# Somerset Medical centre

## 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? | Requires improvement |
| Are services effective? | Inadequate |
| Are services caring? | Inadequate |
| Are services responsive to people's needs? | Requires improvement |
| Are services well-led? | Inadequate |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

Following a comprehensive inspection of Somerset Medical Centre on 21 July 2015, the practice was given an overall inadequate rating and due to serious concerns about patient safety a decision was made to suspend the registration of the provider for a period of three months from 27 July 2015 to 27 October 2015. The provider appealed to a first-tier tribunal and a hearing was held on 01 October 2015. The appeal was dismissed by the tribunal upon agreement that we would re-inspect the practice on 14 October 2015. During this inspection we found sufficient improvements had been made to lift the suspension however there were still serious concerns in relation to the management and leadership of the practice.

We carried out an announced comprehensive inspection at 09:30hrs on 14 October 2015. Overall the practice is rated as inadequate.

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

- There was a lack of effective leadership at the practice.
- Procedures had been reviewed to keep patients safe however further improvements were necessary in relation to significant event analysis and safeguarding children and adults.
- There was insufficient assurance to demonstrate people received effective care and treatment. For example clinical audit was not used to improve outcomes for patients, NICE guidance was not routinely shared and clinical staff had a limited understanding of the Mental Capacity Act 2005 and how to carry out mental capacity assessments.
- National patient survey data showed the practice scored below average in terms of access to appointments, access to a preferred GP and several other aspects of care.

The areas where the provider must make improvements are:

# Summary of findings

- Ensure effective leadership is in place to include oversight and understanding of all the systems in place to deliver a high standard of care to patients.
- Introduce procedures to ensure all clinicians are kept up to date with national guidance and guidelines and updates shared within the clinical team to improve whole practice care.
- Ensure audits of practice are undertaken, including completed clinical audit cycles to improve patient outcomes.
- Ensure all staff understand and implement the key principles of the Mental Capacity Act 2005 and Gillick competences.
- Ensure safeguarding policies contain up-to-date guidance.
- Develop a clear vision for the practice and a strategy to deliver it. Ensure it is shared with staff and staff know their responsibilities in relation to it.
- Ensure staff appraisals are carried out by staff who are competent to do so.
- Act on feedback from the national GP patient survey to ensure areas of poor performance are addressed.

I am placing this practice in special measures. Practices placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The practice will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration. Special measures will give people who use the practice the reassurance that the care they get should improve.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, not all staff had an adequate understanding of significant event reporting procedures and analysis in that it included reflecting on the events, learning points and implementing any changes in practice. We also found safeguarding policies contained out-of-date guidance.

**Are services effective?**

**Inadequate**

The practice is rated as inadequate for providing effective services and improvements must be made. Data showed that care and treatment was not delivered in line with recognised professional standards and guidelines. Patient outcomes were hard to identify as little or no reference was made to audits and there was no evidence that the practice was comparing its performance to others; either locally or nationally. There was minimal engagement with other providers of health and social care. An appraisal process was in place for staff however appraisals were not carried out by an appropriately skilled and experienced person.

**Are services caring?**

**Inadequate**

The practice is rated as inadequate for providing caring services, as there are areas where improvements must be made. Data showed that patients rated the practice lower than others for many aspects of care. Data showed that patients were not always treated with compassion, dignity and respect and not all felt care for, supported and listened to. Patients were not always fully supported to cope emotionally with care and treatment.

**Are services responsive to people's needs?**

**Requires improvement**

The practice is rated as requires improvement for providing responsive services as there are areas where improvements should be made. Feedback from patients reported that access to a preferred GP and continuity of care was not always available quickly, although urgent appointments were usually available the same day. Data showed that the practice was rated lower than others for access to appointments and satisfaction with opening hours. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The complaints procedure was accessible and easy to understand.

# Summary of findings

**Are services well-led?**

Inadequate 

The practice is rated as inadequate for being well-led. It did not have a clear vision and strategy. Staff we spoke with were not clear about their responsibilities in relation to the vision or strategy. Effective leadership was not in place. Leaders had poor oversight and understanding of all the systems in place to deliver a high standard of care to patients and their knowledge of the day to day running of the practice was inadequate.

# 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

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a lower than national average number of older patients. The percentage of over 75 years was 4.3% and over 85 years was 0.9% (National average 7.6% and 2.2% respectively). The practice participated in the integrated care pilot and had identified 177 older patients at risk of unnecessary hospital admission and had completed 37 care plans. Regular multidisciplinary team meetings were held with district nurses, palliative care team, health visitors and community matrons to manage older patients. There was a named GP for older patients and safeguarding vulnerable adults training for all staff.

**People with long term conditions**

Inadequate

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The percentage of patients at the practice with a long standing health condition or with health related problems in daily life were 39.2% and 37.6%. These were lower than the England averages of 54% and 48.8%. QOF performance in 2015 for diabetes QOF indicators was 67%, which was well below the CCG average of 86% and the national average of 89%.

**Families, children and young people**

Inadequate

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice had a higher number of children aged 0 to 4 years compared to the national average (6.6% compared to 6%) and a lower number of children aged 5 to 14 years (8.6% compared to 11.4%). The percentage of children aged under 18 years was lower than the national average (11.7% compared to 14.8%). The practice provided services to meet the needs of families, children and young

# Summary of findings

people including childhood immunisations, cervical cytology and a smoking cessation service aimed at this population group. The practices' performance for childhood immunisations was generally below the local CCG average.

**Working age people (including those recently retired and students)**

Inadequate

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The percentage of patients in paid work or full time education was 61.6% which was above the national average of 60.2%. The practice offered extended hours for this population group which provided eight additional appointments a week. The practice provided online access to appointments and repeat prescriptions. A text message reminder system was in place for appointments.

**People whose circumstances may make them vulnerable**

Inadequate

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice carried out annual reviews of patients with learning disabilities. The practice worked with a local agency for homeless people and register patients under the agencies office. The practice provided open access for travellers, migrants and patients who are unemployed or going through financial difficulties.

**People experiencing poor mental health (including people with dementia)**

Inadequate

The provider was rated as inadequate for effective, caring and well-led and requires improvement for safe and responsive. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice carried out annual reviews of patients on the mental health register and screened patients for dementia. QOF performance in 2015 for mental health was 69%, which was well below the CCG average of 95% and the national average of 93%.

# Summary of findings

## What people who use the service say

Because we could not speak with patients during this inspection the evidence in this section is the same as that collected at our July inspection.

We spoke with nine patients who used the service. We reviewed 17 completed comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 to which 108 patients responded and an improving practice questionnaire (IPQ) completed in December 2014 by an external company, to which 85 patients responded. Evidence from all these sources showed a mixed response in terms of satisfaction with their GP practice. Data from the national patient survey showed the practice scored below average for a number of aspects of care although patients we spoke with and comment cards received where more positive.

# Somerset Medical centre

**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 advisor and a practice manager specialist advisor.

## Background to Somerset Medical centre

Somerset Medical Centre is situated at 64 Somerset Road, Southall, Ealing, UB1 2TS. The practice provides primary medical services through a General Medical Services (GMS) to approximately 1800 patients in Southall (GMS is one of the three contracting routes that have been made available

to enable commissioning of primary care services). The practice is part of the NHS Ealing Clinical Commissioning Group (CCG) which comprises 79 GP practices.

The ethnicity of the practice population is predominantly of Indian origin with a higher than national average number of patients between 20 and 44 years of age. Life expectancy is 79 years for males and 84 years for females which is in line with national averages. The local area is the fourth most deprived in the London Borough of Ealing (people living in more deprived areas tend to have greater need for health services).

The practice team consists of a male GP partner (five sessions) who is the registered manager, a female salaried GP (five sessions), a practice manager, a practice nurse (10 hours), two healthcare assistants, a phlebotomist and a small team of reception / administration staff. There is a second male GP partner whose registration is currently suspended by the General Medical Council (GMC).

As well as providing general medical services, the practice offers the following reviews opportunistically; asthma and allergy, diabetes, hypertension, child health surveillance, vaccines and immunisation, antenatal and family planning.

The service is registered with the Care Quality Commission to provide the regulated activities of diagnostic and screening procedures, treatment of disease, disorder and injury, surgical procedures, family planning and maternity and midwifery services.

The practices' opening hours are 08:00hrs to 18:30hrs Monday to Friday with extended hours on Mondays and Fridays to 19:15hrs. The practice closes for lunch between 13:00hrs and 14:00hrs. The practice has opted out of providing out-of-hours services to their own patients and directs patients to out-of-hours providers through the NHS 111 service.

Following a comprehensive inspection of Somerset Medical Centre on 21 July 2015, the practice was given an overall inadequate rating. Due to serious concerns about patient safety a decision was made to suspend the registration of the provider for a period of three months from 27 July 2015 to 27 October 2015. The provider appealed to a first-tier tribunal and a hearing was held on 01 October 2015. The appeal was dismissed by the tribunal upon agreement that we would re-inspect the practice on 14 October 2015 to assess if sufficient improvements had been made to lift the suspension.

When we inspected the practice on 21 July 2015, the practice was required to take the following action:

- Ensure there is adequate clinical staff employed in the practice and with the appropriate skills to meet the needs of patients and there is adequate clinical leadership within the practice.
- Ensure staff receive appropriate support, training, professional development, supervision and appraisal as

is necessary to enable them to carry out the duties they are employed to perform including providing clinical care and treatment in accordance with national guidance and guidelines.

- Review arrangements for storing and accessing emergency equipment / medicines and ensure regular checks are recorded. Provide access to an automated external defibrillator (AED) or carry out a risk assessment to assess the risk of not having access to this equipment. Ensure vaccine fridge temperatures are checked daily and recorded.
- Implement effective procedures for identifying, reporting, taking appropriate action and sharing learning from significant events / incidents and ensure safeguarding procedures are effective.
- Introduce a detailed locum induction pack to ensure all locums have adequate information to carry out their roles safely.
- Ensure information received from other service providers is acted on in all instances and effective handover procedures are in place for staff to follow at the end of clinical sessions.
- Implement action plans to improve Quality and Outcomes Framework (QOF) performance and carry
- out clinical audit to drive improvement in patient outcomes.
- Develop a clear vision for the practice and a strategy to deliver it. Ensure it is shared with staff and staff know their responsibilities in relation to it.
- Ensure all of the practices' policies and procedures are up to date, accurate and staff know where they are located and understand them.

This inspection was carried out to consider if all shortfalls identified in the July 2015 inspection had been addressed and to consider whether sufficient improvements had been made to lift the suspension of the regulated activities.

## 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. This 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.

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.

## How we carried out this inspection

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 are provided for specific groups of people and what good care looks 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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 14 October 2015. During our visit we spoke with a range of staff including two GPs, the practice nurse, the health care assistant, the phlebotomist, the practice manager and two non-clinical staff. We did not speak with patients who used the service or review comment cards where patients and members of the public share their views and experiences of the service as the practice was currently suspended and therefore not seeing patients.

Requires improvement

# Are services safe?

## Our findings

**Safe track record**

When we inspected the practice in July 2015 we found the system in place for identifying, reporting, investigating and learning from significant events was inadequate. There was limited evidence of a safe track record and significant events had not been managed consistently over time.

At the inspection on 14 October 2015 evidence was provided of a significant events policy and staff training in identifying and reporting significant events. The practice had reviewed the procedures in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were now a standing item on the monthly practice meeting agenda. Although the procedures had been reviewed we were very concerned that the principal GP who led on significant events was unfamiliar with the form used for incident reporting. He also showed a lack of understanding of significant event analysis in that it included reflecting on the events, learning points and implementing any changes in practice. The GP could not provide us with an example of reflection of a significant event analysis other than a basic scenario of someone slipping on the floor and he was unable to describe the learning points from such an incident.

Since our inspection in July 2015 the practice had implemented new procedures for disseminating national safety alerts. Safety alerts were to be disseminated by the practice manager to practice staff, saved to a central folder and collated as hard copies and checked to ensure they were acted on.

**Reliable safety systems and processes including safeguarding**

When we inspected the practice in July 2015 we found the systems in place to safeguard children and adults were not effective. There was no written protocol for staff to follow when referring safeguarding concerns and not all staff were trained to the appropriate level. The practice's safeguarding policies were not up to date and not all staff were aware of the practice lead for safeguarding and where the policies were located.

During this inspection we found the practice had reviewed their procedures to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew the basics of how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice lead for safeguarding vulnerable adults and children was the principal GP. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern. They were also aware of how to access the safeguarding policies. The lead had been trained in child safeguarding to Level 3. The principal GP told us the practice had never needed to make any safeguarding referrals. Therefore specific examples of active engagement in local safeguarding procedures and effective working with other relevant organisations could not be evidenced. The practice's safeguarding policies had been reviewed since we inspected the practice in July however we found they still contained out of date guidance.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

There were chaperone notices which were visible on the consultation room doors (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

**Medicines management**

Requires improvement

# Are services safe?

When we inspected the practice in July 2015 we found that records of vaccine fridge temperature checks were missing from January to April 2015, and one omission was found for 17 July 2015. The practice were given the opportunity during the inspection to produce the missing records however were not able to locate them. The practice did not have a policy for Methadone prescribing and Patient Group Directives (PGDs) used by the nurses to administer vaccines were incomplete.

During this inspection we found improvements had been made. We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice had created new temperature logs to accurately record fridge temperatures moving forward.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Prescriptions were kept securely. The practice had implemented a Methadone prescribing protocol and policy since our previous inspection.

The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated since the inspection in July 2015. The nurse had received appropriate training to administer vaccines. The health care assistant told us they administered vaccines using Patient Specific Directions (PSDs) that had been produced by the prescriber. Although we could not see evidence of these being used at this inspection because the practice was not seeing patients, we would expect to see evidence at future inspections.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Treatment rooms had the necessary hand washing facilities and personal protective equipment (such as gloves and aprons) was available. Hand gel was available throughout the building and hand washing sinks with soap, gel and hand towel dispensers were available in treatment rooms. The practice had completed an infection control audit in June 2015 and points for action had been implemented which included increasing the amount of hand gel available in the practice.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection and staff had received infection control training. The practice nurse was the designated lead for infection control in the practice. Clinical waste disposal contracts were in place and spillage kits were available.

The practice had undertaken a risk assessment for Legionella (a bacterium which can contaminate water systems in buildings) and monthly water temperature checks were being carried out to mitigate risks.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The last calibration date was May 2015.

**Staffing and recruitment**

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff, and appropriate recruitment checks had been undertaken prior to employment including those for locum staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

When we inspected the practice in July 2015 we were very concerned that there was not enough clinical staff to keep patients safe. The principal worked at the practice for only one clinical session a week, the salaried GP working five sessions a week and a regular locum GP working three sessions per week. There was only one GP providing sessions at the practice at any one time and handover

arrangements were not effective. This was also concerning because of a reliance on locums. We also found the locum induction pack was incomplete and did not include enough information for locums to work safely at the practice especially when there were no other GPs on the premises.

During this inspection we were told the principal GP would increase the number of sessions to four a week and the salaried GP was to remain at five sessions a week from when the practice reopens. The practice's reliance on locums was also to be reduced when the practice reopens.The practice had created a new comprehensive locum induction pack which included all the necessary information to provide safe care to patients. A new handover policy was in place which detailed more thorough handover procedures and the handover policy had been signed by staff.

**Monitoring safety and responding to risk**

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included a health and safety audit carried out in 2015. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. The practice had carried out risk assessments to ensure the environment was safe and had revised their staffing levels.

**Arrangements to deal with emergencies and major incidents**

When we inspected the practice in July 2015 there were inadequate arrangements were in place to deal with emergencies. We found the oxygen cylinder was stored inappropriately and therefore inaccessible in an emergency situation. There was no automated external defibrillator (used in cardiac emergencies) or risk assessment to mitigate the risks of not having immediate access to one. There was no evidence of regular checks of emergency medicines and the keys to access them were stored some distance away at reception.

During this inspection we found improvements had been made. The practice had purchased a defibrillator and a log sheet for defibrillator checks had been created. The oxygen cylinder was stored in an accessible location and additional cylinders had been purchased for all the consultation rooms. The log sheet for oxygen cylinder checks had also been updated. Records showed that all staff had received training in basic life support in the previous year.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location including the keys to access them. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were now in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The principal GP told us they had a buddy system with another local practice although no evidence was seen to confirm this.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training.

Inadequate

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

When we inspected the practice in July 2015 we discussed with the salaried GP how National Institute for Health and Care Excellence (NICE) guidance was received into the practice. The GP told us these were received electronically and emailed to her by the practice manager, however as she did not meet with the other doctors guidance was not disseminated further within the practice. There was also no evidence from meeting minutes to demonstrate that NICE guidance was discussed, implications for the practice's performance and patients identified, and required actions agreed and staff could not provide any examples.

During this inspection we discussed with the principal GP (who was absent on our last inspection) how he kept up-to-date with guidance. The GP told us that he kept up-to-date with NICE guidance and read medically related publications on a daily basis. However he was unable to provide any examples of topics he had read recently. When asked what he does about information learnt the GP told us he would change his own practice. However, there was no mention of dissemination of learning or changes to whole practice care. The GP could not provide any examples of changes that had been implemented within the practice from clinical updates.

**Management, monitoring and improving outcomes for people**

When we inspected the practice in July 2015 the practice were unable to show us evidence of clinical audit that demonstrated improved outcomes for patients. We were shown two audits relating to the local CCG prescribing incentive scheme which the practice manager told us had been completed by the principal GP. Both audits were incomplete in that there were no re-audits to measure improved outcomes and any learning had not been disseminated to staff.

During this inspection we were shown the same audits during our interview with the principal GP. The GP told us that the practice manager had carried out the audits and his only involvement was to sign the audits off. The principal GP was unaware of any learning points or changes to practice that had emerged from these audits and any learning had still not been disseminated to staff. The principal GP told us he was intending to do an audit on frequent child attendance to the urgent care centre. He stated he was unable to do this as the practice had been suspended, although to carry out this audit involved using retrospective data so it would have been possible to conduct this audit while the practice was closed.

This practice achieved 92% of the total QOF target in 2014/15 (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF performance was below the CCG average of 95% and the national average of 94% and the exception rate was 11% which was much higher than the national average of 4%.

Specific clinical indicators where the practice had maximised their QOF points in 2014/15 included asthma, atrial fibrillation, cancer, chronic kidney disease, chronic obstructive pulmonary disorder, depression and hypertension.

Specific examples to demonstrate where the practice were underperforming include:

- Performance for diabetes QOF indicators was 67%, below the CCG average of 86% and the national average of 89%
- Performance for mental health was 69%, below the CCG average of 95% and the national average of 93%
- Performance for osteoporosis QOF indicators was 67%, below the CCG average of 74% and the national average of 82%

When we inspected the practice in July 2015 we found action plans to improve QOF performance were not in place. During this inspection we were told the practice was planning to address areas of poor performance by recalling patients for review.

There was no evidence that the practice was comparing its performance to other practices either locally or nationally. The principal GP was unable to provide any information on how the practice was performing compared to others within the CCG and only had a vague knowledge of national performance.

**Effective staffing**

When we inspected the practice in July 2015 we found that staff were up to date with attending mandatory courses

Inadequate

# Are services effective?

## (for example, treatment is effective)

such as annual basic life support, safeguarding and infection control. The salaried GP had a special interest in methadone prescribing and minor surgery. However we found that the GP had not completed formal training in methadone prescribing and no up to date refresher courses had been undertaken. In addition the GP had not attended any training in minor surgery in the previous two years to refresh their skills. Since the inspection in July 2015 the GP had completed accredited training in substance misuse and updated their skills in minor surgery and we saw certificates to confirm this. Annual appraisals were in place for staff.

The GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice nurse and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, anticoagulation therapy, smoking cessation, ear care and tissue viability.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. When we inspected the practice in July 2015 the salaried GP gave us examples of where information was not acted on which included a urine result showing a urinary tract infection and a fracture diagnosis. During this inspection we found the practice had reviewed their procedures for receiving and acting on information to ensure all results were acted on daily. However, when we asked the principal GP if the practice used special notes for 111 or out of hours he was unable to answer the question.

The principal GP told us that the practice intended to ensure that two week wait referrals occured by checking with the hospital if they have received the fax and a new addition was to check with the patient at two weeks. However there is no evidence of procedures or a policy in place. It was not clear who would be checking with the patient to ensure they had attended their appointments.

The practice held multidisciplinary team meetings monthly. These meetings were attended by district nurses, palliative care nurses, health visitors and the community matrons to discuss patients with complex needs. However, the principal GP told us he did not attend multidisciplinary team meetings for any particular population group.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice had also signed up to the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). However the principal GP was unable to evidence the use of shared summary care records as he was unaware as to what they were.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005 in terms of definition, however not all clinical staff were adequately able to explain how to conduct assessments of mental capacity. The principal GP told us he would look at consultant letters and ask for a second opinion and therefore refer patients with learning disabilities to check capacity. The principal GP was unable to provide examples of where he had assessed patients capacity or able to adequately explain the use or relevance of advanced directives (legal documents that allow you to spell out your decisions about end-of-life care ahead of time). The principal GP was also unable to articulate a clear understanding of Gillick competence.

**Health promotion and prevention**

The practice had not used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

Inadequate

# Are services effective?

## (for example, treatment is effective)

It was practice policy to offer a health check to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 2.1% of patients in this age group took up the offer of the health check and the practice had met the CCG target of 2%.

The practice had 13 patients on the mental health register and seven patients on the learning disability register, all of whom had received annual physical health checks. The health care assistant offered smoking cessation advice to patients who smoked and there was evidence of success. For example, out of 21 patients offered advice in the previous year, eight patients had stopped smoking.

The practice's performance for the cervical smears performed in the last five years was 82%, which was above the CCG average of 78%. The practice also encouraged its patients to attend national screening programmes for bowel cancer, breast cancer and mammogram screening. Weight checks were completed for patients at risk of obesity and they were referred to weight management programs when appropriate.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice's performance for 2014 was overall below CCG averages for childhood immunisation rates. Vaccinations given to one year olds ranged from 64.7% to 85.3% (CCG average; 77% to 92.6%), two year olds from 85.7% to 92.9% (CCG average; 86.6% to 100%) and vaccinations for five year olds ranged from 33.3% to 90.5% (CCG average; 73.3% to 94%).

Inadequate

# Are services caring?

## Our findings

We were unable to re-inspect this domain as the practice has not been providing services to patients, as such our assessment and rating of caring remains unchanged. Therefore the evidence in this section is the same as that collected at our July inspection.

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2015 to which 108 patients responded and an improving practice questionnaire (IPQ) completed in December 2014 by an external company, to which 85 patients responded.

The evidence from the national patient survey showed the practice achieved below the CCG and national average for patient satisfaction with their GP practice. For example, data from the national patient survey showed that only 52% of respondents would recommend the practice to someone new in the area compared to the CCG average of 69% and national average of 78%.

The practice was also below average for its satisfaction scores on consultations with doctors and nurses. For example:

- 74% said the GP was good at listening to them compared to the CCG average of 84% and national average of 89%.
- 75% said the GP gave them enough time compared to the CCG average of 80% and national average of 87%.
- 89% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 95%.
- 77% said the nurse was good at listening to them compared to the CCG average of 84% and national average of 91%.
- 82% said the nurse gave them enough time compared to the CCG average of 85% and national average of 92%.

Results from the IPQ survey aligned with these results where the practices' average score for similar areas of patient satisfaction were below benchmark figures.

For our inspection in July 2015 patients completed CQC comment cards to tell us what they thought about the practice. We received 17 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, helpful and caring and treated them with dignity and respect. We observed throughout the inspection that members of staff were courteous to patients attending at the reception desk. Five comment cards were less positive but there were no common themes to these. We also spoke with nine patients during our inspection in July 2015 most of whom told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national patient survey showed that 78% found the receptionists helpful, below the CCG average of 81% and national average of 87%. This aligned with the IPQ survey where the practice scored below the benchmark figures for satisfaction with reception staff.

During our inspection in July 2015 staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was a request for a chaperone notice displayed on consultation / treatment room doors.

The practice switchboard was located in the reception area, which was shielded by glass partitions which helped keep patient information private. However the reception area was small and it was difficult to promote privacy in this area. One patient we spoke with during our inspection in July 2015 told us they would phone the practice if there was something they wished to speak privately about as they could be overheard in the reception area. Additionally the results of the national patient survey showed that the practice scored 78% for the helpfulness of reception staff compared to the CCG average of 81% and national average of 87%. Results from the practice survey showed that patient satisfaction with reception staff and privacy/ confidentiality were in the middle 50% of all practices surveyed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Inadequate

# Are services caring?

**Care planning and involvement in decisions about care and treatment**

The national patient survey information we reviewed showed the practice scored below average in relation to questions about patients' involvement in planning and making decisions about their care and treatment. For example:

- 78% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 81% and national average of 86%.
- 58% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75% and national average of 81%.
- 83% said the nurse they saw was good at explaining tests and treatments compared to the CCG average of 83% and the national average of 90%.
- 74% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 77% and the national average of 85%.

Patients we spoke with during our inspection in July 2015 told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Comment cards we received were also positive in these aspects of patient care.

Staff told us that translation services were available for patients who did not have English as a first language. The practice information leaflet and practice website informed patients of the languages spoken in the practice. The service had access to a language service to support those patients where English was not their first language. We saw notices in the reception areas informing patients this service was available.

**Patient/carer support to cope emotionally with care and treatment**

The national patient survey information we reviewed showed the practice scored below average in relation to questions about emotional support provided by the practice. For example:

- 65% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 85%.
- 72% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 83% and national average of 90%.

Results from the IPQ survey aligned with the national patient survey where the practice's average score for similar areas of patient satisfaction were below benchmark figures. The patients we spoke with on the day of our inspection and the comment cards were more positive. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room told patients how to access a number of support groups and organisations. For example, cancer support and information for carers. Patients were unable to comment on bereavement support offered by the practice as they had never needed it.

Requires improvement

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

We were unable to re-inspect this domain as the practice has not been providing services to patients, as such our assessment and rating of responsive remains unchanged. Therefore the evidence in this section is the same as that collected at our July inspection.

**Responding to and meeting people's needs**

The practice engaged with the local Clinical Commissioning Group (CCG) to discuss local needs and service improvements that needed to be prioritised, for example extended opening hours. The practice manager attended monthly CCG meetings however there was no clinical representative for the practice at these meetings.

The practice had not met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area and is used to help focus services offered by practices.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the Patient Participation Group (PPG). For example, the PPG had requested more information to educate patients. The practice had acted on this by displaying information on a noticeboard in the waiting area, on the practice website and providing more leaflets. Patients also suggested the session time for the practices' pathology service be extended. The practice responded by increasing the session time by one hour.

The practice participated in the Integrated Care Pilot and had completed 37 care plans for patients over 70 years of age.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and older patients. The practice population were of mainly Indian origins and staff spoke a range of languages to cater for them including Urdu, Punjabi, Pashto, Hindi, Gujarati and Tamil. Access to online and telephone translation services were also available if needed. Information in the waiting area was also available in different languages. We did not see evidence of a hearing loop or access to British Sign Languages services for those patients hard of hearing.

The premises had not been specifically designed to meet the needs of people with disabilities and it was in need of an upgrade and general redecoration. There was ramp access at the front door for patients with mobility difficulties, a disabled toilet facility and the consulting rooms were all on the ground floor. However the waiting area was cramped with limited space for wheelchairs and prams. This made movement around the practice more difficult and restricted patients' independence.

The practice manager told us that they had patients who were of "no fixed abode" and worked closely with a local homeless agency to ensure they could access services. We were told that the practice also provided care for asylum seekers, migrants and travellers and promoted an open access policy. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

**Access to the service**

The surgery was open from 08:00hrs to 18:30hrs Monday to Friday with extended hours Mondays and Fridays until 19:15hrs. The surgery was closed between 13:00hrs to 14:00hrs for lunch. The patient leaflet stated that appointments were available from 08:00hrs to 18:30hrs weekdays by phone, in person or online. However the practice website stated that the phone was answered during lunch break only. There was a text messaging service for appointment reminders.

Information was available to patients about appointments on the practice website and in the patient leaflet including how to arrange home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients. We found no information on how to arrange urgent appointments or telephone consultations.

Requires improvement

# Are services responsive to people's needs?

## (for example, to feedback?)

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP. Home visits were made to those patients who were housebound. The patient survey information we reviewed showed the practice scored below average in relation to questions about access to appointments. For example:

- 34% with a preferred GP usually got to see or speak to that GP compared to the CCG average of 53% and national average of 60%.
- 71% were satisfied with the practice's opening hours compared to the CCG average of 71% and national average of 75%.
- 56% described their experience of making an appointment as good compared to the CCG average of 66% and national average of 73%.
- 52% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 53% and national average of 65%.
- 67% said they could get through easily to the surgery by phone compared to the CCG average of 69% and national average of 73%.

Results from the IPQ survey did not align with the national patient survey where the practices' average score for similar areas of patient satisfaction with appointments were above benchmark figures.

The nine patients we spoke with during our inspection in July 2015 were generally satisfied with the appointments system and said it was easy to use. They confirmed that they could see the on duty doctor on the same day if they felt their need was urgent. They also said they could see a GP of choice if they were willing to wait one week.

**Listening and learning from concerns and complaints**

The practice had a system in place for handling complaints and concerns. 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 including a complaints procedure available at reception. Patients we spoke with during our inspection in July 2015 were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. Complaints were discussed in practice meetings and this was confirmed by meeting minutes we reviewed.

# Are services well-led?

Inadequate

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

## Our findings

**Vision and strategy**

When we inspected the practice in July 2015 the practice did not have a clear vision or strategy to deliver high quality care and promote good outcomes for patients.

During this inspection the principal GP told us the vision of the practice was to provide a high standard of patient care, however there was no strategy in place to deliver it. There was no business plan in place and the GP was unable to indicate the direction of travel for the practice. The principal GP acknowledged that a vision and strategy had not been formalised since our previous inspection.

Staff we spoke with were not aware of a vision for the practice or their responsibilities in relation to it and had not been involved in developing one.

**Governance arrangements**

When we inspected the practice in July 2015 we found governance arrangements were ineffective. Not all staff knew how to access the policies and procedures of the practice, they had not been reviewed consistently and important policies were missing. There was a lack of effective leadership. The principal GP was only present at the practice for up to one day a week and he was the designated lead for QOF, complaints handling, significant events analysis, child and adult safeguarding and confidentiality. The principal GP was based at another practice for most of the week and therefore unavailable to deal with concerns relating to those areas he led on. There was limited evidence from meeting minutes of the principal GPs attendance at practice meetings to update staff, discuss concerns or share learning.

During this inspection we were told by the principal GP that he would increase his weekly attendance at the practice to four clinical sessions from when the practice reopens. The practice had implemented a clear leadership structure with all staff aware of the practice leads and the areas which they led. Policies had been updated and missing policies implemented. Staff had read the policies and procedures and signed a front sheet to evidence they had understood them. The staff meeting agenda had been reviewed to accommodate important topics such as significant events. The principal GP told us he intended to chair monthly meetings for the practice staff on Mondays. We were shown a sample agenda and a twelve month practice meeting timetable. The agenda included significant events and incidents and we were told the meeting would last up to two hours. The practice manager clarified that it would be a whole practice meeting with a clinical meeting within that time. It would also include invitations to outside agencies. Minutes would be produced and disseminated within the practice.

When we inspected the practice in July 2015 the principal GP did not take an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective, including using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). QOF data was not regularly discussed at monthly meetings or action plans produced to maintain or improve outcomes for patients.

During this inspection we were still very concerned about the lack of effective leadership. We asked the principal GP about the oversight of the practice's clinical performance. The GP told us that he led on QOF at the practice. However when questioned the GP was unsure of the number of QOF points attained for 2014/15 or how many the practice had gained for the first quarter of 2015/16. The principal GP did not know in any detail in which areas of QOF improvements were needed despite the practice having put in place a plan to improve performance since our July 2015 inspection.

When we inspected the practice in July 2015 we found the practice did not have an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Since our inspection in July no improvements had been made in this respect. The principal GP confirmed a program of audit had still not been implemented and the practice had not formulated which audits were going to be conducted over the next year. The principal GP simply stated they would do as many audits as possible.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example maternity leave, redundancy and training policies which were in place to support staff. The policies were also available to all staff, in a folder kept behind the

# Are services well-led?

Inadequate

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

reception and staff knew of their location. The practice had a whistleblowing policy in place, however when we inspected the practice in July 2015 not all staff we spoke with were aware of the policy and did not know what action to take if they had any suspicions of malpractice. During this inspection we found staff had improved their knowledge in this regard. However, we found the principal GP had a lack of knowledge of the practice's recruitment procedures. He told us that he would carry out a health check and check medical history of new staff, would only request references if need be and did not mention carrying out Disclosure and Barring Service checks (DBS). He also was not clear on how variable staff performance was dealt with and told us it was detailed in the staff handbook.

**Leadership, openness and transparency**

When we inspected the practice in July 2015 we found that there was a lack of visible leadership at the practice. One GP partner was under suspension by the General Medical Council and therefore was not practising. The second GP partner who was also the registered manager was present at the practice for up to one day a week as he was based at another GP practice. The salaried GP told us that she rarely had any contact with the principal GP. During this inspection we were informed that the second GP had reduced his weekly commitments at his other practice to five sessions and intended to increase to four clinical sessions and one administration session at Somerset Medical Centre moving forward.

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

The practice sought feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), annual surveys and the NHS friends and family test. It had an active PPG with 15 members including representatives from various population groups such as older patients and those of working age and of different nationalities. The PPG had been involved in patient satisfaction surveys and met twice a year. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results from these surveys were available on the practice website. We were unable to speak to any members of the PPG at this inspection as the practice was not seeing patients.

**Management lead through learning and improvement**

When we inspected the practice in July 2015 sufficient support was not provided to ensure staff maintained their clinical professional development through training and mentoring. GPs were not up to date with important clinical training and there was no oversight of it. During this inspection we found that although clinical training had been updated, oversight was still lacking. The principal GP did not know the name of a locum nurse who regularly worked in the practice. He was also unsure of her weekly commitments and had not checked if training was up to date. The principal GP did not routinely check that clinicians were up-to-date in training.

The principal GP told us that the salaried GP carried out all the staff appraisals which he would review. However there as no appraisal plan in place to show this was a formal arrangement and the salaried GP had received no training to conduct appraisals. When we asked the salaried GP how learning needs were assessed whilst doing appraisals, she was unable to provide an adequate response.

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>How the regulation was not being met:<br>Patients were not protected from unsafe care or treatment because not all staff had an adequate understanding of the practice's incident reporting procedures and significant event analysis to ensure patients were kept safe.<br>Regulation 12(2)(a)(b) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br>How the regulation was not being met:<br>Although staff received regular appraisal of their performance, appraisals were not carried out by an appropriately skilled and experienced person.<br>Regulation 18 (2)(a) |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment<br>How the regulation was not being met:<br>Patients were not protected against the risk of abuse and improper treatment because safeguarding policies did not contain up-to-date guidance<br>Regulation 13(1)(2) |

| Regulated activity | Regulation |
|---|---|

This section is primarily information for the provider

# Requirement notices

Diagnostic and screening procedures

Family planning services

Maternity and midwifery services

Surgical procedures

Treatment of disease, disorder or injury

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

How the regulation was not being met:

Patients were not protected from unsafe care or treatment because not all clinical staff understood how to assess capacity in line with the Mental Capacity Act 2005 and did not have an understanding of Gillick competence.

Regulation 11(1)(2)(3)(4)(5)

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<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**Regulation 17 Good governance**<br>**How the regulation was not being met:**<br>**Effective leadership was not in place, clinical audit was not used to drive improvements in outcomes for patients, national guidance and updates were not shared within the clinical team to improve whole practice care and no vision or strategy for the practice to deliver high quality care had been formalised. Feedback from national surveys had not been acted on.**<br>Regulation 17 (1)(2) |