Dr Nagarajan

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection on 7 January 2015. The practice is rated as requires improvement.

Specifically, we found the practice to require improvement for providing safe, effective and well led services. It was good for providing caring and responsive services. The practice also requires improvement for providing services to all of the population groups: older people; people with long-term conditions; families, children and young people; working age people (including those recently retired and students); people living in vulnerable circumstances; and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed, with the exception of those relating to dealing with medical emergencies.
- Information about services and how to complain was available and easy to understand.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice sought feedback from staff and patients, and acted on it.
- There was a leadership structure with staff happy to discuss concerns or issues with management.
- There was insufficient assurance to demonstrate people received effective care and treatment. We did

Summary of findings

not see evidence of personalised care delivered following best practice guidance. Performance data showed that patient outcomes were below average for the locality.
- Some clinical staff were unclear about obtaining and documenting patient consent.
- Clinical staff training needs in infection prevention and control and the new computer system had not been met.

The areas where the provider must make improvements are:

- Ensure staff have access to medical oxygen in the event of a medical emergency.
- Ensure that suitable arrangements are in place for obtaining and documenting the consent of patients in relation to their care and treatment.
- Ensure clinical staff receive support and training in infection prevention and control and accessing the electronic patient record system, to enable them to carry out their roles.
- Ensure all patient test results and letters received by the practice relating to patient care are seen by a GP. In the event of abnormal test results discussions with the patient should be undertaken by a clinician.
- Ensure all patient referrals are reviewed by the GP before being entered onto the system and the referral process is completed.
- Ensure all patients identified as in need of an annual health check are offered one and actively arrange for patients to have a regular review of their medicines as appropriate.
- Ensure vulnerable patients, such as those with mental illness or learning disabilities are offered an annual health check and that care plans are patient-centred and completed collaboratively with patients to reflect their preferences.
- Introduce a system for the accurate recording and review of data from QOF to support learning and demonstrate what actions are taken to address poor clinical outcomes for patients.

In addition the provider should:

- Ensure that staff responsible for medicine refrigerator temperature checks know what action to take should the thermometer read under or over the recommended temperature.
- Ensure appraisals are undertaken for all staff.
- Ensure repeat prescriptions are authorised by a GP.

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 was rated as requires improvement for providing safe services as there were areas where it must make improvements. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Most risks to patients were assessed and managed, with the exception of those related to dealing with medical emergencies. Specifically, the practice did not have access to medical oxygen and had not assessed the risks of this or explored further options for accessing medical oxygen.

There were systems in place to manage the risks of healthcare associated infections, however one member of clinical staff had not received training in infection prevention and control and there was no risk assessment to determine whether non-clinical staff required training.

Are services effective?

Requires improvement

The practice was rated as requires improvement for providing effective services. Clinical staff told us they used national guidelines and other locally agreed guidelines to outline the rationale for their approaches to treatment.

Care plans were not available for the majority of people with long term conditions and the 15 we reviewed for patients with diabetes showed patients were not routinely involved in their development and did not reflect individual patients' needs.

Performance data for the practice also showed that patient outcomes were below national and local averages.

We found that some clinical staff were unclear about how consent should be obtained and documented. Whilst there was evidence of appraisals and personal development plans for staff, we found that some clinical staff had difficulty using the patient electronic record system and required further training to enable them to access information with ease.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with

Summary of findings

compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice was rated as good for providing responsive services. Patients said they found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day. Information about how to complain was available and easy to understand.

At the time of inspection the practice were considering offering facilities for patients to book appointments and request repeat prescriptions online, and following our inspection we saw evidence that this had now been implemented.

The practice had good facilities and was well equipped to treat patients and meet their needs. However, the practice did not have a female clinician who was trained to undertake cervical screening as the nurse was currently undergoing training in this area.

Are services well-led?

Requires improvement

The practice was rated as requires improvement for being well-led. It had a clear vision and strategy, which staff were aware of. There was a leadership structure and staff felt management were approachable. The practice had a number of policies and procedures to govern activity.

We found some staff were not following the practice's consent policy. Whilst there were some systems in place to monitor and improve quality and identify risk, improvements were needed to demonstrate how the practice was addressing poor clinical outcomes and the risks associated with dealing with medical emergencies.

The practice sought feedback from patients, which it acted on. The patient participation group (PPG) was newly formed and had provided suggestions for improving the service. Staff had received performance reviews and attended staff meetings.

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

Requires improvement

The practice was rated as requires improvement for the care of older people. The concerns which led to this rating apply to everyone using the practice including this population group.

The practice offered personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. All patients over the age of 75 had a named GP, and the practice worked with other healthcare providers including district nurses to coordinate patient care. The practice ensured that referrals for appointments for vulnerable elderly patients were booked by the practice. The practice also offered the flu vaccination to older patients in line with current national guidelines.

People with long term conditions

Requires improvement

The practice was rated as requires improvement for the care of people with long-term conditions. The concerns which led to this rating apply to everyone using the practice, including this population group. The GPs and the nurse managed and monitored patients with chronic conditions, however the GPs we spoke with were unable to show us the historical care these patients had received as they were unable to recall patients with specific long-term conditions or run a search to locate such records on the new computer system. We reviewed 15 printed care plans for patients with diabetes and found these were not personalised care plans. The practice did work with other healthcare providers to coordinate patient care.Longer appointments and home visits were available when needed.The practice also conducted clinical audits on the management of patients with long-term conditions.

Families, children and young people

Requires improvement

The practice was rated as requires improvement for the care of families, children and young people. The concerns which led to this rating apply to everyone using the practice, including this population group. There were systems in place to identify and follow up children who were at risk. There was a dedicated clinical lead for safeguarding children, and all staff had received relevant role-specific training in child protection. Longer appointments were

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allocated for antenatal and postnatal checks, and childhood immunisations were carried out by the GPs and nurses. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Requires improvement

The practice was rated as requires improvement for the care of working-age people (including those recently retired and students). The concerns which led to this rating apply to everyone using the practice, including this population group. The age profile of patients at the practice was mainly those of working age, students and the recently retired but the services available did not fully reflect the needs of this group. Although the practice offered extended opening hours for appointments on Monday evenings, online facilities to book appointments and order repeat prescriptions had not been implemented until after the inspection. The practice offered health promotion and screening that reflected the needs for this age group, however there was no female clinician to carry out cervical screening as the nurse was undergoing training in this area.

People whose circumstances may make them vulnerable

Requires improvement

The practice was rated as requires improvement for the care of people whose circumstances may make them vulnerable. The concerns which led to this rating apply to everyone using the practice, including this population group. There was a system to highlight vulnerable patients and the practice worked with multi-disciplinary teams in the case management of these patients. We were told that care plans were being created for two percent of the practice's most vulnerable patients who had been identified as 'at risk; however clinical staff were unable to show us evidence of this. Patients who were housebound were supported by home visits and telephone consultations, and could request repeat prescriptions over the telephone.

There was a lead GP responsible for patients with learning disabilities, and the practice offered longer appointments for patients on the learning disabilities register.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

There was a system in place for identifying carers, and these patients were offered health checks and immunisations. Referrals were also made so that carers could access further support.

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People experiencing poor mental health (including people with dementia)

Requires improvement 

The practice was rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The concerns which led to this rating apply to everyone using the practice, including this population group. There was a register of patients with mental health conditions and care plans were in place for a minority of these patients. Urgent referrals were sent to the appropriate mental health team when a patient's capacity to make decisions was in question. The practice made referrals to community and secondary care mental health teams, as well other emotional support services.

Summary of findings

What people who use the service say

We spoke with five patients during our inspection, and received feedback from one member of the patient participation group (PPG). We reviewed 21 CQC comment cards which had been completed by patients, data from the National GP Patient Survey 2014, and the results of the Friends and Family Test carried out by the practice in December 2014.

The 2014 National GP Patient Survey showed that 85% of respondents described their overall experience of the practice as 'fairly good' or 'very good', which was above the clinical commissioning group average of 83%. This was reflected in the results from the Friends and Family test and our interviews with patients. Patients we spoke with said staff always treated them with dignity and respect, and they felt supported in making decisions about their care and treatment. They told us they were happy with the cleanliness of the environment and the facilities available. Patients we spoke with told us that they were able to get an appointment when they needed one, but there was often a wait to see the GP of their choice. Urgent appointments were available the same day. The comment cards reviewed were all positive and said the practice offered a professional service, and that staff were helpful and caring.

Areas for improvement

Action the service MUST take to improve

The areas where the provider must make improvements are:

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- Ensure clinical staff receive support and training in infection prevention and control and accessing the electronic patient record system, to enable them to carry out their roles.
- Ensure all patient test results and letters received by the practice relating to patient care are seen by a GP. In the event of abnormal test results, discussions with the patient should be undertaken by a clinician.
- Ensure all patient referrals are reviewed by the GP before being entered onto the system and the referral process is completed.
- Ensure all patients identified as in need of an annual health check are offered one and actively arrange for patients to have a regular review their medicines as appropriate.
- Ensure vulnerable patients, such as those with mental illness or learning disabilities are offered an annual health check and that care plans are patient-centred and completed collaboratively with patients to reflect their preferences.
- Introduce a system for the accurate recording and review of data from QOF to support learning and demonstrate what actions are taken to address poor clinical outcomes for patients.

Action the service SHOULD take to improve

In addition the provider should:

- Ensure that staff responsible for medicine refrigerator temperature checks know what action to take should the thermometer read under or over the recommended temperature.
- Ensure appraisals are undertaken for all staff.
- Ensure repeat prescriptions are authorised by a GP.

Dr Nagarajan

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. The specialist advisors were granted the same authority to enter the registered person's premises as the CQC inspector.

Background to Dr Nagarajan

Dr Risiyur Nagarajan, also known as Dr R. K. Nagarajan, provides GP-led primary care services to around 3,200 patients living in the surrounding areas of Queens Park and Kilburn.

The practice is located within the City of Westminster. The Indices of Multiple Deprivation (2010) shows that the City of Westminster was the 75th most deprived local authority (out of 326 local authorities, with the 1st being the most deprived). The practice holds a General Medical Services (GMS) contract with NHS England for delivering primary care services to the local community. The practice has a higher proportion of patients between the ages of 0-19 and 30-59, when compared with the England average. The proportion of patients over the age of 60 is lower than the England average.

The practice staff comprise of a male GP principal, two male sessional GPs, a nurse, a practice manager, and three reception / administration staff. The number of sessions covered by the GPs equates to 2 whole time equivalent (WTE) staff. The nurse worked 30 hours per week. There are also district nurses attached to the practice.

The practice is located on the ground floor of Queens Park Health Centre, and shares the premises with other health care providers. It is open every weekday from 09:00 to 18:30, except on Thursday afternoons when it closes at 12.30. Extended hours are offered on Monday evening from 18:30 to 20:00. Appointments must be booked in advance over the telephone or in person. The practice opted out of providing out-of-hours services to their patients. On Thursday afternoons and outside of normal opening hours patients are directed to a GP out-of-hours service, or the NHS 111 service.

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, and maternity and midwifery services.

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, and to look at the overall quality of the service. The practice had previously been inspected during our pilot phase in May 2014, and we have an obligation to conduct inspections at those practices that were inspected during our pilot phase in order to provide a rating for the service under the Care Act 2014.

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?

Detailed findings

- 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 inspection on 7 January 2015. During our inspection we spoke with a range of staff including: the GP principal; two sessional GPs; the practice manager; and two reception / administrative staff. We observed how patients were being cared for and sought the views of patients. We spoke with five patients, and received comments from a member of the patient participation group. We reviewed 21 comment cards where patients and members of the public shared their views and experiences of the service. We reviewed the practice's policies and procedures.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. A log was kept of incidents that had occurred since 2012, and significant event reviews since November 2014 were made available to us. The staff we spoke with were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events. We reviewed safety records, incident reports and minutes of meetings where these were discussed.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Staff reported all significant events to the practice manager, recorded the incident in the practice's log book, and completed a 'significant event review' form which was accessible to staff on the practice's computers. Urgent incidents were discussed with the staff involved as soon as possible, and routinely with other staff during practice meetings.

The practice had completed three significant event reviews in the last three months. These reviews contained a summary of the event, risk issues identified, actions required, learning outcomes, and a date for review of actions. We saw evidence of action taken as a result. For example, one incident we reviewed involved a patient's telephone number not being updated on their records and therefore the practice were unable to contact the patient to discuss abnormal test results. Practice staff took action by posting a letter to the patient and carrying out a home visit the next day, however as the patient was not home another letter was left at their residence causing further delays. The patient made contact with the practice the next day. As a result of this incident all practice staff were instructed to routinely update patient details to prevent reoccurrence of such an event in urgent situations. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists and administrators, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Patient safety alerts were received by the practice manager, and disseminated by email to relevant staff. We were told that safety alerts were also discussed at weekly clinical meetings when changes to practice were required, however as these meetings were informal there were no meeting minutes.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The GP principal was the appointed lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. The practice had separate policies for child protection and safeguarding vulnerable adults. There were procedures for escalating concerns to the relevant protection agencies in working hours and out of normal hours, and their contact details were accessible to staff. We looked at training records which showed that all GPs and the nurse had received training in child protection to Level 3 and non-clinical staff to Level 1. We asked members of medical and administrative staff about their most recent training. Staff knew who the safeguarding lead was, how to recognise signs of abuse in older people, vulnerable adults and children, and how to escalate concerns within the practice. 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. Contact details were easily accessible in each consultation room and at reception.

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 was a chaperone policy which included guidelines for staff to follow. (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). A notice informing patients of the chaperone service was visible at reception. Non-clinical staff had undertaken chaperone training and understood their responsibilities when acting as chaperones, including where to stand to be

able to observe the examination. They had also received a criminal records check via the Disclosure and Barring Service (DBS), furthermore, we saw the presence of a chaperone had been documented in medical records.

Medicines management

We checked medicines stored in the treatment rooms and the medicine fridge, 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. We were told that the fridge temperature was checked twice a day by the nurse or practice manager and evidence we reviewed confirmed this. The records showed that staff documented the minimum, maximum, and actual temperatures in the fridge. All the 'actual' temperatures recorded were within the recommended range of 2 – 8 degrees Celsius, and there was a clear sign on the front of the fridge to remind staff of this. However, we found that some of the maximum temperatures recorded were above 8 degrees. We brought this to the attention of the practice manager. The practice manager checked the maximum fridge temperature and this showed it had been set at 10 degrees. The practice manager informed us that this was incorrect and may be due to staff error or the fridge unit itself. The practice manager took immediate action by ordering a new fridge, and contacting the clinical commissioning group pharmacist regarding the stability of the vaccinations after a potential cold chain breach. Following our inspection we saw evidence from the pharmacist to confirm that the vaccinations stored by the practice were stable and safe to use.

The GP principal met with the local medicines management team to ensure prescribing was safe and effective. We saw evidence of ongoing audit initiated by the clinical commissioning group pharmacist. There was also evidence that prescribing data was reviewed and shared with staff during practice meetings.

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. We were told expired and unwanted medicines were disposed of in line with waste regulations.

The nurse administered vaccines using Patient Group Directions (PGDs) that had been produced in line with legal requirements and national guidance. We saw up-to-date and signed copies of these, and evidence that the nurse had received appropriate training to administer vaccines.

The practice's 'repeat prescribing protocol' stated that repeat prescriptions for chronic conditions was for three months, and high-risk medicines were prescribed for shorter durations depending on the patients' medical history. The GPs we spoke with were adhering to the practice policy for repeat prescribing. The GP principal told us that patients' medicines were reviewed annually if they attended the practice, however the practice were not proactive in contacting patients to review their medicines. Repeat prescriptions could be requested by completing a practice request form, in writing or by fax. It was the practice's policy to only accept telephone requests from patients who were housebound, terminally ill, or in an emergency situation. At the time of inspection the practice did not have the facilities for patients to request prescriptions online, however following our inspection we were provided with evidence that showed the practice had now implemented an online system for patients to request repeat prescriptions. Repeat prescriptions were processed within two working days of a request being made. The practice manager authorised repeat prescriptions and these were then reviewed and signed by a GP. The practice arranged pre filled medicine administration systems for patients with long term conditions taking multiple medicines. They also liaised with the local chemist to deliver medicines to patients who were housebound. Blank prescription forms and uncollected signed prescriptions were stored securely at all times.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An external healthcare provider was responsible for the management of infection prevention and control within the health centre. They had carried out a programme of infection control checks and audits for the practice, and we saw that the last audit carried out was in 2014. Cleaning was also contracted out by the landlords, and we saw there were cleaning schedules and cleaning records in place. The communal areas were cleaned daily, and a deep clean (with everything removed from all surfaces) was

undertaken every six months. We were shown evidence that the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal) was carried out to reduce the risk of infection to staff and patients.

The nurse was the practice lead for infection control and had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that two GPs had also received training in infection control, but there was no evidence for the third GP. Non-clinical staff told us they had not received training. 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. For example, personal protective equipment including disposable gloves and aprons were available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Notices about hand hygiene techniques were displayed by hand washing sinks, along with hand soap, hand gel and hand towel dispensers.

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 records that confirmed this. All portable electrical equipment was routinely tested by the building's management. Equipment had been tested and calibrated in March 2014, and we saw equipment such as blood pressure monitors and the fridge displayed stickers indicating the last testing date.

Staffing and recruitment

The practice employed nine members of staff. Eight of those staff members had been employed before 2008, and all staff had received a criminal records check through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. This included the recruitment checks to be undertaken prior to employment. For example, proof of identification, two references, qualifications, registration with the appropriate professional body and a DBS check. We checked records for the member of staff most recently employed and saw that appropriate recruitment checks had been undertaken prior to employment.

There were arrangements for planning and monitoring the number of staff needed to meet patients' needs. We were told that there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. For example, there were usually three reception/administrative staff on duty in case a staff member was on leave or off sick that day.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of medicines management, staffing, and dealing with emergencies and equipment. The practice had a health and safety policy which identified named staff members and their responsibilities, and there was health and safety information displayed for staff. The landlord managed the premises and had carried out risk assessments for health and safety, fire safety, and infection control.

Arrangements to deal with emergencies and major incidents

The practice had some arrangements in place to manage emergencies. All staff had received annual training in basic life support. Emergency equipment was available including an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The practice did not have access to medical oxygen. The practice manager told us this was because the landlords did not permit oxygen cylinders to be stored at the premises however, we did not see evidence that the practice had assessed the risks of this or explored further options for accessing medical oxygen. Oxygen is considered essential in dealing with certain medical emergencies, such as acute exacerbation of asthma and other causes of hypoxaemia.

Emergency medicines, including those for the treatment of anaphylaxis, were available in a secure area of the practice and all staff knew of their location. Processes were also 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 policy 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

Requires improvement

Are services safe?

mitigating actions recorded to reduce and manage the risk. Risks identified included loss or premises, power failure, and incapacity of staff. We saw that the last 'business impact' risk assessment was undertaken in March 2014.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE), British Medical Association (BMA), Royal College of General Practitioners (RCGP), and from local commissioners. Clinical meetings were incorporated into the monthly practice meeting. One GP told us new guidelines were discussed when they were relevant to the practices' patient population. The GP principal also attended clinical commissioning group meetings and local Clinical Learning Sets (CLS) where appropriate guidelines were discussed.

The GPs were supported by the practice nurse with the management and monitoring of patients with chronic disease. When we asked the GPs about patients with long-term conditions, they were unable to recall the name of a patient with a long-term or complex condition, or run a search to locate such records on the new computer system. This meant we could not access patient records electronically to view their care pathway. We were later provided with printed copies of care plans for patients with diabetes.

The practice reviewed their performance in areas such as A&E attendance and referrals during practice meetings. This information was also discussed at CLS, where performance was compared with other practices in the locality.

Most referrals were sent via Choose and Book, which is an electronic referral service that provides patients with a choice of where they are seen for their first specialist appointment. Specific local care pathways were in place for referrals for dermatology, diabetes, and musculoskeletal care. The GPs we spoke with used national standards for urgent referrals seen within two weeks, and national templates were saved on the computer system for easy access. The GPs told us that they provided handwritten referrals to the practice manager, who subsequently entered them onto the system and completed the referral process. Urgent referrals were followed by a telephone call to confirm the referral had been received. The practice also ensured that referrals for appointments for vulnerable elderly patients were booked by the practice.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice showed us four clinical audits that had been undertaken in the last two years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one audit we reviewed was to determine if gastroenterology referrals could have been managed in primary care. The results showed that all referrals from the practice were appropriate and performance was similar to their peer group. To ensure this standard was maintained, a second audit was completed nine months later. Another completed audit looked at patients with diabetes to ensure they had received a blood test that checked their average glucose levels. Patients identified as not having a recent check were called for monitoring and a review of their medicines. The results of clinical audits were shared with clinical staff.

The quality and outcomes framework (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. Last year (2013/14), the practice achieved 478 out of a possible 835 points for QOF, which was 33% below the clinical commissioning group (CCG) average and 37% below the England average. The practice achieved 42% in the clinical domain for QOF, which was below the CCG average of 89%, and the England average of 92%. The practice told us they were aware of their performance and stated that some interventions may have been coded incorrectly. Staff discussed the information collected for the QOF and performance against national screening programmes at team meetings, however there was no evidence to demonstrate what action the practice had taken to address these poor clinical outcomes for patients.

We were told that patients in receipt of palliative care were referred to the palliative care team, and that the GPs carried out home visits when required. We were advised there were no patients currently on the practice's palliative care register.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data in respect of referrals showed that the practice had outcomes that were comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. All GPs were up to date with their yearly continuing professional development requirements and all either had 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 practice and remain on the performers list with NHS England).

All staff (excluding GPs) undertook annual appraisals that identified learning needs from which action plans were documented. We saw appraisals had been completed for three out of the four administrative staff. We noted that the nurse had yet to be appraised, and the practice manager informed us that this was because the nurse was employed in May 2014 and was only due for appraisal this year.

With the exception of infection control and prevention, staff were up to date with attending mandatory courses such as basic life support, and safeguarding. The nurse was expected to perform defined duties and we saw evidence to demonstrate that she was trained to fulfil these duties. For example, immunisations and smoking cessation. The nurse was undertaking a course to carry out cervical screening. We saw that she had completed part one and was under supervision with another healthcare provider when carrying out smear tests. We were told that once the nurse had completed part two of the training she would be able to carry out cervical smear tests independently at the practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those 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 electronically. The practice manager reviewed all electronic results and correspondence and made the decision as to which required action by a GP. These were then printed and the GP who saw these documents and results was responsible for the action required. The practice manager would undertake further tasks such as contacting the patient for an appointment or informing them of abnormal results.

The practice worked with other healthcare providers to coordinate patient care. The district nursing team and community matron service were based within the same building and would attend practice meetings when required to discuss patients they were seeing, for example those with multiple long-term conditions, housebound patients, and those recently discharged from hospital. We saw from recent minutes that a nursing care manager had attended a practice meeting to explain their role in the care of patients with complex needs, in particular patients with frequent admissions to hospital, or those who required social support.

The practice made referrals to the rapid assessment team who were able to urgently support patients, such as the elderly, at home. Referrals were also made to the chiropody and podiatry service (based within the health centre) that provided a domiciliary service to housebound patients and transport for patients who required it.

The GP principal attended a monthly clinical commissioning group meeting called "putting patients first". This was a multidisciplinary meeting involving primary and secondary care clinicians who discussed vulnerable patients and patients identified as 'high risk'. The GP principal was also on the executive committee of 0-4 years early start local service, which met quarterly to discuss key factors affecting children's health and development in the early years.

Information sharing

The practice used electronic systems to communicate with other providers. For example, there was a shared system with the GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, such as those through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Requires improvement

Are services effective?

(for example, treatment is effective)

record to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We found that some clinical staff had difficulty using the new system and required further training to enable them to access information with ease.

Consent to care and treatment

Although the practice had a consent policy which provided staff with detailed information relating to obtaining consent from patients, we found that some clinical staff were unclear about how consent should be obtained and documented. For example, one GP told us consent was only recorded in 'serious cases' such as termination of a pregnancy. Two GPs we spoke with were also unclear about Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). When we asked GPs to show us examples of patient records where consent to treatment had been recorded, they were unable to do so, although we did see an example where an urgent referral to the mental health team had been made to assess a patient's capacity to make decisions.

Health promotion and prevention

The practice met with the clinical commissioning group (CCG), the locality group of practices, and as a team to discuss the needs of their patient population. This information was used to help focus health promotion activity. New patients were offered a health check with the nurse following registration with the practice. A health-check pod which measured patients' blood pressure, height and weight, was also available for patients to utilise.

The practice had ways of identifying patients who needed additional support. For example, the practice kept a register of all patients with learning disabilities and there were currently ten patients on the register. The practice had opted not to sign up for the 'directed enhanced service' for learning disability and had not seen all those on the register for an annual health check.

Clinical staff told us that health promotion was provided opportunistically during consultations. There was a variety of health promotion information for patients to access in the waiting room. The practice leaflet also contained general health promotion advice such as: dietary control; smoking cessation; exercise; health screening; and immunisations.

The practice kept a register of patients with mental health conditions. Data showed that 12 out of 32 of patients with a mental health condition had a care plan in place. Patients with long-term conditions such as diabetes, asthma, chronic obstructive pulmonary disorder, hypertension, and coronary heart disease were monitored by the GPs and nurses. We were shown 15 printed care plans for patients with diabetes. However, we noted that these were not personalised with the problems that needed to be addressed, what outcome was being sought, or what the patient's involvement was in agreeing to the care plan. We were also told that care plans were being created for 2% of the practice's most vulnerable patients who had been identified as 'at risk', however the GPs were unable to show us evidence of these care plans on the computer system.

The practice's performance for cervical smear uptake was 50%, which was 24% below the CCG average and 27% below the national average. The practice was aware of their low performance in this area and told us this was because all the GPs were male and the nurse was currently undertaking training in this area. Patients who preferred to have their cervical screening with a female clinician were directed to a local walk-in clinic.

The practice also offered a full range of immunisations for children, travel vaccinations and flu vaccinations in line with current national guidance. Data showed that the practice had performed below the CCG averages for childhood immunisations for children aged 24 months and five years. Last year the practice had provided flu vaccinations to 62% of patients over the age of 65, and 49% of patients aged six months to 65 years in the defined influenza clinical risk groups.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2014 National GP Patient Survey (86 responses received), and a Friends and Family Test from December 2014 (26 adults responses, and one children/young people's response received). Data from the National GP Patient Survey showed that 85% of respondents described their overall experience of the practice as 'fairly good' or 'very good'. This was above the clinical commissioning group (CCG) average of 83%. Feedback from the Friends and Family Test showed that 100% of adult respondents were 'extremely likely' or 'likely' to recommend the service to their friends and family.

The 2014 National GP Patient Survey showed that the practice was above the CCG averages for patient satisfaction scores on consultations with the GPs. For example, 91% of respondents said the GP was good at listening to them (CCG average 83%), and 88% said the GP gave them enough time (CCG average 79%). Satisfaction scores for consultations with the nurses were slightly below the CCG averages. For example, 70% of respondents said the nurse was good at listening to them (CCG average 72%), and 69% said the nurse gave them enough time (CCG average 73%).

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a professional service and staff were efficient, helpful and caring. Reception staff were praised for being friendly and welcoming. Patients also said that all staff treated them with dignity and respect. We also spoke with five patients on the day of our inspection. All these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected by clinical and non-clinical staff.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains or screens were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The waiting room was shared with other healthcare providers. We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that an empty room in the practice could be utilised to prevent patients overhearing potentially private conversations between patients and receptionists. There was also a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The 2014 National GP Patient Survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 National GP Patient Survey showed 74% of practice respondents said the GP involved them in care decisions (CCG average 71%), and 80% felt the GP was good at explaining treatment and results (CCG average 78%).

Patients we spoke with on the day of our inspection 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 usually had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. Staff told us that translation services were available for patients who did not have English as a first language, although we did not see notices in the reception areas informing patients this service was available.

Patient/carer support to cope emotionally with care and treatment

The practice made referrals to emotional support services, such as MIND counselling, community and hospital psychiatric teams, and the Improving Access to Psychological Therapies (IAPT) service. Information on IAPT

Good

Are services caring?

and other local support services was available in the waiting room. The patients we spoke with highlighted that staff responded compassionately when they needed help and they were signposted to support services to help them manage their treatment and care when it had been needed. Comment cards we received also showed that patients were positive about the emotional support provided by the practice.

The practice had a carer's lead and policy in place to identify and support carers and their families. Referrals were made to external organisations and charities so that carers could access further support and information which may be relevant to them, for example financial support. We saw a carer's pack including information and referral forms was available for patients in the waiting room. Staff were aware of patients' needs and told us that carers were offered health checks and immunisations. We saw that out of nine carers who had been identified to receive the flu vaccination, three had received one.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The needs of the practice population were understood. The GP principal attended networking meetings with practices in the local area. The aim of these meetings was to discuss the needs of the local population, and we saw presentations and minutes from recent meetings attended by the GP principal. Topics discussed included patients' experience of local healthcare services, and the results of audits carried out by the local network of practices.

Patients could only access a male GP. Staff told us that patients were informed of this when registering with the practice, and if the person preferred to register with a female GP they were signposted to other healthcare providers within the health centre. There was currently no cervical screening with a female clinician as the nurse was undergoing training in this area. We spoke with four female patients who told us they were happy seeing a male GP and had been offered a chaperone for examinations.

All patients over the age of 75 years had a named GP who had overall responsibility for their care and support. The practice offered longer appointments for patients who might require them, including patients with learning disabilities and multiple long-term conditions. Antenatal and postnatal appointments were also allocated additional time. Home visits and telephone consultations were available to patients who required them, including housebound patients and older patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to patient feedback. For example, one of the GPs had increased their afternoon hours in response to patients requesting more GP sessions during these times. The practice had a newly established participation group (PPG). At the time of inspection the practice had yet to implement suggestions put forward by the PPG as their first meeting with the group was two days prior to our inspection.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients whose circumstances may make them vulnerable, such as housebound patients and carers, were flagged in individual records. The practice also liaised with district nurses to assist in the management of care for these patients.

The practice told us they had a diverse patient population. Many of the patients came from Bangladeshi, Portuguese, African, and Irish backgrounds. The practice had access to telephone translation services and some of the GPs spoke languages other than English, including Tamil, Hindi, Bengali, Urdu, and Burmese. Patients were signposted to relevant social activities in the area, and we saw further information was available in the waiting room.

The premises and services had been adapted to meet the needs of patients with disabilities. The practice was located on the ground floor, and there were accessible toilet facilities and baby changing facilities available. The waiting area could accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. A hearing loop was also in place to assist patients who had a hearing impairment.

Access to the service

The practice was open every weekday 9.00am to 6.30pm, except on Thursday afternoons when it closed at 12.30pm. If patients called the practice when it was closed, they were directed to the out-of-hours service. We were told that if patients contacted the practice between 8.30am-9.00am, the out-of-hours service could contact the GP principal who was on-call at this time. The GP principal would then contact the patient in emergencies. Extended hours were offered on Monday evening from 6.30pm -8pm. These appointments were useful for patients who could not access the practice during working hours.

Patients could book appointments over the phone or in person. At the time of inspection the practice did not have facilities for patients to book appointments online, however following our inspection we were provided with evidence that showed the practice had now implemented an online appointment booking system. Data from the 2014 National GP Patient Survey showed that 80% of respondents said their experience of making an appointment was good, which was higher than the clinical commissioning group average of 74%. A number of emergency appointments were available each day, and patients were required to telephone the practice as early as possible to book these. Patients we spoke with confirmed

Good

Are services responsive to people's needs?

(for example, to feedback?)

they had previously been given emergency appointments on the same day of contacting the practice. Information about appointments was available to patients in the practice leaflet.

Routine appointments were 10 minutes with the GPs and 15 minutes with the nurse. Longer appointments were available for patients who needed them. Patients we spoke with were generally satisfied with the appointments system. They told us that they were able to get an appointment when they needed one, but there could be a wait of up to two weeks to see the GP of their choice.

There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on local walk-in centres and the out-of-hours service were available in the waiting room and in the practice leaflet.

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. The practice manager was the designated responsible person who handled all complaints in the practice.

We saw that information on the complaints system was made available to patients in the waiting room and the practice leaflet. Most patients we spoke with said they were unaware of the process to follow if they wished to make a complaint, but they told us they would be comfortable to approach staff with their concerns. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had not received any written complaints in the last 12 months. Staff told us this was because they tried to diffuse any complaints before they escalated. If this did not resolve the issue then the patient would be directed to the practice manager in line with the practice's complaints policy.

Are services well-led?

Requires improvement

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's mission statement was clearly displayed in all treatment rooms. The practice vision and values included to serve and improve the health of the community, provide a helpful and safe environment for their patients, and to value the contributions made by their patients and staff. Staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff in a folder within the practice. We looked at 21 of these policies and procedures and all had been reviewed annually and were up to date. We found that some clinical staff were unclear about how consent should be obtained and recorded, and were not following the practice's consent policy.

There was a leadership structure with named members of staff in lead roles. For example, the nurse was the clinical lead for infection control and the GP principal was the lead for safeguarding. The practice manager was responsible for most clinical and administrative functions, including arranging prescriptions, and sending referrals. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, supported, and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing below the national standards. We saw that QOF data was discussed at monthly team meetings, however there was no evidence to demonstrate how the practice were addressing poor clinical outcomes in QOF.

The practice carried out clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of inadequate smears and smear takers was undertaken to ensure that adequate samples were taken during cervical screening. If more than 2% of samples were returned as inadequate then the practice had procedures to follow, such as supporting staff with training. The practice re-audited this every two years. The practice was also involved in a peer review system with other practices in their locality to look at areas such as referral rates and A&E attendance.

Governance arrangements were discussed during the monthly practice meetings which were attended by all staff. We looked at minutes from the last three meetings and found that performance, quality and some risks had been discussed. However, the risks associated with dealing with medical emergencies without medical oxygen had not been undertaken.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff unable to attend meetings were provided with minutes so that they were kept up to date with any changes that may have been implemented. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. A staff handbook was available to support staff. They could also access a 'whistleblowing' policy which detailed internal and external procedures to follow if they had any concerns. Staff we spoke with knew where to find these policies if required.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had recently established a patient participation group (PPG) which consisted of six members. They had met with the PPG once prior to our inspection, and we saw the minutes of this meeting. Suggestions had been put forward by the PPG and the practice had documented the actions to be taken. For example, the PPG suggested a newsletter would be useful to provide up-to-date practice information such as the times each clinician worked. Where the practice was unable to accommodate requests, the reason was given. For example, the group had requested for the surgery to open at 8.45am. The practice explained the opening times were governed by health and safety issues related to the health centre, however they would feedback these suggestions to the health centre. Another suggestion by the PPG was the implementation of online facilities to order repeat

Are services well-led?

Requires improvement

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

prescriptions and book appointments, which at the time of inspection was under consideration by the practice. Following our inspection we were provided with evidence to show the practice had implemented these systems. The plan was for the PPG to meet every two months, and the next meeting was scheduled for March 2015. The practice also reviewed their performance and patients' comments from the Friends and Family Test. This was shared with staff during practice meetings.

The practice gathered feedback from staff through monthly meetings and annual appraisals. They also discussed feedback informally when issues arose. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

During our inspection clinical staff told us they had difficulties using the new computer system which was introduced in August 2014. When asked some clinical staff were unable to access care plans for patients with specific long-term conditions. We observed administrative staff assisting clinical staff with accessing some areas of the system. The practice manager was aware that some staff required further training and told us that this would be being arranged.

Administrative staff told us that the practice supported them through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Non-clinical staff told us that the practice was supportive of training and that they had attended training relevant to their roles. For example, non-clinical staff had received chaperone training.

The practice also contributed to the clinical learning sets (CLS) by sharing their experiences and learning outcomes with other practices in the area. For example, we saw evidence of a recent presentation given by the GP principal about the practice's previous CQC inspection.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that there was lack of arrangements for dealing with medical emergencies because staff did not have access to medical oxygen and no risk assessment had been undertaken as to why medical oxygen was not available. We found that there was lack of clinical oversight when dealing with patient test results and letters received by the practice; abnormal test results were communicated to patients by non-clinical staff, repeat prescriptions were not being authorised by a GP; patient referrals were handwritten and not reviewed by a GP before being electronically entered onto the system and the referral process completed. This was in breach of regulation 9(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(2)(b,c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent We found that the registered person did not have suitable arrangements in place for obtaining and documenting the consent from service users in relation to the care and treatment provided for them. This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing We found that staff had not received appropriate support or training necessary to enable them to carry out the duties they are employed to perform. This was in breach of regulation 23(1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 We found that the registered person had not established effective systems or processes to accurately record, assess, monitor and address poor clinical outcomes improve the quality and safety of the services; annual health checks were not consistently being offered and we saw lack of evidence that care plans were completed collaboratively with patients to reflect their preferences. This was a breach of regulation 10 of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17(1) (2)(a, b, c, f) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.