Durdells Avenue Surgery

Quality Report

1 Durdells Avenue
Kinson
Bournemouth
Dorset
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Website: www.durdellsavenuesurgery.co.uk

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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?	
Are services effective?	
Are services responsive to people's needs?	
Are services well-led?	

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced focussed inspection of Durdells Avenue Surgery on 9 May 2017. This was to check compliance relating to the serious concerns found during a comprehensive inspection on 7 February 2017 which resulted in the Care Quality Commission issuing a Warning Notice with regard to Regulation 12, Safe care and treatment; Regulation 17, Good Governance and Regulation 18, Staffing.

Other areas of non-compliance found during the inspection undertaken on 7 February 2017 will be checked by us for compliance at a later date.

Following our inspection undertaken on 7 February 2017 we rated the practice as inadequate overall and the practice was placed in special measures. Specifically, the domains of safe, effective, responsive and well-led were assessed as providing inadequate services. The domain of caring was rated as good.

This report covers our findings in relation to the warning notice requirements only and should be read in conjunction with the latest comprehensive inspection report for the February 2017 inspection. This can be found by selecting the 'all reports' link for Durdells Avenue Surgery on our website at www.cqc.org.uk.

At this inspection in May 2017, we checked the progress the provider had made to meet the significant areas of concern as outlined in the Warning Notices dated 3 March 2017, for breaches of regulations 12, 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We gave the provider until 30 April 2017 to rectify these concerns. The Warning Notices were issued because we found there were inadequate systems or processes to effectively reduce risks to patients and staff and ensure high quality care as follows:

- Patients were at risk of harm because systems and processes were not being followed to keep them safe. For example, not all staff had received training in safeguarding and emergency procedures were not adequate.
- The practice had no clear leadership structure and limited formal governance arrangements to ensure high quality care.

Summary of findings

- Staff were able to report incidents, near misses and concerns; however the practice had not ensured that learning from such events was consistently shared with all staff to ensure improvements to care were made.
- A limited amount of clinical audits had been carried out, and there was no effective system to manage performance and improve patient outcomes.
- Staff were not adequately supported. There were gaps in training that staff required to perform their roles effectively, a lack of staff meetings and staff appraisals.

At our inspection on 9 May 2017 we found the provider had achieved compliance in regulation 12 as set out in the Warning Notice. We found the provider had achieved compliance in some areas of regulation 17 and regulation 18 as set out in the Warning Notices. However, there were still areas relating to these Warning Notices that required improvement. Our key findings were:

- There were systems in place to ensure significant events were reported and investigated.
- Clinical audits had been commenced and the practice could demonstrate patient outcomes were monitored.
- The practice had taken steps to reduce any potential health and safety risks for patients and staff.
- Risks were assessed and generally well managed with the exception of security of clinical areas.
- Staff had received the training necessary for them to carry out their roles effectively, however not all staff had received appraisals.
- The partners in the practice did not have the capacity to ensure high quality care.
- Complaints from patients were not responded to within appropriate time frames.

The other key lines of enquiry will be reassessed by us at another inspection when the provider has had sufficient time to meet the outstanding issues. At that time a new rating will be assessed for the provider. The outstanding issues that the practice must address are:

- Ensure that the process for handling and responding to patient complaints is in line with contractual agreements.
- Ensure that staff receive regular appraisals.
- Ensure a programme of audit and other activity is in place to monitor improvements to patients care and outcomes have been achieved.

In addition, the issues that the practice should address are:

- Review the security arrangements for clinical areas, so that blank prescription stationery is consistently kept secure.
- Review the arrangements to monitor staff training.
- Continue to review the process for recording and investigating significant events so learning and improvements to the quality of care can be demonstrated.

The ratings for the provider will remain in place until a comprehensive inspection is undertaken.

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?

The practice is rated as inadequate for safe until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that the Warning Notice had been met. These were:

- Arrangements to record and investigate significant events had improved, however were not yet embedded.
- The practice had safe systems to ensure patients were safeguarded from harm or abuse.
- Risks to patients were assessed and generally well-managed. However, the security arrangements for blank prescription stationery was not consistently kept secure
- The practice had taken steps to ensure risks from infection were minimised.
- The practice had taken steps to ensure its emergency procedures, including lone working by staff, were failsafe.

Are services effective?

The practice is rated as inadequate for effective until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that the Warning Notice had been partially met. These were:

- The practice could demonstrate that some clinical audits were completed and the impact of these on patient outcomes. However, there was not a programme of audit and other activity is in place to monitor improvements to patients care and outcomes.
- Staff had completed the training considered to be mandatory by the practice to enable them to perform their role. However, the arrangements to monitor staff training requirements were not reliable
- Some staff appraisals had been completed and there was a plan in place to complete the remaining appraisals by the end of May 2017.

Are services responsive to people's needs?

The practice is rated as inadequate for responsive until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that this part of the Warning Notice had not been met. These were:

Summary of findings

- The complaints system required improvement. The practice could not demonstrate that complaints were handled and responded to within appropriate time frames.

Are services well-led?

The practice is rated as inadequate for being well-led until a further comprehensive inspection takes place. Improvements had been made since the previous inspection and we found that the Warning Notice had been partly met. These were:

- Systems to support communication and sharing of learning between all staff were in place. For example, with regard to significant events and staff feedback.
- There was a system for reporting significant events. However, the review process for recording and investigating significant events so learning and improvements to the quality of care can be demonstrated was not fully established.

The practice had taken steps to reduce any potential health and safety risks for patients and staff.

Durdells Avenue Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a GP specialist adviser.

Background to Durdells Avenue Surgery

Durdells Avenue Surgery is based in a residential area of Kinson, Bournemouth, and is part of NHS Dorset Clinical Commissioning Group (CCG). The practice is in a purpose-built two storey building. Durdells Avenue Surgery provides services under a NHS Personal Medical Services

contract to approximately 2850 patients living within the practice boundary. The practice is located in an area of greater deprivation compared to the average for England and has a higher proportion of older patients compared to the average for England.

The practice has two male GP partners. One GP works part-time and does not offer regular clinical sessions, which had been the case over the last 18 months. At the time of our inspection, this GP was on leave. The practice employs regular locum GPs, some of whom were male and some were female, to cover clinical sessions. Since April 2017, a neighbouring practice had supported the practice by releasing two of their GPs to work up to six sessions per week at Durdells Avenue Surgery. The practice also employs a female practice nurse. The clinical team are supported by a practice manager and a team of six secretarial and reception staff.

Durdells Avenue Surgery is open between 8.30am and 6.30pm Monday to Friday. Phone lines open at 8am. Extended hours surgeries are available every Tuesday evening until 7pm. Appointments are available every day from 9am until 11am and from 2pm until 4pm on

Mondays, Wednesdays and Fridays and from 2pm until 5pm on Tuesdays. GPs also perform daily home visits to patients who are unable to attend the practice.

Durdells Avenue Surgery has opted out of providing out-of-hours services to their own patients and refers them to the Boscombe and Springbourne Health Centre (based in Bournemouth) walk in service at weekends, and the Dorset Urgent Care service via the NHS 111 service. The

practice offers online facilities for booking of appointments and for requesting prescriptions.

We carried out our inspection at the practice's only location which is situated at:

1 Durdells Avenue

Kinson

Bournemouth

Dorset

BH11 9EH

Why we carried out this inspection

We carried out an announced focussed inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection

Detailed findings

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.

We carried out an announced focussed inspection on 9 May 2017 to look specifically at the shortfalls identified in the warning notice served to the practice after our inspection in February 2017.

How we carried out this inspection

During this inspection, we did not look at population groups or speak with patients who used the service.

We spoke with the lead GP, the practice manager and three reception and administration staff.

We looked at documents, including practice policies and procedures, and inspected records related to the running of the service. These included minutes of staff meetings, significant events and action plans produced by the practice to address concerns and complaints.

Are services safe?

Our findings

Following our inspection in February 2017, we rated the provider as inadequate for safe. A Warning Notice was issued in respect of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection on 9 May 2017, we specifically assessed gaps highlighted in the Warning Notice dated 3 March 2017 relating to safe care and treatment.

Safe track record and learning

At our inspection on 7 February 2017 we found shortfalls in identifying and acting on significant events. Reporting processes did not ensure that significant events were reported, recorded appropriately or monitored when action points to improve care had been identified. Significant events were discussed at clinical meetings however, there were no regular staff meetings for all staff to keep them informed of, or learn from, significant events.

At this inspection, we found that the processes for managing significant events had improved, but the practice could not demonstrate this was embedded. We were given a copy of the significant event policy which we were told had been reviewed since our last inspection, however the policy did not include a date, nor the date the policy would be due for review. The policy appropriately set out who staff should report significant events to and how they would be handled. Staff understood their responsibilities to raise concerns, and to report incidents and near misses and told us they would inform the practice manager or, in their absence, a GP of any incidents. There had been two monthly whole staff meetings since our previous inspection in February 2017; significant events had not been discussed at either. We were told this was because there had been no significant events since our previous inspection.

The practice showed us a significant event toolkit they had begun to use. This included a template to use for reviewing significant events; however at the time of our inspection this had not been used. We were told this was because there had been no significant events since our previous inspection. There was a recording form for staff available on the staff shared area of the computer system.

Overview of safety systems and processes

At our inspection in February 2017, we found processes for to keep patients safe and safeguarded from abuse were not embedded. None of the staff were trained in adult safeguarding and the practice could not demonstrate that clinical staff were trained to the appropriate level of child safeguarding. There were no practice specific safeguarding policies, including for chaperone procedures, for staff to refer to. Non-clinical staff performing chaperone duties, were not trained for the role. Staff were not clear on how to report safeguarding concerns appropriately.

At this inspection, we found that all staff had undergone training in adult safeguarding and all staff had now undergone child safeguarding training to the appropriate level. This has been monitored for completion by the practice manager. Safeguarding policies had been reviewed and updated to include practice specific procedures. The chaperone policy had been reviewed and a copy of this was readily available to reception staff. Staff told us that only clinical staff now perform chaperone duties. However, the chaperone policy stated that clinical or non-clinical staff who were trained could perform chaperone duties. We highlighted this to the practice who amended their policy during our inspection.

At our last inspection in February 2017, we found that the practice did not maintain appropriate standards of cleanliness and hygiene. Not all areas in the premises were clean and tidy and

patients commented to us that the practice did not feel clean. No staff had received infection prevention control training, despite the practice policy stating this would be on an annual basis. The practice had not acted on the findings from infection control audits.

At this inspection, we found that actions identified to minimise the risk of infection had been completed. The practice had liaised with its cleaning contractor to closely monitor performance. Staff used a communication book to highlight areas of the practice which required specific attention for cleaning. Torn seating in the patient waiting area, which had been identified as a risk in 2016, had been replaced in May 2017. Blinds had also been replaced in the patient waiting area. Since our last inspection, all staff had now received training in infection prevention and control.

At our inspection in February 2017, we found that blank prescription stationery in clinical areas was not consistently stored securely.

Are services safe?

At this inspection, the process for maintaining security of blank prescription stationery was not embedded. Some staff told us that blank prescription stationery was now removed from clinical rooms each evening and kept secure. Other staff told us that stationery was not removed from clinical rooms, but that clinical rooms were locked each evening. The action plan returned to us stated that clinical rooms would be locked at all times when not in use. During our inspection, we found that blank prescription stationery was kept in unlocked and unoccupied clinical areas. This meant the practice could not guarantee that unauthorised access to this stationery could be prevented.

We saw that blank prescription pads, used for home visits, and new batches of prescription stationery for use in computers, were stored securely and an appropriate log of their issue and use was maintained.

Monitoring risks to patients

At our inspection in February 2017, we found the procedures in place for monitoring and

managing risks to patient and staff safety were not consistently effective. Actions from a health and safety risk assessment carried out in 2011 had not been completed. Actions from a fire safety assessment from 2011 had not been carried out to minimise the risk of fire. Actions from a legionella assessment in October 2016 had not been carried out (legionella is a term for a particular bacterium which can contaminate water systems in buildings and cause breathing difficulties). The box for patients to leave requests for repeat prescriptions was not locked which meant that sensitive patient information was not secure.

At this inspection we found that the practice had employed a specialist contractor to complete a new fire risk assessment in April 2017. Actions required to reduce the risk of fire had been completed. For example, fire doors had been supplied and fitted on 7 May 2017. Weekly tests of fire alarm systems and monthly tests of emergency lighting were completed. The practice had sought quotations from a specialist contractor to carry out further remedial work to improve electrical safety, as recommended in their health and safety risk assessment.

The provider had now acted upon their legionella risk assessment. The practice had a monthly contract with a specialist contractor to carry out tasks to minimise the risk of legionella infection. Remedial work to clean, disinfect and flush water tanks had been completed in March 2017.

The box for patients to leave requests for repeat prescriptions had been replaced and was now lockable so that patient information was kept securely.

Arrangements to deal with emergencies and major incidents

At our inspection in February 2017, we found the arrangements to deal with emergencies were not adequate. Not all clinical staff had received up to date training in basic life support. The practice did not keep a full complement of emergency medicines or equipment as recommended by national guidance. Non-clinical staff were, on occasion, left alone in the premises without clinical support.

Since our last inspection, we found that all clinical staff had now undergone basic life support training. We reviewed emergency equipment and medicines and found these were fit to use, stored appropriately and contents now reflected national guidance.

The practice gave us a copy of the lone worker policy dated January 2017. This stated that staff could work alone in the practice providing staff assessed risks and that these were controlled. This included preventing public access. Since our last inspection, the practice had ensured staff were familiar with the policy and had changed staffing levels to ensure no receptionist would be in the practice on their alone.

Are services effective?

(for example, treatment is effective)

Our findings

Following our inspection in February 2017, we rated the provider as inadequate for safe. A Warning Notice was issued in respect of regulation 18 (Staffing) and regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection on 9 May 2017, we specifically assessed gaps highlighted in the warning notices dated 3 March 2017 relating to staffing as follows:

Management, monitoring and improving outcomes for people

At our inspection in February 2017, we found that there was a limited focus on monitoring outcomes for patients. Audits were limited to those supported by the Clinical Commissioning Group (CCG) relating to the prescribing of medicines. The practice was unable to demonstrate the impact these audits had had on patient outcomes.

At this inspection we found that the practice could demonstrate the impact of CCG prescribing audits. For example, the practice could demonstrate how patients had had their prescriptions changed from branded medicine to generic medicine where appropriate. This meant that patients received the same medicine, but at a lower prescribing cost.

The practice had also started one additional clinical audit. This was an audit to identify whether patients with psoriasis (a long-term skin condition) had active or inactive disease to review treatment options. The first cycle of the audit was started in April 2017 and a date for repeating was planned. However, there was no planned programme for further clinical audits.

The practice could demonstrate that performance against the Quality and Outcomes Framework was monitored on a regular basis (QOF is a system intended to improve the quality of general practice and reward good practice). The practice conducted monthly searches to identify patients who were due a review for their long-term condition. For example, for patients with diabetes or asthma. The practice conducted weekly searches to identify patients who might require further treatment or support. For example, patients who were taking a specific medicine to thin their blood and who did not have the appropriate blood test recorded were identified to ensure they received the correct treatment.

Effective staffing

At our inspection in February 2017, the learning needs of staff were not systematically identified. There were no regular meetings or reviews of practice development needs. Staff had access to appropriate training to meet their learning needs, however this was not monitored by the practice. There had been no formal appraisals since our last inspection in February 2016. The practice were unable to demonstrate that all staff had received training in areas they considered to be mandatory.

At this inspection, we saw that the practice had ensured that all staff undertook the training they considered to be mandatory such as; infection prevention control; child safeguarding; adult safeguarding, including the Mental Capacity Act 2005 and Deprivation of liberty status; basic life support and information governance. The practice provided training to staff through an on-line training package and through face to face whole staff training. Practice closures due to staff training, were clearly advertised on the practice website.

Since our last inspection, three staff appraisals had been conducted. Staff had received pre-appraisal paperwork to complete and we were told the remaining staff would have their appraisals completed by the end of May 2017. The practice confirmed after our inspection that all staff had received an appraisal by 18 May 2017.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Following our inspection in February 2017, we rated the provider as inadequate for responsive. A warning notice was issued in respect of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

At this inspection on 9 May 2017, we specifically assessed gaps highlighted in the warning notice dated 3 March 2017 relating to good governance as follows:

Listening and learning from concerns and complaints

At our last inspection, there was not an effective system to deal with complaints. The complaints process was ineffective and did not meet contractual agreements. Complaints had not been responded to within the agreed time frame. There was no evidence that the practice conducted an analysis of complaints for trends and to identify where care could be improved and there was limited evidence that lessons were learnt from concerns or action was taken to improve the quality of care.

At this inspection in May 2017, we saw that complaints were now stored on a shared computer drive. We were shown a practice action plan which stated that outstanding complaints had been revised and forwarded to the relevant body. The action plan stated that outcomes of complaints had been discussed with staff.

We looked at the minutes of two staff meetings dated 30 March 2017 and 6 April 2017 and found that complaints had not been recorded as being discussed. We were told this was because there had been no new complaints since our inspection on 7 February 2017. However, we found a complaint dated 6 February 2017 which the practice had acknowledged to the patient on the 9 February 2017. The practice response stated the patient would be contacted with a full response in the next few weeks. This had not been acted upon. Therefore, the practice did not demonstrate the full process for handling complaints.

Are services well-led?

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

Our findings

Following our inspection in February 2017, we rated the provider as inadequate for well-led. A warning notice was issued in respect of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the delivery of high-quality care was not assured by the leadership and governance in place. The provider did not have an effective governance framework which supported the delivery of the strategy and good quality care.

At this inspection on 9 May 2017, we specifically assessed gaps highlighted in the warning notice dated 3 March 2017 relating to good governance as follows:

Governance systems

At our inspection in February 2017, we found the practice did not have suitable systems in place to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activities. Systems in place to monitor or mitigate risks were not operated effectively to ensure that risks to patients were minimised as far as possible. For example, we found that risk assessments for legionella and fire had not been fully acted upon.

At this inspection we found that the practice had received support from the Clinical Commissioning Group (CCG) and Local Medical Council (LMC) to ensure the quality of care was improved. The practice had developed an action plan to address the concerns identified and was working through this plan based on the areas of greatest risk. The practice had ensured an appropriate risk assessment was conducted to be assured that the risk from fire was minimised and necessary actions to reduce risk were completed. The practice had taken the necessary actions to minimise the risk from legionella infection and emergency situations. The practice had ensured systems were in place to monitor staff training and safeguarding procedures.

However, governance systems in respect of handling and responding to complaints required improvement.

At our last inspection in February 2017, we found that the policies which the practice had in place did not reflect procedures in the practice. For example, the infection control policy stated that staff would receive annual training; this had not been achieved.

At this inspection, we found that the practice had developed an action plan to monitor and review policies. At the time of our inspection, this was marked as 75% complete. Policies were available to staff electronically via a shared area on the computer. We found that some practice policies required updating to reflect the practice procedures or required dating to ensure they were regularly reviewed.

At our inspection in February 2017, we found that there was limited oversight of the monitoring of patient outcomes. At this inspection we found that the practice had begun some clinical audits and could demonstrate that patient outcomes were regularly monitored by the practice.

At our inspection in February 2017, we found there was no oversight of the training and development needs of staff. At this inspection we found that systems to monitor training had improved but were not yet embedded. All training the practice considered to be mandatory was now up to date for all staff. Individual staff files contained details of the training staff had undergone. The practice had developed a record to be able to monitor training for completion; however we noted this was not kept up to date and did not reflect training details recorded within staff files. The practice did not have a policy which outlined what training staff should undertake and how often. The practice displayed details of the local training available to staff in staff areas.

Leadership and culture

At our last inspection we found that the partners in the practice had the experience to run the practice, however they did not have the capacity to ensure consistently safe and high quality care.

At this inspection, we found the situation regarding the capacity of the two partners whom form the registered provider had not improved and leadership was reactive rather than proactive. One partner was on long-term absence. The remaining partner, was also the registered manager, (the registered manager has responsibility to

Are services well-led?

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

ensure that people who use services have their needs met). The partners did not demonstrate an overview of the practice and had delegated business management responsibilities to the practice manager.

Following our previous inspection in February 2016, the provider had not returned to us an action plan to set out how they planned to address our previous concerns and meet the requirements of the regulations within the agreed time frame. At this inspection, the provider had again failed to return to us an action plan following the inspection in February 2017. We raised this with the registered manager during the inspection who was unaware it needed to be completed. The practice manager completed the documents and submitted this to us during the inspection.

The provider had been supported by external stakeholders, such as NHS England, the clinical commissioning group (CCG) and local medical council (LMC), to look at ways to improve patient care. Actions taken to reduce any potential risks included:

- The provider was pursuing a merger with a local practice to provide and improve services for patients and had liaised with the CCG to achieve the merger. We were told the merger was due to complete in 2017.
- The practice was receiving clinical support from the practice they were due to merge with through the vulnerable practice scheme.
- The provider was receiving some support from an external practice manager specialist appointed by the LMC to support the practice.

At our last inspection in February 2017, we found there were no routine whole staff meetings or meetings for specific staff roles. Staff told us the outcomes of complaints or significant events were not always fed back to staff so that learning and improvements to care could be made. At this inspection we found that whole staff meetings were now taking place and these were minuted.

The practice was due to merge with another practice in 2017. Some non-clinical staff had decided to leave the practice due to the merger and the practice had sought additional support to ensure their duties were covered. The practice was following the correct procedures to support staff through the merger process.

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

At our last inspection in February 2017, we found that staff had not had an appraisal since our last inspection in February 2016. Staff told us that they had been asked to completed pre-appraisal forms and that some staff had appraisals booked for Spring 2017.

At this inspection in May 2017, we found that three staff appraisals had now been completed and we were told that other appraisals were booked. We asked the practice to submit to us evidence to demonstrate that booked appraisals had been completed. The practice informed us after our inspection that all staff had received appraisals by 18 May 2017.

At our last inspection, the practice had not displayed the ratings from our previous inspection findings in February 2016 in a clear manner on the premises or on the website.

At this inspection, we found that the practice had displayed the ratings awarded to the practice from our February 2017 inspection on their website. There was also a display of ratings on a board in the patient waiting area.

At our inspection in February 2017, we found that the practice gathered feedback from staff on an ad hoc basis. There were no regular staff meetings, despite requests from staff to discuss issues, and staff told us that they did not regularly receive appraisals.

Since our last inspection, we saw that there had now been two whole staff meetings. These had agendas set before the meeting and included training, CQC, press, reception items and matters relating to the proposed merger. The practice had also conducted a staff survey and the results of these had been discussed and areas for improvement and of achievement had been noted.

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 Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not have suitable systems in place to assess, monitor and improve the quality and safety of services provided in the carrying on of the regulated activities (including the quality of the experience of service users in receiving those services).** • There was limited oversight of patient outcomes such as through planned clinical audit programmes. • The processes for complaints were not always followed. **This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Not all staff received regular appraisals. **This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**