to take 16

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at the Roehampton Surgery Health Centre on 14 April 2016. The overall rating for the practice was requires improvement. The full comprehensive report on the April 2016 inspection can be found by selecting the 'all reports' link for The Roehampton Surgery on our website at www.cqc.org.uk.

This inspection was an announced focused inspection visit on 12 January 2017 to confirm that the practice had carried out their plan to meet the legal requirements in relation to the breaches in regulations that we identified in our previous inspection on 14 April 2016. This report covers our findings in relation to those requirements and any improvements made since our last inspection.

Overall the practice is now rated as requires improvement.

Our key findings were as follows:

- The practice had made some improvement in implementing formal governance arrangements; however there was still no programme of continuous clinical and internal audit to monitor quality and to make improvements to patient outcomes. For example, performance in the quality and outcomes framework (QOF) for 2015/16 and unverified data from 2016/17 showed the practice was still below the local and national average for a number of clinical indicators.
- Arrangements in respect of identifying, monitoring and managing risks to staff and service users had improved; however the practice did not have action plans in place to effectively manage risks and issues identified through risk assessments and implement mitigating actions. Staff recruitment records did not demonstrate the provider had carried out the required pre-employment checks that were absent at our last inspection, as the practice had not employed any new staff.
- The practice had made attempts to reintroduce an effective patient participation group (PPG) but this was not yet operational.
- There were effective systems in place for recording, investigating and learning from complaints and significant events.

Summary of findings

- The practice had introduced a carer's register which identified 88 patients as carers who were offered additional support under the CCG led Planning All Care Together (PACT) scheme whereby patients receive a comprehensive health and social care review with a healthcare assistant and a GP.
- The practice had reviewed and improved advertising in the reception area of translation services and the availability of a room for discreet conversation if required by patients.

There are areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Implement monitor and effectively manage a programme of quality improvement, including clinical audit, to improve patient outcomes.

In addition the provider should:

- Implement, monitor and review action plans to effectively manage risks, issues and mitigating actions identified through risk assessment.
- Consider, implement, monitor and review ways to engage patients, including continuing with actions to reintroduce the patient participation group.
- Review the practice complaints policy to ensure the timeline for acknowledging and responding to complaints is in line with guidance and contractual obligations for GPs in England.

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing safe, effective, responsive and well led services as staff recruitment records did not demonstrate the provider had carried out required pre-employment checks, performance for patient outcomes was below the local and national average and governance arrangements did not support the delivery of good quality care. At this inspection we found that these arrangements had not improved in all areas. Consequently, the practice is still rated as requires improvement for providing effective and well led services.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of identifying, monitoring and managing risks to staff and service users were not effective.

We saw some improvement in these arrangements when we undertook a follow up inspection on 12 January 2017.

- We saw that infection control audits had been carried out both by the practice and by the local Clinical Commissioning Group, and that action had been taken to address concerns and make improvements identified, however whilst carpets were visibly clean, the practice had not introduced a steam cleaning schedule for carpets in clinical areas until such time as the carpets could be replaced.
- The practice had improved systems processes and procedures to monitor and manage risks to patients; however the practice did not have in place action plans documenting actions undertaken or planned to manage identified risks and issues. For example the practice had not introduced a steam cleaning schedule for carpeted patient areas.
- Staff recruitment records did not demonstrate the provider had carried out the required pre-employment checks that were absent at our last inspection, as the practice had not employed any new staff.
- Significant events were effectively recorded, investigated, learned from and learning was shared with staff.
- The practice had reviewed their chaperone policy, ensuring only clinical staff provided chaperone duties as they had been appropriately trained and had undergone checks through the disclosure and barring service (DBS).
- The practice had purchased and installed an automatic external defibrillator (AED) at the main site and we saw evidence an AED had been purchased for the branch practice.
- The practice business continuity plan had been reviewed and emergency contact numbers for key staff included.

Are services effective?

Requires improvement

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing effective services as the practice performance in the quality and outcomes framework (QOF) for 2014/15 was below the local and national average for a number of clinical

Summary of findings

indicators, there was no programme in place for quality improvement including clinical audit. These arrangements had not improved when we undertook a follow up inspection on 12 January 2017.

Quality and outcomes framework data from 2015/2016 and unverified data for 2016/17 up to 12 January 2017 showed:

- Overall QOF performance was below the local and national average.
- Performance for diabetes, heart condition and mental health related indicators was below the local and national average.
- Performance for indicators related to respiratory conditions was comparable to the local and national average.
- Exception reporting had improved in line with CCG and national averages; however some specific indicators had significant variance.

Are services responsive to people's needs?

Good

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints were not effective.

These arrangements had improved when we undertook a follow up inspection on 12 January 2017, for example:

- The practice had introduced a complaints policy which was in line with recognised guidance and contractual obligations for GPs in England, with the exception of the timeline for acknowledging and responding to complaints which did not reflect guidance.
- There was a designated responsible person who handled all complaints in the practice.
- Information was available to help patients understand the complaints system.
- A system for recording verbal as well as written complaints had been introduced.
- Learning from complaints was recorded and shared.

Are services well-led?

Requires improvement

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance framework supporting the delivery of the strategy. We also recommended that the practice should re-introduce a patient participation group.

Summary of findings

We found arrangements had not significantly improved when we undertook a follow up inspection of the service on 12 January 2017, for example:

- The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care.
- The practice did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements.
- A comprehensive understanding of the performance of the practice was not maintained.
- There were improved arrangements for identifying and recording risks and issues and implementing mitigating actions, however the practice did not have action plans documenting actions undertaken or planned to manage identified risks and issues.
- We saw evidence that improvements had been made in the recording of regular clinical and whole practice meetings that took place, including attendance, agendas and minutes and actions.
- The practice had attempted to reintroduced an effective patient participation group (PPG).

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

People with long term conditions
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

Families, children and young people
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

Working age people (including those recently retired and students)
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

People whose circumstances may make them vulnerable
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

People experiencing poor mental health (including people with dementia)
The provider had not resolved the concerns for effective and well-led services identified at our inspection on 14 April 2016 which applied to everyone using this practice, including this population group. The population group ratings have been updated to reflect this.

Requires improvement

The Roehampton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector. The inspection team included a GP Specialist Adviser and a Practice Manager Specialist Adviser.

Background to The Roehampton Surgery

The Roehampton Surgery provides primary medical services in Wandsworth to approximately 5,800 patients and is one of 44 member practices in the NHS Wandsworth Clinical Commissioning Group (CCG). The practice operates under a General Medical Services (GMS) contract and provides a number of local and national enhanced services (enhanced services require an increased level of service provision above that which is normally required under the core GP contract).

Wandsworth has 50% more 20 to 40 year olds, but 33% fewer older people than other south west London boroughs, and this is reflected in the patient demographics for the practice with 18% of patients aged 65 or over, 62% of patients aged 18-65 years old and 20% aged 18 or younger.

The practice population is in the fifth most deprived decile, with income deprivation affecting children and older people above CCG and national averages.

The practice operates from a converted residential property with three floors. On the ground floor are a reception area, waiting area, treatment room and consultation rooms. There is also a patient toilet which is wheelchair accessible on the ground floor.

On the first floor there are rooms for staff facilities, a meeting room, a room used by the local counselling service and a waiting room for their patients. The second floor of the building is primarily used for storage and is not accessed by patients.

The building is wheelchair accessible via a ramp. There are no automatic doors; however, staff told us they would assist entry for any patient who needed help. There is no lift between floors; the practice told us they only see patients on the ground floor. There is no hearing loop at reception; staff told us that they would communicate in other ways with patients with hearing impairments such as in writing or use a free area of the practice to talk in private. There are no baby changing or breast feeding facilities.

The practice clinical team is made up of one female GP partner, one male GP partner and one female nurse. The practice also has one male and one female part time regular locum GP. A healthcare assistant (HCA) who previously worked as a receptionist at the practice has recently been appointed but at the time of the inspection had not completed their training. The non-clinical team consists of one IT manager, one office manager, three senior reception staff and two administrative staff.

The practice opens between 8.30am and 6.30pm Monday to Friday. Telephone lines are operational between the hours of 8.30am and 1.00pm and 3.30pm and 6.30pm on a Monday, Tuesday, Thursday and Friday. On Wednesdays the telephone lines are operational between the hours of 8.30am and 6.30pm. Extended hours are available Monday to Thursday from 6.30pm to 8.00pm. Appointments during extended hours are pre-bookable only.

The provider has opted out of providing out-of-hours (OOH) services to their own patients, directing them to seek

assistance from the locally agreed OOH provider during the following times; Monday, Tuesday, Thursday and Friday between 1.30pm and 3.30pm, between 6.30pm and 8.30am Monday to Friday and at all times on weekends.

The practice also operates some of its registered activities from another site located at 105 Carslake Road, Putney Heath, SW15 3DD, known locally and to staff and patients as the Ashburton Medical Practice. The site opens between the hours of 8.30am and 11.30am Monday to Friday and between 4.00pm and 6.00pm on Friday. Appointments are available at these same times. Telephone lines operate between these same hours. This site was not visited as part of the inspection.

The provider is registered with the Care Quality Commission to provide the regulated activities of Diagnostic and Screening Services, Maternity and Midwifery Services, Family Planning, Treatment of Disease, Disorder and Injury.

Why we carried out this inspection

We undertook a comprehensive inspection of The Roehampton Surgery on 14 April 2016 under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The practice was rated as requires improvement. The full comprehensive report following the April 2016 inspection can be found by selecting the 'all reports' link for The Roehampton Surgery on our website at www.cqc.org.uk.

We undertook a follow up focused inspection of The Roehampton Surgery on 12 January 2017. This inspection was carried out to review in detail the actions taken by the practice to improve the quality of care and to confirm that the practice was now meeting legal requirements.

How we carried out this inspection

During our visit we:

- Spoke with a range of clinical and non-clinical staff including GPs, GP Partners, nursing staff and administrative staff.
- Observed how patients were being cared for in the reception area.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Looked at information the practice used to deliver care and treatment plans.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing safe services as the arrangements in respect of identifying, monitoring and managing risks to staff and service users were not effective. For example:

- **The practice did not have an effective system in place for recording, investigating and learning from significant events.**
- **Non clinical staff acting as chaperones had not been trained for the role or had Disclosure and Barring Service checks.**
- **The practice had not carried out a fire risk assessment, or implemented any fire detection and prevention measures such as alarms and fire extinguishers.**
- **The practice had not undertaken adequate pre-employment checks for all staff, such as DBS checks, photo identification checks and references from previous employers.**
- **The practice had not acted to address improvements required as the result of an NHS England infection control audit carried out in 2014.**
- **The practice did not have an Automatic External Defibrillator (AED) for use in medical emergencies, or a risk assessment as to why this equipment was not required.**

We saw improvement in these arrangements when we undertook a follow up inspection on 12 January 2017. The practice is now rated as good for providing safe services.

Safe track record and learning

There was an effective system in place for recording significant events. We saw evidence that significant events were effectively recorded, investigated, learned from and that this learning was shared with staff. We noted examples of three significant events raised since our last inspection which had all been documented, investigated and learning shared, including an incident involving a patient who presented challenging behaviours. The staff involved raised a significant event with the lead GP partner, the incident was investigated and the patient written to by the practice in line with the practice zero tolerance policy. The incident was discussed at the next practice meeting where staff were also reminded of the policy.

Overview of safety systems and process

The practice had reviewed their chaperone policy, ensuring only clinical staff provided chaperone duties as they had been appropriately trained and had undergone checks through the disclosure and barring service (DBS) to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Non clinical staff had received formal chaperone training from an external provider and the GP partner had submitted the required documentation for DBS checks to be undertaken. Non clinical staff were not permitted to perform chaperone duties until this process had been completed.

We observed the premises to be clean and tidy in staff and patient areas. The practice nurse was the infection control clinical lead and had liaised with the local infection prevention teams to keep up to date with best practice. We saw that infection control audits had been carried out both by the practice and by the local Clinical Commissioning Group, and that action had been taken to address concerns and make improvements identified. For example, we saw that the practice had submitted funding applications to make remedial building works and we saw that fabric chairs in patient areas had been replaced with chairs that were impermeable to fluids and wipe able. However the infection control audits had also recommended that carpets in patient areas were steam cleaned regularly until they were replaced with impermeable flooring but cleaning had not been completed or scheduled.

As part of our inspection we asked to review personnel records for staff to see if the appropriate recruitment and pre-employment checks had been carried out. The GP partner responsible for recruitment informed us that staff personnel records were not available as they were kept at the GP partner's private residence and not at the practice. We did have access to one personnel folder which was on site and following the inspection the GP partner sent us copies of a further five staff personnel folders. We reviewed all six personnel folders and found they did not contain appropriate pre-employment checks and recruitment processes such as proof of identity, references from

previous employers, qualifications, and signed contracts. However the practice had reviewed recruitment procedures, but could not apply these new procedures as the practice had not employed any new staff since our last inspection.

Monitoring risks to patients

The practice had improved systems processes and procedures to monitor and manage risks to patients. For example, shortly after the April 2016 inspection, the practice carried out a comprehensive risk assessment for the service through an external contractor. This covered areas such as fire risk, health and safety, equipment checks, certification and insurance, electric and gas supply, and environmental risk. The practice had carried out a number of actions to address recommendations identified through this comprehensive risk assessment; however action plans were not put in place to manage, monitor, and review the effectiveness of actions undertaken.

The practice carried out a follow up fire risk assessment in October 2016 through the same external contractor. This risk assessment included recommended actions that the practice should have smoke detectors and fire extinguishers installed and that fire signage should be improved. Whilst this risk assessment did not cover the amount, type or size of fire extinguisher, the amount and position of smoke detectors and the amount, type and position of signage required in order to meet fire safety regulations, the practice had purchased and installed on the ground floor and the first floor a small powder fire extinguisher, a smoke detector and a fire action sign.

The practice had carried out checks on electrical and clinical equipment and we saw that clinical equipment which had not passed testing had been replaced, for example a nebuliser, used to deliver medicine as a mist into the lungs, weighing scales and ear syringes had all been replaced.

Arrangements to deal with emergencies and major incidents

The practice had purchased and installed an automatic external defibrillator (AED) at the main site and we saw evidence an AED had been purchased for the branch practice.

The practice business continuity plan had been reviewed and emergency contact numbers for key staff included. The plan was discussed with staff and staff we spoke to during the inspection knew about the plan and their role during a disruption.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing effective services as the practice performance in the quality and outcomes framework (QOF) for 2014/15 was below the local and national average for a number of clinical indicators, there was no programme in place for quality improvement including clinical audit and Staff recruitment records did not demonstrate the provider had carried out the required checks prior to new staff starting work.

These arrangements had not improved when we undertook a follow up inspection on 12 January 2017. The practice is now rated as inadequate for providing effective services.

Management, monitoring and improving outcomes for people

The practice used information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). In 2015/16 the practice achieved 83% of the total number of points available. This was below the local clinical commissioning group (CCG) average of 94% and the national average of 95% and was also lower than the practice achievement in 2014/15 which was 87%.

The practice overall exception reporting rate for 2015/16 was 3% which was in line with the CCG average of 4% and the national average of 6%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Performance in exception reporting rates for specific clinical indicators had improved in 2015/16 and performance was in line with CCG and national averages, however some specific indicators had significant variance, for example:

- Osteoporosis at 0% exception reporting (CCG average 11%, national average 15%).
- Cardiovascular disease at 0% exception reporting (CCG 23%, national 31%).

We noted that low numbers of patients on practice registers and the practice being able to see all patients meant that there was no exception reporting for these indicators.

Quality and outcomes framework data from 2015/2016 and unverified data for 2016/17 up to 12 January 2017 showed:

Performance for diabetes related indicators was below the local and national average. For example:

- The percentage of patients on the diabetes register, in whom the last IFCC-HbA1c (a specific blood glucose level test) is 64 mmol/mol or less in the preceding 12 months was 62%, compared to the local clinical commissioning group (CCG) average of 74% and the national average of 78%. At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 67%.
- The percentage of patients on the diabetes register, in whom the last blood pressure reading (measured in the preceding 12 months) is 140/80 mmHg or less was 53% (CCG 74%, national 78%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 53%.
- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (measured within the preceding 12 months) is 5 mmol/l or less was 61% (CCG 75%, national 80%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 66%.

Performance for mental health related indicators was below the local and national average. For example:

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 78% (CCG 89%, national 89%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 33%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 70% (CCG 89%, national 89%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 11%.

Requires improvement

Are services effective?

(for example, treatment is effective)

- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was 85% (CCG 90%, national 84%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 70%.

Performance for indicators related to heart conditions was below the local and national average. For example:

- In those patients with atrial fibrillation with a record of a CHA2DS2-VASc (risk classification) score of 2 or more, the percentage of patients who are currently treated with anti-coagulation drug therapy was 68% (CCG 81%, national 83%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 73%.
- The percentage of patients with hypertension in whom the last blood pressure reading (measured in the preceding 12 months) is 150/90 mmHg or less was 68% (CCG 81%, national 83%). (2016/17 data not available at the time of inspection for this indicator).

Performance for indicators related to respiratory conditions was comparable to the local and national average. For example:

- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months that includes an assessment of asthma control, was 72% (CCG 75%, national 76%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 55%.
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness in the preceding 12 months was 90% (CCG 90%, national 90%). At the time of the January 2017 inspection, 2016/17 data showed performance for this indicator was 40%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing responsive services as the arrangements in respect of recording, investigating and learning from complaints were not effective.

These arrangements had improved when we undertook a follow up inspection on 12 January 2017. The practice is now rated as good for providing responsive services.

Listening and learning from concerns and complaints

The practice had reviewed the system for handling complaints and concerns and made improvements, for example:

- The practice had introduced a complaints policy which was in line with recognised guidance and contractual obligations for GPs in England, with the exception of the timeline for acknowledging and responding to complaints which did not reflect guidance. The practice policy stated complaints would be acknowledged within 14 days and did not give a timescale for responding to complaints; however we did see that complaints were dealt with in a timely way.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system including posters and leaflets in reception and information on the practice website.
- The practice had introduced a system for recording verbal as well as written complaints.

We looked at three complaints received since our last inspection and found these were satisfactorily handled, dealt with in a timely way and with openness and transparency. Systems were now in place to learn from individual concerns and complaints and also from analysis of trends. We saw that complaints were discussed in practice meetings and that action was taken to as a result to improve the quality of care. For example, a patient complained when they believed their child had been prescribed the wrong dose of antibiotics. The practice reviewed the complaint and investigated the incident, finding that the correct dose had been prescribed. This information was passed back to the patient and the complaint was discussed at the next practice meeting, reminding staff of the importance of checking doses of medicines prescribed and ensuring patients were also properly informed about medicines prescribed.

Are services well-led?

Requires improvement

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

At our previous inspection on 14 April 2016, we rated the practice as requires improvement for providing well-led services as there was no overarching governance framework supporting the delivery of the strategy, for example in regards to risk management and monitoring and improving patient outcomes. We also recommended that the practice should re-introduce a patient participation group.

We found arrangements had not significantly improved when we undertook a follow up inspection of the service on 12 January 2017. The practice is now rated as requires improvement for being well-led.

Governance arrangements

The practice did not have an overarching governance framework which supported the delivery of the strategy and good quality care, for example:

- The practice did not have a programme of continuous clinical and internal audit to monitor quality and to make improvements and had not put in place actions to improve performance since our last inspection.
- A comprehensive understanding of the performance of the practice was not maintained and used to drive improvement.
- There were improved arrangements for identifying and recording risks and issues and implementing mitigating actions, however the practice did not have action plans in place to effectively manage risks and issues identified through risk assessments and implement mitigating actions.
- However we saw evidence that improvements had been made in the recording of regular clinical and whole practice meetings that took place, including attendance, agendas and minutes and actions, the recording and management of significant events and in effectively managing complaints in the practice.

Seeking and acting on feedback from patients, the public and staff

We saw evidence the practice had reached out to other practices for guidance and assistance in developing and maintaining an effective patient participation group (PPG). The practice had encouraged patients to join a re-introduced PPG however at the time of the inspection the PPG had one member and had not held any meetings or engaged with patients other than through the NHS Friends and Family Test (FFT).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Good governance **How the regulation was not being met:** • The practice did not maintain records in relation to the management of the regulated activity to enable to registered person to evaluate and improve their practice. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.