Merseybank Surgery

Quality Report

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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	Inadequate 
Are services safe?	**Inadequate** 
Are services effective?	**Requires improvement** 
Are services caring?	**Requires improvement** 
Are services responsive to people's needs?	**Good** 
Are services well-led?	**Inadequate** 

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We initially carried out an announced comprehensive inspection at Dr Iain Hotchkies Merseybank Surgery on the 14 July 2015 when the practice was rated inadequate and was placed into special measures. Services placed in special measures are re-inspected again within six months.

On 4 April 2016 we carried out an announced re-inspection of Merseybank Surgery when the practice had made improvements but remained inadequate for safety and continued in special measures for a further six months. Although improvements had been made, further improvement was still necessary and overall the practice was rated as requires improvement.

This most recent inspection was an announced comprehensive re-inspection undertaken on 31 January 2017 following the continued period of special measures. Overall the practice had received a period of eighteen months to improve since its initial rating of Inadequate. At this inspection we found that the practice had made only minor improvements in some areas, but had not progressed at all regarding other improvements required. Overall the provider has been given significant time to make improvements but the findings of this inspection indicate that they are not able to maintain the improvements required. As the provider has not been able to make more substantial improvements over a prolonged period of time, the practice is rated as inadequate.

Our key findings across all the areas we inspected were as follows:

- Although some minor improvements were evident they did not fully reflect all the areas identified for improvement in the previous inspection reports. Significant shortfalls remained regarding the quality of the service.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons and actions were highlighted but were still not carried out. There was no understanding of the requirement to review incidents to ensure that learning had been achieved and this had been highlighted at the previous inspection.

Summary of findings

- When risks to patients were identified they were not always well managed and appropriate action was not always taken.
- The practice had a number of policies and procedures to govern activity, but they were not all followed in accordance with what they contained.
- Health checks, childhood immunisations and cervical screening rates remained lower than average compared with the local CCG and national averages.
- A patient participation group had been implemented but the practice did not find it useful and there was limited benefit to the practice or its patients.
- Improvements had been made to patient outcomes and data showed that the majority of patient outcomes were comparable to the CCG and national average.
- Effectiveness at the practice had progressed and there was evidence that clinical audit was being used to improve patient outcomes.
- All the patients we spoke to or provided written feedback said they were treated with compassion, dignity and respect.
- The practice offered open surgeries each morning and fixed appointments each afternoon except Wednesdays when the practice was closed.
- Patients had been informed that a merger of the practice was imminent but no formal arrangements had yet been agreed.

The areas where the provider must make improvements are:

- Have systems and processes that are established and operated effectively to ensure that good governance is maintained.
- Do all that is reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients.
- Monitor and review that staff have the required training and understanding to enable them to carry out their roles effectively.
- Have a system to obtain patient feedback and monitor verbal comments and complaints
- Ensure care and treatment is provided in a safe way.
- Take appropriate action whenever risks and issues are identified.
- Ensure that care plans are in place for all patients that need them.
- Have a system to ensure competency and understanding of training such as chaperoning and Data Barring and Service (DBS) checks.
- Be able to demonstrate sufficient understanding of the requirements of the Health and Social Care Act 2014 and how to implement and maintain the necessary changes
- Demonstrate that they have the necessary qualifications, competence, skills and experience required to undertake their role, such as mental capacity, Deprivation of Liberty Safeguards (DoLS) and leadership skills.

The areas where the Provider should make improvements are as follows :

- Have a system to identify and support those patients that are carers.
- Consider a continual review of procedures and guidance to ensure they are being followed.
- Consider the needs of the practice population and make changes where appropriate such as increasing the number of staff or maximising the skills of existing staff to meet these needs.

This service was originally placed in special measures in July 2015. The service was kept under review for six months and a re-inspection was conducted in April 2016. The practice was advised that if there was not enough improvement further action could be taken in line with our enforcement procedures.

The practice was re-inspected for a third time in January 2017. Insufficient improvements have been made such that the rating remains as inadequate overall. We are therefore taking action in line with our enforcement procedures.

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?

Inadequate

At this most recent inspection we found that the issues highlighted within the last inspection report dated 4 April 2016 were still not dealt with to ensure that incidents and risks were addressed and the practice remained unsafe . For example :

- Where incidents were logged as having occurred, learning and actions were recorded but action was not taken.
- Where potential risks were identified, no action was taken to reduce the likelihood of an incident.
- Staff had undertaken chaperone training but they did not understand the requirements of the role.
- There was limited understanding of mental capacity, deprivation of liberty safeguards (DoLS) or guidelines on how and when to obtain consent from children.

Some improvement continued:

- Communication between the staff remained satisfactory and meetings continued.
- There was evidence that people's medicines were checked and emergency medicine and equipment was available and maintained.
- Arrangements were in place to safeguard adults and children from abuse.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and people received a timely apology when things went wrong.

Are services effective?

Requires improvement

Whilst some improvement had been made we still identified ongoing concerns regarding the effectiveness at the practice. For example:

- Data from the Quality and Outcomes Framework (QOF) showed that some patient outcomes were at or above average compared to the CCG and national average. Cervical screening, bowel and breast screening and immunisation rates still remained lower than average. The practice remained outliers for antibiotic and hypnotic drug prescribing.
- The GP told us that they delivered care in line with current evidence based guidance. They were the only member of clinical staff at the time of this inspection.

Summary of findings

- Not all staff had the required skills, knowledge and experience. For example they did not monitor verbal comments, understand the role of chaperone, assess mental capacity or obtain consent, in order to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all administration staff, and evidence that learning was taking place, but there was no monitoring to ensure competency.
- Multidisciplinary working was taking place but was generally informal and record keeping of discussions was still limited or absent.
- Staff meetings were held regularly and good communication continued.
- The audit and monitoring system had continued sufficiently and we saw at least two completed audit cycles showing improvement.

Are services caring?

Requires improvement 

Although there were some previous improvements in this domain the practice had still not addressed one of the issues highlighted in the last inspection on 4 April 2016.

- There was still no carers' register and carers were not pro-actively identified or supported.
- Information for patients about the services available was easy to understand and accessible, however it was not always correct. For example patients had been informed that a merger was imminent and this was not the case
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were satisfied with the service and were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good 

The practice was rated good for responsive

- The practice had good facilities and was well equipped to treat the patients it cared for and meet their needs. Patients continued to be referred to other services such as for advice on smoking cessation, diet and mental health issues.

Summary of findings

- We were told that patients were invited for regular reviews. Chronic disease management and health check clinics were not routinely offered but issues were dealt with reactively when patients attended for acute problems.
- Extended hours were available via the South Manchester GP Federation and drop-in clinics were available every morning.
- Information about how to complain was available and easy to understand and evidence showed the practice recently responded quickly to an issue that had recently been raised.

We found that recent learning from a complaint was shared with staff.

Are services well-led?

Inadequate

We found ongoing concerns regarding how the practice was led. The practice had still not addressed the issues that were highlighted in the last inspection report dated 4 April 2016. Proposed improvements had not been implemented and there was concern that the provider having been given an opportunity, was not able to make the improvements required.

- The leaders at the practice could not demonstrate sufficient understanding of the requirements of the Health and Social Care Act 2014 or how to implement the necessary changes which would demonstrate effective management. The GP told us that they did not have the skills or the staff to manage the practice in accordance with the required regulations.
- The GPs revalidation had been due in 2015 but this had been deferred by the Responsible Officer and was therefore not yet completed.
- The practice had increased the number of policies and procedures it had to govern activity but they were not sufficiently embedded and they were not effective. For example, they did not ensure that incidents were reviewed or that appropriate action was taken.
- The patient participation group had been implemented but there was no evidence of patient feedback since the last inspection on 4 April 2016 or any improvement to services as a result.
- The practice still did not monitor and record verbal complaints and comments to review trends.
- The practice had initiated discussions, leaflets had been printed and patients had been informed that a merger was taking place in 2017. However no formal framework or any arrangement had yet been agreed.

Summary of findings

- The practice was aware of the needs of its local population and the areas that required improvement but there was no formal evidence of how those improvements would be made. For example the lead GP had told patients that they would be able to access nurse services, baby clinics and travel advice from another practice when the merger took place, but did not have a plan on how those needs would be met in the interim

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

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- The practice had a lower than local average older population. 10% of patients were over 65 (national average 16%) and 4% were over 75 (national average 8%).
- Care and treatment for this small number of older people did not always reflect current evidence-based practice, for example some older people did not have care plans where necessary as the GP did not consider them effective.
- Seven patients had been identified and were on the dementia register. They received appropriate investigations and were referred for memory tests.
- Nationally reported data showed that outcomes for patients for conditions commonly found in older people such as dementia, atrial fibrillation (heart disease) and risk of stroke were 100% which was above average.

People with long term conditions

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- There were no specific clinics for patients with chronic diseases. We were told that patients were regularly invited for reviews which were undertaken by the GP. A diabetic nurse attended the practice on a monthly basis.
- The practice nurse had recently left and there was no plan in place for agency nursing staff to have lead roles in chronic disease management which was managed by the GP.
- There was still no formal process to monitor patients at risk of hospital admission which was highlighted at the last CQC inspection.
- Not all patients with long term conditions had care plans that were regularly reviewed.
- Longer appointments and home visits were available when needed.

Summary of findings

- For those patients with the most complex needs, the named GP told us that they worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Families, children and young people

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- 59% of the registered population was under the age of 40 years and 13% were under the age of 10 years. This was higher than the CCG and national averages (50% and 11% respectively).
- Although improved, cervical screening rates were still lower than the CCG and national averages. The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 71% compared to the CCG average of 82% and the national average of 82%.
- The expected standard for immunisation rates was 90%. Immunisation rates for this practice were low (72% and 87%) for two out of the four requirements for children under the age of one year. There were no specific immunisation clinics.
- Child health surveillance services were provided by a nearby buddy practice.
- The GP did not demonstrate during discussions that Gillick and Fraser guidelines were followed. These guidelines support sole decision making in children under the age of 16. The GP told us that children mostly attended appointments with a parent.
- There was an informal system in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. There was a risk register in place but this was not systematically looked at or reviewed.

Working age people (including those recently retired and students)

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- The practice did not offer pro-active appointments for health checks and there was low uptake for health screening such as

Summary of findings

breast and bowel cancer. For example females aged 50-70 screened for breast cancer in the last 36 months was 55% compared to the CCG average of 63% and national average of 73%.

- The practice had introduced on line services and patients could register and request access to their medical records. They could also make appointments and repeat prescription requests.
- There was sufficient health promotional advice and accessible information in the waiting room and a notice board with community news and support agencies.
- Patients were able to drop in to see the GP every weekday morning and could make specific appointments in the afternoon.

People whose circumstances may make them vulnerable

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, while children were identified as being at risk through the risk register, they were not routinely reviewed or monitored
- The practice was identifying patients with a learning disability and longer appointments were always available if required.
- The practice was now working with other health care professionals in the case management of vulnerable patients although there was limited documentation to support that.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

People experiencing poor mental health (including people with dementia)

Inadequate

Due to the continuing issues the provider is rated as inadequate in safe and well led and requires improvement for effective and caring services. The issues identified in those domains overall affected all patients including this population group.

- Patients with mental health illnesses were prescribed medicines to keep them stable. The practice remained outliers

for the prescription of hypnotic medicines (sleeping pills). The GP told us that they had discussed reduction regimes with patients but they had not implemented any reduction programmes.

- The GP still did not carry out regular physical and mental health review of patients with mental illness but had identified 23 patients and had generated and agreed care plans with 10 of them.
- The practice did not have a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Not all staff had received training on how to care for people with mental health needs and the GP had not undertaken recent training on the Mental Health Act 2015 or Deprivation of Liberty Safeguards (DoLS) although this was planned for the future.
- 100% of patients identified and diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months.

Summary of findings

What people who use the service say

What people who use the practice say

The latest national GP patient survey results were published in July 2016. 354 survey forms were distributed and 104 were returned which represented approximately 4% of the practice's patient list.

- 94% of patients found it easy to get through to this practice by phone compared to the national average of 73%. This was a 2% improvement from January 2016.
- 92% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%. This was a 7% improvement from January 2016.
- 86% of patients described the overall experience of this GP practice as good compared to the national average of 73%. This was a 4% improvement from January 2016.
- 79% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%. This was a 5% improvement from January 2016.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 25 comment cards which were mostly positive about the standard of care received. Six cards expressed a need for more clinical staff. Some comments included praise for the GP and the other staff and long term satisfaction from patients who had been at the practice for several years. There were some negative comments about GP attitude, lack of a female GP and the fact that there was only one GP.

We spoke with one patient during this inspection. They were very happy with the care and treatment they received. They said the staff were thoughtful and approachable and they were happy with the services provided which they felt met their needs.

We also received feedback from 11 patients who completed an anonymous CQC patient survey which was made available at the inspection. The feedback was mostly positive and patients were satisfied. All the patients reported that they did not know how to make a complaint or provide feedback to the practice.

Areas for improvement

Action the service MUST take to improve

- Have systems and processes that are established and operated effectively to ensure that good governance is maintained.
- Do all that is reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of patients.
- Monitor and review that staff have the required training and understanding to enable them to carry out their roles effectively.
- Have a system to obtain patient feedback and monitor verbal comments and complaints
- Ensure care and treatment is provided in a safe way.
- Take appropriate action whenever risks and issues are identified.
- Ensure that care plans are in place for all patients that need them.
- Have a system to ensure competency and understanding of training such as chaperoning and Data Barring and Service (DBS) checks.
- Be able to demonstrate sufficient understanding of the requirements of the Health and Social Care Act 2014 and how to implement and maintain the necessary changes
- Demonstrate that they have the necessary qualifications, competence, skills and experience required to undertake their role, such as mental capacity, Deprivation of Liberty Safeguards (DoLS) and leadership skills.

Action the service SHOULD take to improve

- Have a system to identify and support those patients that are carers.
- Consider a continual review of procedures and guidance to ensure they are being followed.

Summary of findings

- Consider the needs of the practice population and make changes where appropriate such as increasing the number of staff or maximising the skills of existing staff to meet these needs.

Merseybank Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a second CQC inspector.

Background to Merseybank Surgery

Merseybank Surgery is situated in a deprived area of Chorlton within South Manchester Clinical Commissioning Group area . It is located in a row of shops and has disabled access and toilet facilities. Dr Hotchkies is a single-handed, male practitioner who has provided GP services at this location for over twenty five years under a General Medical Services contract.

The practice population is around 2,600 patients, currently increasing, and has a higher than average proportion of patients between the ages 15 and 49. The highest group of patients are aged between 25 and 29, higher than the local and national average. The number of patients over the age of 65 is less than the local and national average at fewer than 2%.

Staff at the practice consist of the lead GP, a part time practice manager and three part time administration staff. The part time (one day per week) practice nurse has left the practice and the gap will be filled by agency nurses in the interim. The practice does not offer surgical procedures, maternity or midwifery services or minor injury treatments. These can be accessed through the local community services. Child surveillance clinics are provided by a buddy practice nearby. There is no female GP.

The surgery is open from 8.30am until 6pm Monday to Friday (except Wednesdays). On Wednesday the practice closes at 1pm. Patients are directed to out of hours services when the practice is closed after 6pm and at the weekend.

Patients have access to an open surgery from 9.15am until 11.30am Monday to Friday and appointments are pre-bookable in the afternoons (except Wednesdays). The practice has a website and patients can register and request access to their medical records, make appointments and request prescriptions.

We initially carried out an announced comprehensive inspection at Dr Iain Hotchkies Merseybank Surgery on the 14 July 2015 when the practice was rated inadequate overall and was placed into special measures. Services placed into special measures are re-inspected again within six months. We also issued a warning notice to ensure the practice immediately carried out actions required to meet Regulation 12, Safe care and treatment.

On 4 April 2016 we carried out an announced full comprehensive re-inspection when we found the practice had made improvements but remained inadequate for safety. We found that other improvements were still required and overall the practice was rated as requires improvement. The practice were placed into special measures for a further six months and given a warning notice for concerns relating to Regulation 17, Good Governance.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal

requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 31 January 2017. During our visit we:

- Spoke with all the staff which included the sole GP, the practice manager and three reception staff.
- Observed how patients were being treated at reception.
- Looked at sections of personal care or treatment records of patients with the GP.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed CQC patient surveys which were made available to patients visiting on the day.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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.

Inadequate

Are services safe?

Our findings

Merseybank Surgery was found inadequate for safety in July 2015 and a Warning Notice was issued in relation to Regulation 12, Safe Care and Treatment. The issues at that time were predominantly in relation to incident reporting and medicines management. The practice took appropriate actions to deal with the concerns and the actions required within the Warning Notice were met in October 2015.

When we re-inspected the practice in April 2016 we found that although some minor improvements had been made and systems had been introduced, the systems were not effective and the practice required further improvements. They remained inadequate for the safe domain and a Warning Notice was issued relating to Regulation 17, Good Governance. At that time the practice took appropriate actions to plan to deal with the concerns that had been highlighted and again the actions required within the Warning Notice were met in November 2016. However at this most recent inspection significant concerns were again identified regarding how safe the practice was.

Safe track record and learning

At this inspection we found that safety remained a concern. Previous issues that had been highlighted were still not actioned and the system in place did not ensure that incidents and risks were dealt with effectively.

- There was a lack of understanding around the rationale for reviewing incidents and an apathetic attitude towards action that needed to be taken .
- Although learning and action was identified no reviews were undertaken to ensure that identified action was taken. We saw that there was still outstanding action from the first significant event that had been written up following our original inspection in July 2015. For example the practice had identified that a pillow and privacy screen should be purchased but this was still not done. This action was required so that the practice would be in a more effective position to respond to the emergency needs of a patient based on previous learning.
- Although risks to patients who used services were assessed, the systems and processes to address those risks were still not implemented well enough to ensure continual patient safety. For example, the fridge remained unlocked and no action was taken to mitigate any likely risk. This showed a dismissive attitude by the leaders who did not take action to remedy the simplest risks even after they had been pointed out at several inspections.
- We saw evidence that when something had recently gone wrong, the patient was informed of the incident, received reasonable support, truthful information and a written apology. For example we reviewed the action taken by the practice when a patient had been erroneously sent to an outpatient appointment not meant for them. This was the only recorded incident/ complaint. We saw that there was a proposal of checking in place to reduce the risk of this happening again in the future.

Overview of safety systems and processes

The practice had sustained the improvement to some of the systems, processes and practices in place to keep patients safe and safeguarded from abuse, however concerns were identified in other areas. For example :

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements, and policies were accessible to all staff. The policies outlined who to contact for further guidance if staff had concerns about a patient's welfare. The GP was the lead member of staff for safeguarding and had undertaken the required training. However, at the inspection in April 2016 we were told that they had arranged deprivation of liberty safeguards (DoLS) training to take place later in the year and that was not yet completed and the GP was unable to demonstrate a clear understanding of mental capacity.
- Although the GP told us they had been more involved, and attended meetings, with outside agencies there was no recorded evidence of this. Administration staff continued to say that they had a better understanding of safeguarding issues since undertaking the required training and this was demonstrated in their answers to questions by inspectors.
- There was a notice in the waiting room to advise patients that they could request a chaperone if they wished and the part time practice manager had been trained for this in addition to the nurse. The nurse however had left the practice and we were told that a member of administration staff had been trained to

undertake the procedure if required. That member of staff did not have a Disclosure and Barring Service check (DBS check) or a risk assessment. (DBS checks 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). Other reception staff had completed on-line chaperone training, but they were not all aware of their responsibilities in this regard when we spoke to them.

- Fridge temperatures were monitored and actions were taken if and when the temperature went out of range and the reasons were documented. However we found that medicines were not secured, the fridge was not kept locked, was in the kitchen which was not locked and it was possible for patients to enter. When we raised this with the practice manager we were told that they understood it should be kept locked but they had not taken any action to reduce the likelihood of any incident because it was easier to leave it unlocked.
- The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Patient Group Directions were in place but the practice nurse had left and the practice had not considered any system to ensure that agency nurses worked to the same directions.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice manager was the infection control lead and liaised with the local infection prevention team who had carried out an audit in October 2015 and the actions required had been completed. There was an infection control protocol in place and all staff had received up to date training. Improvements had occurred since our last visit. Cloth curtains had been replaced with disposable ones and dates for replacement were logged. Spill kits were available and staff knew where they were and what to do if vomit, urine or blood spills occurred.

Monitoring risks to patients

Some improvements had been made with regard to risks to patients and some systems to assess and manage these had been implemented. However, further improvements were required to ensure these systems were more effective. For example :

- The arrangements to plan and monitor the number of staff and mix of staff needed to meet patients' needs had been reviewed. Staff told us that a better and fairer system was now in place. For example, they had been given more responsibility and specific lead areas and there was a rota so that all duties were covered during staff absence.
- We saw that there were procedures to monitor and manage some of the risks to patient and staff safety. A health and safety policy was in place and had been seen and signed by staff. We saw that monthly room checks had been implemented and carried out at our last inspection in April 2016.
- Helath and safety was still limited to the physical environment and did not extend to working procedures which should also be monitored such as high risk of hospital admission and children and vulnerable adults at risk.
- We saw that all electrical equipment had been checked to ensure that it was safe to use and clinical equipment was also checked to ensure it was working properly. A legionella check had also been completed and gas and electrical actions had been dealt with. (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Appropriate fire checks were in place apart from regular checks of the smoke alarms. This was highlighted at our last inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to respond to emergencies and major incidents with the exception of those relating to smoke alarms, but not everyone knew about them.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff had received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available. There was no evidence that the oxygen was opened and regularly checked to ensure it was always working in case it was required in an emergency.

Inadequate

Are services safe?

- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage and a copy was kept at the practice manager's home. The plan included emergency contact numbers for staff. However the lead GP told us he was not aware of the plan or its whereabouts.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

The practice were found to be inadequate for effectiveness in July 2015. Our inspection in April 2016 identified that a number of improvements had been made. Those improvements, such as audit and monitoring had continued at this most recent inspection. However, the practice continued to require improvement in order to reach the required standard.

Effective needs assessment

The GP told us that they continued to assess patients' needs and deliver care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. There were still no formal systems in place to monitor that guidelines were followed but as the GP was sole clinical provider this was not deemed necessary. The GP was able to evidence that they received up to date information and had access to guidelines for NICE which they followed. They showed us where they had made changes to medicines, where they could, in line with best practice.

Management, monitoring and improving outcomes for people

The practice used the 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). The most recent published results were 95% of the total number of points available. This was an improvement to previous years.

Data from 2015/2016 showed :

- Performance for diabetes related indicators was 86% which was 6% higher than the CCG average and 8% higher than the national average. A diabetic nurse attended the practice once a month. However other chronic disease management and health check clinics were not routinely offered and issues were dealt with reactively when patients attended for acute problems.
- The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-to-face review in the preceding 12 months was 100%. The exception rate for this outcome was 16.7% compared to the CCG exception rate of 11.3% and national rate of 12.7%. (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).
- The percentage of patients with COPD who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 100%. The exception rate for this outcome was 7.6% compared to the CCG exception rate of 16.4% and national rate of 13%

However, the practice remained outliers for the following :

- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 39% compared to the CCG average of 86% and the national average of 89%. This was a rise from 33% in our previous report.
- The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been performed in the preceding 5 years was 71% compared to the CCG average of 82% and the national average of 82%. This was a rise from 62% in our previous report.
- The average daily quantity of Hypnotics prescribed was 2.5 compared to the CCG average of 1.5 and the national average of 1. These figures had risen. In July 2014 and June 2015 the average daily quantity of Hypnotics prescribed by the practice was 0.64 compared to the national average of 0.26.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) was 1.5 compared to the CCG average of 1.1 and the national average of 1.
- The percentage of children aged 2 who had received their immunisation for Haemophilus influenza type b (Hib) and Meningitis C (MenC) (i.e. received Hib/MenC booster) was 72% against the required standard of 90%.
- The percentage of children aged 1 who had completed a primary course of immunisation for Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenza type b (Hib)((i.e. three doses of DTaP/IPV/Hib) was 87% against the required standard of 90%.

Previous inspections identified that the practice had implemented a system of audit and

monitoring and had carried out some checks on patients to ensure they were receiving the most appropriate treatment. At that time, two cycle clinical audits had not been completed to show improvements. At this inspection we saw there was evidence of continuing quality improvement identified through a programme of clinical audit.

There had been a number of clinical audits undertaken in the previous 18 months and at least two of those were now completed audits where the improvements made were implemented and monitored.

Findings were now being used to improve services. For example, recent action taken showed improvements in the following outcomes :

- Patients on thyroxine who had not had their thyroxine levels checked in nine months had reduced from 32 patients in 2015 to 14 patients in 2017.
- Patients on metformin who had not had their vitamin B12 levels checked in 12 months had reduced from 36 patients in 2016 to 9 in 2017.
- Patients had been called in to identify if they had atrial fibrillation (abnormal heart rhythm). In 2016, 60 patients were identified and included on a register and since then, the practice continued to identify, screen and treat patients with AF.

Effective staffing

This was a small practice with a small complement of staff which consisted of the sole GP, part time agency nurses who worked one day per week and four part time administrative staff (including the practice manager). The reception/administration staff and practice manager used an e-learning module to undertake the training required to carry out their duties. The agency nurses were monitored by the nursing agency to ensure their registrations and training were up to date and the GP had been appraised but not revalidated.

There had been no recent employments but there were protocols in place such as an induction form for new staff. However:

- The GP administered vaccines and immunisations and told us they kept up to date with immunisation programmes. There was no evidence to support this.
- Agency nurses were monitored by the nursing agency. There was no induction specific to clinicians, such as ensuring they were up to date with appropriate levels of training to suit the practice. This was assumed to be done by the Agency. The practice did not have evidence to show that the agency clinicians taking samples for the cervical screening programme or those who administered vaccines had specific training which included an assessment of competence.
- A female agency nurse was starting work at the practice the day following our inspection. Although we were told that documents had been applied for, they were not in place before the employee started work
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. All staff had received an appraisal within the last 12 months. There was no competency checking to ensure that learning was understood.

Coordinating patient care and information sharing

The GP was the sole clinician. The information needed to plan and deliver care and treatment was available to them in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. However, not all patients had care plans in place such as those at risk of admission to hospital or those with mental health needs or specific long term conditions.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The GP worked with other health and social care professionals when required, to understand and meet patients' needs. Ongoing care and treatment was planned and included information when patients moved between services. However, the GP told us that the practice did not pro-actively telephone patients that had been discharged from hospital. They were reviewed if and when this was necessary, for example, if stated as required in the discharge summary.

Consent to care and treatment

Patients' consent to care and treatment was obtained when required, such as when giving vaccines and immunisations. However, there was limited use and

Requires improvement

Are services effective?

(for example, treatment is effective)

understanding in relation to the Mental Capacity Act 2005. When providing care and treatment for children and young people, there was no evidence that consent was discussed or sought in line with relevant guidance.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- The practice was aware of patients receiving end of life care and the GP followed the Gold Standards Framework relating to those patients. Other patients at risk of developing a long-term condition such as diabetes and those requiring advice on their diet, smoking and alcohol cessation received support from community or other local services. Not all patients with long term conditions had holistic care plans in place that supported their overall health and wellbeing.
- Cervical screening rates were lower than the CCG and national averages. The percentage of women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding 5 years was 71% compared to the CCG average of 82% and the national average of 82%. The practice nurse had improved this patient outcome by undertaking telephone calls and sending letters to encourage patients to attend. However the longstanding nurse had now left the practice and the GP was not able to tell us how this improvement would be continued in the future.
- The expected standard for immunisation rates was 90%. Immunisation rates for this practice were low (72% and 87%) for two out of the four requirements for children under the age of one year. There were no specific immunisation clinics. Child health surveillance services were provided by a nearby buddy practice.
- Patients had access to health checks. However, the practice did not offer pro-active appointments for health checks and there was low uptake for health screening such as breast and bowel cancer. For example females aged 50-70 screened for breast cancer in the last 36 months was 55% compared to the CCG average of 63% and national average of 73%.

Requires improvement

Are services caring?

Our findings

The practice were found to require improvement for caring in July 2015. Our inspection in April 2016 identified that a satisfactory level had been attained and the practice was rated as Good with further action required if that rating was to be maintained. At this inspection we found that insufficient action relating to support for carers had been taken. There was still no carers' register and carers were not pro-actively identified or supported. Not all patients had the necessary care plans in place.

Kindness, dignity, respect and compassion

We observed that members of staff continued to be courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. However, an action in 2015 had identified that a pillow and privacy screen were required and these had still not been procured.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and could offer them a private room to discuss their needs.

We received 25 comment cards which were mostly positive about the standard of care received. Six cards expressed a need for more clinical staff. Comments included praise for the GP and the other staff and long term satisfaction from patients who had been at the practice for several years.

We spoke with one patient during this inspection. They were very happy with the care and treatment they received. They said the staff were thoughtful and approachable and they were happy with the services provided which they felt met their needs.

We also received feedback from 11 patients who completed an anonymous CQC patient survey which was made available at the inspection. The feedback was mostly positive and patients were satisfied. None of the patients reported that they knew how to make a complaint or provide feedback to the practice.

Results from the national GP patient survey published in July 2016 showed improvement in the way patients felt they were treated with compassion, dignity and respect. The practice was average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 93% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 95% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 87% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 83% and the national average of 82%.
- 90% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 91%.
- 92% of patients said they found the receptionists at the practice helpful compared to the CCG average of 85% and the national average of 87%.

Discussions with reception staff continued to reassure us of their understanding that the way patients were supported had an impact on their care, treatment or condition. The GP had worked at the practice for more than 25 years and knew all the patients and their families very well. They told us that patients were involved in their care as much as they wanted, or were willing to be. We were told that options, and pros and cons of treatment were discussed.

There was a hearing loop in reception for the hard of hearing and the GP said that they used reading and signs to communicate with patients who were deaf or hard of hearing. There was still nothing in the waiting room about information available in different languages or interpretation services. Reception staff were confident about the facilities available, such as interpretation services, if they were required.

Care planning and involvement in decisions about care and treatment

All the patients we spoke to told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Requires improvement

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards and the patient surveys we received was also positive and aligned with these views. The completed care plans we saw were personalised but they were not in place for all patients that needed them.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 83% and national average of 82%.
- 87% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Translation services were available if patients did not have English as a first language.
- Information leaflets could be made available in easy read format if required.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Information for patients about the services available was easy to understand and accessible, however it was not always correct. For example patients had been informed that a merger was imminent to improve services for them, but this was not the case as no formal arrangements had been agreed.

At our inspection in April 2016 we were told that the practice had begun to record patients who were carers and the computer system highlighted and alerted the GP if a patient was also a carer. Written information was available to direct carers to the various avenues of support. At this inspection we were told that they had been unable to sustain this improvement and did not have a current carers' register. Carers were opportunistically, rather than pro-actively identified.

The GP knew families well and would offer bereavement advice if and when required.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was rated good for responsive.

- The practice had good facilities and was well equipped to treat the patients it cared for and meet their needs. Patients requiring smoking cessation, diet advice and alcohol related support, and patients with enduring mental health continued to be referred to other services that could be provided by the practice if existing staff were upskilled to undertake health care checks and smoking cessation.
- We were told that patients were invited for regular reviews. Chronic disease management and health check clinics were not routinely offered and issues were dealt with reactively when patients attended for acute problems. They were then signposted to the appropriate services within the community.
- Extended hours were available via the South Manchester GP Federation and drop in clinics were available every morning.
- Information about how to complain was available and easy to understand and we saw that the practice responded quickly to an issue that had been raised. However, the patients we spoke to said they did not know how to make a formal complaint or provide informal feedback to the practice.
- Learning from complaints was shared with staff when required. The practice still did not monitor and record verbal complaints and comments to review trends.

Responding to and meeting people's needs

The practice was aware of the needs of its patient population and the necessity to increase services and improve patient outcomes such as medicine management, cancer screening and immunisations. There was no plan in place as to how these improvements would be made in the interim and patients had been formally advised that they would be able to access nurse services, baby clinics and travel advice from another practice when a merger took place. There was no formal merger arrangements and no evidence or plan of how those needs would be met in the interim.

Services provided at the practice included the following :

- All patients had access to same day appointments as the practice offered a drop in surgery each week day from 9.30am until 11.30am. Afternoon appointments were pre-bookable each day except Wednesday.
- Telephone consultations and on-line patient access was offered.
- Longer appointments were available for patients that needed them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Patients were able to receive travel vaccinations available on the NHS and referred to other clinics for vaccines available privately.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open between and 8am and 6pm Monday to Friday except Wednesdays when it closed at 1pm. Appointments were on a drop-in basis every morning and between 3pm and 6pm every afternoon. Patients could make appointments on-line and could pre-book appointments up to six weeks in advance.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages but were lower than the previous results.

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 72% and national average of 76%.
- 94% said they could get through easily to the surgery by phone compared to the CCG average of 64% and national average of 73%.
- 92%were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 82% and national average of 85%.

Patients were always able to get an appointment and were always able to see the same GP so had continuity of care. Some patients expressed that they would like to see a different GP. Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The GP assessed whether a home visit was clinically necessary and made the sole decision about the urgency of the need for medical attention.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. However the staff told us they did not get many "official" complaints and verbal comments were not monitored.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- 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. However there was very few complaints logged over a number of years and the GP told us the practice did not get complaints.

We looked at the only complaint logged since our last visit. This was where a patient had been sent an erroneous outpatient appointment. We saw that it had been handled in an open and transparent way. Lessons had been discussed with a plan to prevent the error from happening again in the future. The practice still did not encourage, record or escalate verbal comments and feedback in order that trends could be analysed.

Are services well-led?

Inadequate

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

Our findings

In July 2015 this practice was found to be inadequately led and our inspection report highlighted the areas that needed to be addressed so that the required standards would be met. When we re-inspected the practice in April 2016 following a period of special measures there was evidence that a number of improvements had been achieved. Our inspection report highlighted that further action was required in order to embed and maintain the improvements. An additional period of special measures was awarded to the practice to give them the opportunity to show improvement over a significant period of time. At this inspection, following 18 months in special measures we did not find evidence that significant action had been taken in order to meet the required standards. We saw that some systems that had been introduced had not been sufficiently maintained to evidence that the practice was being effectively led.

Vision and strategy

The purpose of the practice was set out in their statement of purpose. It stated that it offered patients personal health care of a high quality. It outlined the practice objectives which included the development and improvement of patient pathways, reduction in waiting lists and management of patients in primary care through specialist advice and feedback.

The practice was unable to sufficiently evidence that these objectives were being met. There was still a number of areas where the practice remained outliers for patient outcomes and no plan had been introduced to evidence how those issues would be addressed. Outliers included cervical, breast and bowel screening, high prescribing of hypnotic and antibiotic medicine and low standards for childhood immunisations. We had seen improvement from the first inspection but this had not been maintained.

The vision of the sole provider was to merge with another practice but there were no formal arrangements in place at the current time and no plans as to how any failings would be addressed in the interim. The practice had initiated discussions, leaflets had been printed and patients had been informed that a merge was taking place in 2017. However no formal framework or any arrangement had yet been agreed.

Governance arrangements

At our inspection in April 2016 we found that governance arrangements had improved, staff were aware of their roles and responsibilities and practice specific policies had been implemented for staff to follow. At that inspection we highlighted that action was still required to embed this governance structure and ensure that policies were being followed if that improvement were to be maintained. At this inspection we identified further improvement actions had not been carried out which raised concern regarding the provider's capability to make them. We found:

- There was a dismissive attitude by the leaders about the actions required to meet the required standards.
- The arrangements for identifying, recording and managing risks and issues was still not robust and did not ensure that appropriate actions were taken when required.
- The leaders at the practice could not demonstrate sufficient understanding of the requirements of the Health and Social Care Act 2014 or how to implement the necessary changes.
- The practice had increased the number of policies and procedures it had to govern activity but they were not sufficiently embedded and they were not effective. For example, they did not ensure that incidents were reviewed or that appropriate action was taken. The chaperone policy was not being followed in accordance with what it contained and what we were being told.
- Carers were not being pro-actively identified and supported and not all patients who needed a care plan had one.
- Training that the GP had identified as required at our last inspection visit had still not been undertaken such as mental capacity awareness and deprivation of liberty safeguards.
- The GP did not demonstrate during discussions that Gillick and Fraser guidelines were followed. These guidelines support sole decision making in children under the age of 16. The GP told us that children mostly attended appointments with a parent.
- There was an informal system in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. There was a risk register in place but this was not systematically looked at or reviewed.
- Where training had been completed there were no checks to ensure it was understood.

Are services well-led?

Inadequate

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

- The patient participation group had been implemented but there was no evidence of patient feedback since the last inspection on 4 April 2016 or any improvement to services as a result.
- Improved communication and clear roles and responsibilities of staff had continued.
- Staff understood the requirement to monitor, increase and improve outcomes for patients. Clinical audit was being undertaken by the GP for this purpose.

Leadership and culture

The GP was the sole provider and decision maker with ultimate responsibility to plan and decide the future of the practice. Although they said they prioritised safe, high quality and compassionate care this was not demonstrated. They did not demonstrate that they had the experience, capacity and capability to run the practice and ensure high quality care in accordance with requirements. The provider told us that they did not have the staff or the knowledge to meet the standards set out by the Care Quality Commission (Health and Social Care Act 2014 Regulations) and felt there was no future for the practice in its current form.

The provider was aware of the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment) and now encouraged a culture of openness and honesty. We saw that staff were able to report when things went wrong and we saw that people who were affected by errors were given an explanation and a verbal and written apology.

There was a leadership structure in place and the reception/administration staff felt supported by management.

- Staff told us the practice held regular team meetings and minutes of those meetings were recorded. However, they did not follow a formal agenda to ensure that significant issues were consistently discussed.
- Staff told us there was now an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, and felt that they were involved in discussions about the future of the practice.

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

The practice was involved in a direct enhanced service which aimed to encourage GPs to obtain the views of patients through a patient participation group (PPG). A group had been formed following our initial inspection in July 2015 and continued when we inspected in April 2016. The last inspection in April 2016 inspection showed that they had made some improvements, such as setting up a notice board in the reception area and increasing information for patients who attended the surgery. Since the initial set up the group had continued to meet and the GP attended and facilitated those meetings when they could.

We were told that the meeting was only useful to confirm that the patients were happy with the service and did not want it to be removed. There was no formal agenda about how the group could provide feedback and suggest improvements and currently discussions were about the services that would be available to the practice after the merger took place. However, there were still no formal arrangements in place for this merger and the group had not been used to obtain patients views about how services could be improved in the meantime.

The practice was aware that 59% of the registered population was under the age of 40 years and 13% were under the age of 10 years. They had not facilitated discussions about how outcomes for this population group could be improved. Cervical screening rates were still lower than average and there was limited nursing staff to improve these figures. Immunisation rates did not meet the required standards and although children could be brought for immunisations whenever they were needed, there was no specific immunisation clinics at the practice to encourage block attendances and pro-actively monitor outcomes.

Continuous improvement

We did not see evidence that there was a focus on continuous learning and improvement at all levels within the practice. The GP as sole provider and decision maker did have any plan or evidence as to how they would maintain improvement, whilst a merger was negotiated, or if a merger did not take place.

This section is primarily information for the provider

Enforcement actions

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 Treatment of disease, disorder or injury	Regulation 4 HSCA (RA) Regulations 2014 Requirements where the service providers is an individual or partnership **We are taking action in line with our enforcement procedures**

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We are taking action in line with our enforcement procedures**