London Doctors Clinic Ltd

London Bridge

Inspection report

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Overall summary

We carried out an announced comprehensive inspection on 7 December 2017 to ask the service the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations

Are services responsive?

We found that this service was providing responsive care in accordance with the relevant regulations

Are services well-led?

We found that in some areas this service was not providing well-led care in accordance with the relevant regulation

We carried out this inspection 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 service was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

The provider supplies private general practitioner services.

Dr Seth Rankin is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We reviewed six CQC patient comment cards all of which were exclusively positive about the service provided. The comment cards stated that staff were caring and considerate and appointments were easy and convenient to access.

Our key findings were:

- There was a system in place for acting on significant events though there was no supporting policy document at the time of our inspection. A policy was provided after our inspection.

Summary of findings

- Risks were generally well managed though there was a lack of oversight of some risk associated with the premises including infection control and fire safety. We saw evidence that most of these risks had been addressed after the inspection.
- There were arrangements in place to protect children and vulnerable adults for abuse.
- Most staff had received essential training and adequate recruitment and monitoring information was held for all staff.
- Care and treatment was provided in accordance with current guidelines.
- Patient feedback indicated that staff were respectful and caring and appointments were easily accessible.
- The practice did not follow their own complaints policy by consistently responding to complaints in writing.
- There was a clear vision strategy and an open and supportive culture. However there were areas where governance was ineffective.

We identified regulations that were not being met and the provider must**:**

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care

You can see full details of the regulations not being met at the end of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this service was providing safe care in accordance with the relevant regulations.

- The provider was taking action in response to and learning from significant events however there was no policy in place. The service had a policy in place regarding notifiable safety incidents under the duty of candour.
- Some risks were not well managed. For instance there was a lack of systems to ensure oversight of cleaning arrangements and that risks associated with fire were adequately assessed and mitigated.
- Staff knew how to identify signs of abuse in children and young adults and we saw instances where concerns had been escalated to the appropriate authorities. One staff member had expired level three safeguarding training though new level three training was completed shortly after our inspection.
- There were arrangements in place for responding to medical emergencies though it appeared that the working status of the defibrillator had not been checked for the past two months.
- The service had undertaken appropriate recruitment and monitoring checks for staff.
- There were safe systems and processes in place for the prescribing and dispensing of medicines.

Are services effective?

We found that this service was providing effective care in accordance with the relevant regulations.

- Systems and processes were in place to ensure clinical care was provided in accordance with current evidence based guidance.
- The quality of patient care was monitored through reviewing the quality of clinical consultations.
- Most staff had completed the required mandatory training. Continuing professional development sessions were held regularly and GPs had undertaken clinical updates relevant to their role.
- Systems were in place to share information between external services including a pathology service. The service would contact the patient's NHS GP when authorised to do so.
- The provider advertised the cost of services clearly. Clinical staff spoken to had awareness of the mental capacity act and most were trained in this area. Written consent was used where appropriate.

Are services caring?

We found that this service was providing caring services in accordance with the relevant regulations.

- Feedback from patients was positive and indicated that the service was caring and that patients were listened to and supported.
- The provider had systems in place to engage with patients and collate feedback using a survey emailed to all patients after their appointment.
- Systems were in place to ensure that patients' privacy and dignity were respected.

Are services responsive to people's needs?

We found that this service was providing responsive care in accordance with the relevant regulations.

- The provider was not consistently following their own processes for managing and responding to complaints. The two complaints which related to this location had no written responses and we were told that most complaints were resolved through telephone conversations though these conversations were not documented and learning points were not always recorded.

Summary of findings

- The provider was accessible to patients and the service focused on appealing to patients working in central London who wanted convenient same day access to a GP.
- Feedback from patients indicated that the service was easily accessible.

Are services well-led?

We found that in some areas this service was not providing well-led care in accordance with the relevant regulation. We have told the provider to take action (see full details of this action in the Requirement Notices at the end of this report).

- The provider had a clear vision and strategy and there was evidence of good leadership within the service. In most instances there were good systems and processes in place to govern activities. However the provider did not have effective oversight of risks associated with infection control and fire safety and the complaint policy was not being followed consistently. There was no policy for the management of significant events. In spite of this we did see examples of action being taken in response to adverse incidents.
- There was a culture which was open and fostered improvement.
- The provider took steps to engage with their patient population and adapted the service in response to feedback.

London Bridge

Detailed findings

Background to this inspection

London Bridge is a location that is part of London Doctors Clinic Limited which is a provider of private general practitioner services across nine locations in Central London. The service is located at Alpha House, 100 Borough High Street, London, SE1 1NL which is an office space. The practice rents two consultation rooms and a reception area. Other locations can be found at: Fleet Street, Kings Cross, Liverpool Street, Paddington, Soho Square, Victoria and Waterloo; though none of these locations were visited as part of this inspection. The service is open from 9 am to 5.30 pm.

The service is registered with CQC to undertake the following regulated activities: Treatment of Disease, Disorder or Injury, Diagnostic and Screening Services and Maternity and Midwifery services.

The only clinical staff employed at the service were GPs. All clinical staff employed had previous experience working within the NHS. Patients could book appointments on the same day or up to a week in advance. The service told us that 66% of their patients were aged 22 – 44. Forty percent of the patients attending were for minor illnesses and 60% were for notarising services. The provider said that 25% of patients returned to the service.

The service did not manage patients with long term conditions or immunisations for travel or childhood immunisations.

The inspection was undertaken on 7 December 2017. The inspection team was composed of a lead CQC inspector and a GP specialist advisor.

Prior to the inspection we reviewed information requested from the provider about the service they were providing.

During the inspection we spoke with GPs and the clinical services manager, analysed documentation, undertook observations and reviewed completed CQC comment cards.

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?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

We found that this service was providing safe care in accordance with the relevant regulations

Safety systems and processes

- Staff recruitment procedures were in place to ensure staff were suitable for their role. We saw that proof of qualifications, proof of registration with the appropriate professional bodies and checks through the Disclosure and Barring Service (DBS) had been completed for all staff and that references had been taken where appropriate. (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).
- There were no schedules of induction for any staff though staff were able to outline the induction process and a blank schedule which outlined the staff induction process was sent to us after the inspection. We saw that most staff whose files we reviewed had received the required mandatory training including basic life support, infection control, fire safety, and safeguarding and information governance.
- The practice had systems in place to ensure action was taken in response to safeguarding incidents and we saw good examples where action had been taken by staff in the organisation in response to safeguarding concerns. There were alerts on the system which flagged vulnerable adults and children and a monthly newsletter was circulated within the organisation which highlighted children at risk. However the clinical staff member noted as having responsibility for safeguarding for the organisation (though not the lead for safeguarding) only had level one child safeguarding training on file. An expired level three certificate was provided after our inspection and we also received evidence that level three training had been completed within 48 hours of the inspection date. The practice had a general safeguarding policy covering both adults and children. The policy was accessible to all staff and contained the names of the appointed safeguarding leads within the service and the process for reporting and taking action in response to concerns. Community safeguarding contact information was available on a poster in the reception area. Staff interviewed demonstrated they understood their responsibilities regarding safeguarding. We asked the provided after the inspection what systems they had in place for establishing relationship between children and the adults they attended the service with. The provider told us that they did have systems in place to enable them to establish the relationships between adults and the children they attended with but we saw no evidence to confirm this.
- The premises were clean and tidy. The provider had undertaken an infection control audit within the last 12 months. An infection control policy was in place but did not refer to the person who led on infection control. The service was cleaned by a contract company who were responsible for the whole building and we were provided with information which showed the cleaners attended daily. However there were no schedules in place which specified what items or areas needed to be cleaned or the frequency of cleaning. The practice provided an email from the cleaners within 48 hours of the inspection which stated that spot cleaning was undertaken daily and that a deep clean would be done weekly including floors, emptying bins and surfaces. The practice also provided confirmation had implemented schedules which monitored the frequency of cleaning and the items cleaned after our inspection. We saw two legionella testing certificates which tested two water outlets within the building and showed that there was no legionella present.

Risks to patients

There were enough staff, including clinical staff, to meet demand for the service.

There were effective systems in place for managing referrals and test results.

There were arrangements in place to respond to emergencies and major incidents.

- Staff had received annual basic life support training although we were provided with a certificate confirming this had been completed after the inspection.
- The service held a supply of oxygen and a defibrillator. The defibrillator was not listed on the checklist for daily checks of the emergency equipment in November and December 2017 though we saw that this was listed on

checklists for previous months and was working at the time of the inspection. The provider informed us that the oversight of the defibrillator checks being recorded was the result of a printing error.

- Emergency medicines were easily accessible to staff in a secure area known to staff and these medicines were checked on a regular basis.
- A business continuity plan was in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

We were told that the building owners were responsible for assessing risks associated with fire. The provider did not have access to this risk assessment on the day of the inspection but supplied a health and safety audit which covered fire risk after the inspection dated 12 December 2017. Staff had access to a fire procedure for the building which noted the names of the fire marshals within the building and an evacuation point. A service specific policy was provided after the inspection. Reference was made to the previous health and safety assessment which had been completed in 2017. All medical equipment had been calibrated and electrical equipment had been tested to ensure it was safe to use.

Information to deliver safe care and treatment

Information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the service's patient record system and their intranet system. This included investigation and test results, health assessment reports and advice and information about treatment provided. The practice's patient record system was used at all nine sites and clinicians could access the records of patients at any of these sites or remotely.

Safe and appropriate use of medicines

- The service had systems, policies and processes in place to ensure that medicines were prescribed and dispensed safely. The practice dispensed a number of medicines including schedule 4 controlled drugs. There was a standard operating procedure in place for these medicines, all medicines were securely stored and there were effective stock control systems in place. Medicines were dispensed by the practice at the time of the consultation. Details of the medicine's batch number would be recorded in patient notes.
- Private prescriptions were generated from the patient record system and there were no paper prescriptions in the service.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

Track record on safety

The service used a significant incident form to document and record incidents. Staff we spoke with on the inspection all knew how to access this form and we saw examples of incidents that had been recorded using the form from other locations where the provider operated, subsequent discussion noted and learning outcomes implemented. For example we reviewed an incident where results were sent to the wrong clinician; as a result the service introduced a failsafe so that an alert would be flagged with the requesting clinician when results were received.

However the service did not have a policy which outlined the procedure for reporting significant events. A policy was provided within 48 hours of the inspection.

The provider had a system in place for reviewing and acting upon patient safety alerts. There was a responsible clinician who would review all alerts and ensure that the appropriate action was taken and documented in response to these alerts.

Lessons learned and improvements made

The provider was aware of and complied with the requirements of the Duty of Candour. The provider encouraged a culture of openness and honesty. The service had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The service gave affected people reasonable support, truthful information and a verbal and/or written apology.

Are services effective?

(for example, treatment is effective)

Our findings

We found that this service was providing effective care in accordance with the relevant regulations.

Effective needs assessment, care and treatment

Doctors assessed patients' needs and delivered care in line with relevant and current evidence based guidance and standards, such as National Institute for Health and Care Excellence (NICE) evidence based practice. The practice had incorporated a prescribing reference tool into their clinical system to ensure that clinicians had access to the most up to date prescribing guidance.

When a patient needed referring for further examination, tests or treatments they were directed to an appropriate service.

The provider told us that they were working with the laboratory that they used for blood testing to try and improve the cost effectiveness of blood testing.

Monitoring care and treatment

The provider had systems in place to monitor and assess the quality of the service including the care and treatment provided to patients. Monthly audits were undertaken of four consultation notes for each clinician working for London Doctor's Clinic to ensure that consultations were safe, based on current clinical guidance, that medicine batch numbers were recorded and that tests were clinically indicated or ethically requested. Clinicians were then provided with feedback on the quality of their consultation.

The provider told us service had only been in operation from the site for a year so there were no completed audit cycles. They had undertaken the first cycle of an antibiotic prescribing audit in November 2016. A second cycle was due to be completed in December 2017.

Effective staffing

We were told that all staff had to complete an induction which for clinical staff included an overview of systems and processes and undertaking a supervised clinic. An induction timetable for clinical roles was provided after the inspection. Non clinical staff would be trained by one of the clinical managers in the service and had five days of training. An induction schedule for non-clinical staff was provided after the inspection. Online training including: basic life support, fire safety, health and safety, infection control, safeguarding, information governance would be completed on induction. A training matrix was used to identify the training staff had completed and when training was due.

Clinical staff had completed clinical updates relevant to the patients they consulted with including updates in sexual health and dermatology. Continuing professional development sessions were offered monthly.

We were told that appraisals would be held annually for non-clinical staff though the non-clinical staff member working at the site had only been working for the organisation since October 2017. Appraisals undertaken for the GMC were stored with clinical staff files and feedback from audits of patient consultations was given to clinical staff to improve the quality of service provided.

Coordinating patient care and information sharing

When a patient contacted the service they were asked if the details of their consultation could be shared with their registered GP. If patients agreed we were told that a letter was sent to their registered GP.

If patients required urgent diagnostic referrals they would be advised to contact their NHS GP who would make the referral. The service would provide a letter for the patient to give to their GP with the relevant information from the consultation.

If results showed abnormalities patients would be contacted by telephone. All results were sent to patients by email.

Supporting patients to live healthier lives

The service supported patients to live healthier lives by providing same day GP access for patients who worked near the clinic locations but were either unable to take time off to attend their local GP or obtain a same day appointment. The service was also targeted at patients who worked in London but did not have an NHS GP or who were visiting from abroad. These patients were able to access a GP, receive a diagnosis and medication where required in a single quick and convenient appointment with results being sent to the patient by their preferred method at no additional cost. If the provider was unable to provide a service a patient required they would refer them to other services either within the private sector or NHS and the patient would not be charged for the appointment.

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

There was clear information available with regards to the services provided and the cost of these.

Staff understood and sought patients' consent to care and treatment in line with legislation and guidance. All clinical staff had received training on the Mental Capacity Act 2005. Written consent was required for all patients requesting a letter for visa applications and insurance.

Are services caring?

Our findings

We found that this service was providing caring services in accordance with the relevant regulations

Kindness, respect and compassion

We observed that members of staff were courteous and helpful to patients and treated people with dignity and respect.

All feedback we saw about patient experience of the service was positive. We made CQC comment cards available for patients to complete two weeks prior to the inspection visit. We received six completed comment cards all of which were positive and indicated that patients were treated with kindness and respect. Comments included that patients felt the service offered was excellent and that staff were caring, professional and treated them with dignity and respect.

Following consultations, patients were sent a survey asking for their feedback. Patients that responded indicated they were very satisfied with the service they had received.

Staff we spoke with demonstrated a patient centred approach to their work and this was reflected in the feedback we received in CQC comment cards and through the provider's patient feedback results.

Involvement in decisions about care and treatment

The majority of feedback from the service's own post consultation survey indicated that staff listened to patients concerns and involved them in decisions made about their care and treatment.

The service used a number of means to communicate with patients who did not speak English as first language. They employed clinicians who spoke a variety of languages including French, Punjabi, Urdu, Spanish, German, Arabic, Hebrew and Portuguese. The service also had access to a telephone translation service and would use an online written translation programme if necessary.

The service did not have a hearing loop and would communicate with patients who were hard of hearing in writing.

Privacy and Dignity

The provider respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice had systems in place to facilitate compliance with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We found that this service was providing responsive care in accordance with the relevant regulations

Responding to and meeting people's needs

The service was set up to provide GP services at convenient central London locations. Although GPs would consult with patients of any age the service had been designed to appeal to those who worked in central London who wanted GP access near their place of work. The service was also designed to appeal to foreign nationals who were visiting and working in London but did not have access to NHS services.

The provider made it clear to patients on their website what services were offered and the limitations of the service. For example the provider did not provide services for chronic disease management or childhood immunisations. If a patient attended the service and the provider did not provide what the patient required they were not charged and referred to another service either within the private sector or the NHS.

The provider offered consultations to anyone who requested and paid the appropriate fee, and did not discriminate against any client group. All but one staff member had been provided with training in equality, diversity and inclusion.

Discussions with staff indicated the service was person centred and flexible to accommodate people's needs.

Timely access to the service

Appointments were available from 9 am to 5.30 pm Monday to Friday. Patients could contact the service between 8 am and 8 pm Monday to Friday. Patients booked appointments by phone or online through a central appointments management team. Results from blood tests and external diagnostics were sent to the patient in a timely manner using the patient's preferred method of communication. The practice offered a sexual health screening service where results would be sent to the patient within six hours of testing.

Feedback from both the comment cards and the provider's own survey indicated that access was good and patients obtained appointments that were convenient.

Listening and learning from concerns and complaints

The provider advertised its complaint procedure online and dissatisfied patients could feedback when the patient survey was sent to them. There was a lead for complaints and a policy outlining the complaints procedure. The complaint procedure did not include the name of the complaint lead. In several respects the service was not following its complaint procedure. The procedure stated that the complaint procedure should be advertised in public areas of the service but there was nothing within the reception or clinical areas which patients could access regarding how to complain. The policy states that an acknowledgement would be issued within three days of the complaint which contradicted the information on the service's website which stated complaints would be acknowledged within one day. Both the website and the policy stated that patients would receive a written response to their complaint. This location had received two complaints which were documented on a spread sheet that contained details of complaints from across all nine sites. In one instance there was no indication of what action was taken other than a clinician speaking to the patient and in neither instance was there any documented learning from the complaint. We were told that neither patient received a written response and that the service preferred to resolve complaints by telephone.

Staff told us that they had taken action in response to complaints. For example they received a number of complaints about delay in results being sent to patients who had sexual health screening. Clinicians now told patients during consultations that although they would generally be able to provide results within the timeframe advertised there would on a rare occasion be delays with results being sent.

Are services well-led?

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

Our findings

We found that in some areas this service was not providing well-led care in accordance with the relevant regulation.

Leadership capacity and capability;

Leaders had the capacity and skills to deliver high-quality, sustainable care however there were some elements of governance which needed improvement.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- Leaders were easily contactable and approachable. They worked with staff and others to make sure they prioritised compassionate and inclusive leadership.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. However there was a number of areas where there was a lack of effective governance, oversight and management including: risks associated with the premises and complaints.

Vision and strategy

The provider had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and plans for future development.
- The provider's strategy was focused on satisfying a demand for same day quick and convenient access to GP appointments working in Central London. There were plans in place to expand this to other locations in the future.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.

Culture

- The service had an open and transparent culture. Staff told us they felt confident to report concerns or incidents and felt they would be supported through the process.
- Leaders and managers told us that they would act on behaviour and performance inconsistent with the vision and values.
- Staff were supported to meet the requirements of professional revalidation through continuing professional development sessions.
- There was evidence of internal evaluation of the work undertaken by clinical staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. All but one staff member had received equality and diversity training.
- There were positive relationships between staff.

Governance arrangements

When we spoke with staff there was evidence of systems in place and lines of accountability and leadership. However some policies in place lacked clarity and detail which limited the effectiveness of the service's governance arrangements.

- There were gaps in in governance arrangements. Staff could outline the significant event process and we saw examples of action being taken in response to adverse incidents yet there was no policy in place. A policy was provided after the inspection. Although staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control however the practice had no systems in place to monitor the cleaning of the premises and the safeguarding policies did not include details of local safeguarding contacts, although these were located on a poster in the reception area. The provider was not consistently following their complaint policy and there was no policy for significant events.

Managing risks, issues and performance

Most risks were managed effectively. However the provider did not have adequate oversight of risks associated with fire and infection control.

- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audits of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts.
- Clinical audit had a positive impact on quality of care and outcomes for patients. Feedback would be given to individual clinicians as a result of monthly audits of the clinical records in order to ensure that the service provided reflected current guidelines and that tests ordered were necessary and ethical.

Are services well-led?

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

- The practice had plans in place for major incidents and all staff had received fire and basic life support training.
- The systems used to for identify, understand, monitor and address current and future risks were not always effective. For example the service were unable to access any information related to fire risk management which was undertaken by the premises owners on the day of the inspection. However we were provided with this information shortly after the visit. There were no cleaning schedules in place which specified what needed to be cleaned or the frequency of cleaning which meant that the provider could not be assured that adequate infection control measures were in place. The provider supplied a general outline of the cleaning arrangements and cleaning schedules after the inspection.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Accurate quality and operational information was used to ensure and improve performance, for example through audits of patient consultation notes.
- Quality and sustainability of care were priorities for the provider.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice took on board the views of patients and staff and used feedback to improve the quality of services.

- Patients could feedback about the service and we saw that the provider had taken action in response to patient feedback. For example some patients had feedback that locations could be difficult to find. As a result the provider developed sets of clear instructions for each location to ensure that patients knew where the service was located.
- The service told us that they were actively working with the local laboratory to reduce the cost of blood testing.

Continuous improvement and innovation

There was a focus on continuous learning and improvement at all levels within the service. The manager told us that the provider and staff at this location consistently sought ways to improve the service. The provider would highlight areas for improvement for patient record audits and held monthly continuing professional development sessions for staff. The service had made use of IT services to offer every patient the opportunity to feedback and provided test results by email to ensure that patients did not have to re-attend and incur additional fees. Staff used a secure text messaging service to facilitate quick communication between clinicians in the service which enabled fast access to advice or assistance where required.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not established effective systems and processes: • In respect of the management of significant events as there was no policy in place. • In respect of monitoring of infection control risks as there were no cleaning schedules in place. • In respect of risks associated with fire the provider had no access to risk assessment materials. • In respect of the monitoring of emergency equipment. • For the management of complaints as the provider was not following their complaint policy and responding to patients in writing. This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.