# Dr Zaheer Hussain

## Inspection 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 location** | Inadequate |
|---|---|
| Are services safe? | **Inadequate** |
| Are services effective? | **Inadequate** |
| Are services caring? | **Good** |
| Are services responsive? | **Inadequate** |
| Are services well-led? | **Inadequate** |

# Overall summary

**This practice is rated as inadequate overall.**

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Good

Are services responsive? – Inadequate

Are services well-led? - Inadequate

We carried out an announced comprehensive inspection at Dr Zaheer Hussain, also known as Fulham Cross Medical Centre, on 7 October 2014 under section 60 of Health and Social Care Act 2008 as part of our regulatory functions. The overall rating for the practice was requires improvement in safe, effective, responsive and well-led domains, and good in the caring domain. A second announced comprehensive inspection was planned for 5 November 2015; however, the inspection team was refused entry by the Registered Provider, Dr Hussain. The inspection team attended the practice on 10 November 2015 and conducted a comprehensive inspection. This resulted in the practice being rated as inadequate across all domains and the practice was suspended for three months. The suspension was stayed following representations to the Judge, on condition that a repeat inspection be conducted and if found to be "good enough" the practice would be allowed to re-open. A further inspection was conducted on 4 February 2016, the practice was rated inadequate overall, inadequate in well-led, safe and effective domains and requires improvement in responsive and caring domains. The practice was placed in Special Measures. A six-month inspection following Special Measures was carried out on 15 September 2016 and the practice was rated overall as requires improvement, requires improvement in effective and well-led domains and good in safe, caring and responsive domains. The practice was taken out of special measures. A twelve-month follow-up CQC inspection took place on 17 July 2017, at which the practice was rated as being good overall, with requires improvement in well-led domain.

The full comprehensive reports of the previous inspections can be found by selecting the 'all reports' link for Dr Zaheer Hussain on our website at www.cqc.org.uk.

This inspection, on 24 July 2018 was an announced comprehensive inspection with a second unannounced visit on 6 August 2018 to confirm that the practice was now meeting the requirements we had identified in well led domain at our previous inspection on 17 July 2017.

At this inspection we found the practice demonstrated some improvements from previous inspections, for example, significant events, managing complaints and sharing learning with staff, and duty of candour and whistleblowing policies were in place and staff understood what is meant by those terms. However, improvement overall had not been sustained, the provider had failed to respond to issues we have previously identified and raised with them. We found breaches in regulations 12 and 17. In particular:

- The practice did not have clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice did not always learn from them. Risk assessments were not being completed; staff recruitment was not in line with requirements; improvements were required to infection control and there was no recent audit; equipment was not all calibrated; there were fewer GP sessions provided than at our last inspection when patient numbers had increased; there was no system to manage medicines and safety alerts; prescribing and the management of patients being prescribed high risk medicines was not always in line with guidance and requirements.
- There was limited evidence the practice reviewed the effectiveness and appropriateness of the care it provided. We found there was no induction for new staff, staff did not receive training needed to carry out their role, no appraisal, minimal evidence of quality improvement, no process to monitor consent. There were low numbers of women attending for a cervical smear and low child immunisations.
- Staff generally involved patients in their care and treatment and treated patients with compassion, kindness, dignity and respect.
- The practice did not respond to patient needs by providing safe and effective care and treatment. There was no evidence the practice had considered patient feedback regarding access and taken action to improve patient experience.
- There was a lack of governance and no systems in place to assess, monitor and improve quality and safety, while

# Overall summary

clinical meetings were taking place, these were not recorded so there was no evidence of discussions or actions, the practice did not work with other health and social care services to provide joined up care and treatment for patients.

The areas where the provider **must** make improvements as they are in breach of regulations are:

- Ensure care and treatment is provided in a safe way to patients.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If, after re-inspection, the service has failed to make sufficient improvement, and is still rated as inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or varying the terms of their registration within six months if they do not improve.

This service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to remove this location or cancel this provider's registration.

Special measures will give people who use the service the reassurance that the care they get should improve.

**Professor Steve Field** CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

## Population group ratings

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

## Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser, and a second CQC inspector.

## Background to Dr Zaheer Hussain

Dr Zaheer Hussain, also known as Fulham Cross Medical Centre, operates from 322 Lillie Road, Fulham, London, SW6 7PP. The practice has access to three consulting rooms which are based at ground floor level.

The practice provides NHS primary care services to approximately 3100 patients and operates under a General Medical Services (GMS) contract. The practice is part of NHS North West London Clinical Commissioning Group (CCG).

The practice is registered with CQC as an individual provider, and the regulated activities provided are diagnostic and screening procedures, treatment of disease, disorder or injury and maternity and midwifery services.

The practice staff comprises a lead GP (8 sessions per week), a GP partner not currently conducting clinical sessions, two long-term female GP locums (0.2 whole time equivalent (WTE) each). The medical team are supported by a locum practice nurse (0.1 WTE) and one healthcare assistant (0.1 WTE). There is a part-time practice manager (0.4 WTE), a part-time assistant practice manager (0.5 WTE) and four administration/reception staff (1.4 WTE).

The practice population is in the fifth decile in England, on a scale of one to ten, with one being the most deprived and ten being the least deprived. People living in more deprived areas tend to have greater need for health services. Data shows that 30.4% of patients within the practice area were from Black and Minority Ethnic (BME) groups. The highest proportion of patients within the practice population were in the 15 to 44-year old age category.

The practice is open between 8am and 6.30pm Monday to Friday. Extended hours appointments are available on Monday and Tuesday from 6.30pm to 8.30pm, and on Wednesday from 6.30pm to 7.30pm. The practice does not currently have its own website, patients could request appointments and repeat prescriptions on line through the NHS website. Out of hours services are provided by London Central and West.

Inadequate

# Are services safe?

**At our previous inspection on 17 July 2017, we rated the practice as good for providing safe services.**

**At our follow-up inspection on 24 July 2018 we found concerns in relation to medical indemnity insurance; safeguarding; the management of high risk medicines; insufficient GP and nursing capacity; lack of a safe system in assessing patients wellbeing, prioritising and 'red flag' screening of patients; safe staff recruitment; a safe approach to Infection Prevention and Control (IPC); Control of Substances Hazardous to Health (COSHH) and premises/security risk assessments; safe medical equipment; storage of vaccines prescribing and patient safety alerts.**

**Safety systems and processes**

The practice did not have clear systems to keep people safe and safeguarded from abuse.

- The practice had systems to safeguard children and vulnerable adults from abuse but these were limited and disorganised.
- All staff received up-to-date safeguarding and safety training appropriate to their role. However, they had limited knowledge of how to identify and report concerns. We saw evidence of one report of learning from safeguarding incidents were available to staff. Staff did not take steps, including working with other agencies, the lead GP told us the practice did not hold multi-disciplinary meetings, to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. However, after the inspection the practice sent evidence of communication with the district nurse for one patient.
- The practice was unable to provide evidence that recruitment checks had been conducted on all staff. This included retention of interview notes, that two references had been obtained for each member of staff, a signed confidentiality agreement was available and that professional registrations and inclusion on performer's lists had been verified and documented.
- The practice told us there was a system in place to check the professional registration of clinical staff at the point of recruitment. However, they were unable to provide evidence of this or a system in place to regularly monitor this.
- The practice did not provide evidence of current medical indemnity insurance for all clinical staff.
- Staff who acted as chaperones were trained for their role and had received a DBS check. (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.)
- At the time of the inspection the practice was not able to demonstrate that all staff had received annual training for infection control, basic life support and fire safety awareness. After the inspection they sent details of this training for all staff, we noted two staff completed fire safety training after the inspection and two staff had not completed infection control training since 2017.
- Despite several requests and additional time being allowed to provide the required information, the practice has not provided evidence relating to the scope and role of the healthcare assistant.
- The practice did not have an effective system to manage infection prevention and control (IPC). The practice did not demonstrate compliance with infection control guidelines in relation to cleaning materials and storage of equipment. Arrangements in relation to IPC did not mitigate the risk of infection. For example, cleaning cloths were not colour-coded and were found clumped together in a small cardboard box. This was a finding of an Infection Control and Prevention (IPC) audit undertaken by the Commissioning Support Unit in May 2017. The practice had not completed two action points within their agreed action plan of twelve months. They had not subsequently undertaken an internal IPC risk assessment within twelve months of the external audit. In addition, the practice could not provide a record to evidence decontamination of medical devices, for example, ear irrigator and nebuliser.

We saw that IPC online training was made available to staff. Furthermore, the non-clinical lead for IPC had not undertaken enhanced training to support their role, and records show:

- On the day of inspection the practice were not able to demonstrate all staff had completed infection control training. After the inspection the provider sent copies of certificates confirming the cleaner had completed

training in 2016 and three clinical and eight non clinical staff had completed this training in 2018, with the certificates for two staff demonstrating it was done in September 2018 which was after the inspection.

- The practice was unable to demonstrate that all staff in direct patient contact had received appropriate vaccinations in line with current Public Health England (PHE) guidance. The practice sent us evidence that only one member of staff who had direct patient contact had completed a complete set of required immunisations.
- We saw that the practice had completed a Legionella Risk Assessment, and regularly flushed taps and tested water temperatures.
- The arrangements in place to ensure that facilities and equipment were safe and in good working order were insufficient. Although the practice could demonstrate that calibration of medical equipment had been undertaken in July 2018, however they did not have a system in place to check that calibration was up to date for locums GPs using their own equipment.
- The practice did not provide evidence of risk assessments relating to the Control of Substances Hazardous to Health, (COSHH) Premises and Security and Health and Safety. However, after the inspection, a Health and Safety risk assessment was submitted albeit with an outstanding action point relating to a broken glass door panel. A COSHH risk assessment was also sent after the inspection, again this was incomplete, as it only contained details of one cleaning material used at the practice and contained details of risks not related to substances which may be hazardous to health. A premises and security risk assessment was sent after the inspection.
- Arrangements for managing waste and clinical specimens kept people safe.

**Risks to patients**

The practice did not have adequate systems to assess, monitor and manage risks to patient safety.

- We found the practice had not adequately assessed risks and monitored the impact on safety.
- Clinicians told us they knew how to identify and manage patients with severe infections including sepsis.
- The practice told us all calls were triaged by the doctor on duty. However, one of our inspectors sat with one of the non-clinical members of staff at reception and observed that patients who called for an appointment were not appropriately managed. Patients were informed by staff there were no appointments available that day with no referral to a clinician for them to assess and there was no waiting list in place for appointment cancellations. There was no triage of these patients undertaken; patients were not asked if they required an urgent appointment or if the patient was experiencing any 'red flag' symptoms. Red flag symptoms which may indicate a patient is suffering from potentially life-threatening disease, for example, shortness of breath or chest pains. Patients were not heard to be offered any appointments within the group of practices in the area or signposted to other services, for example, Urgent Care facilities, NHS 111, OOH services.
  Non-clinical staff told us they had not had red flag symptoms training to recognise those in need of urgent medical attention. However, after the inspection the practice sent evidence they had appointment slots available
- Arrangements were in place for planning and monitoring the number and mix of non-clinical staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics. However, we were unable to see evidence of how GP and nursing staff hours were effectively managed during annual leave and when the service was under pressure due to patient demand. The practice sent a copy of the business continuity plan after the inspection, this noted the arrangements with two neighbouring practices to support during staff shortages due to sickness.
- There was not an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and some staff were suitably trained in emergency procedures. Not all staff had undergone annual basic life support(BLS) and fire safety training. Consequently, some staff had limited knowledge and understanding regarding their responsibilities to manage emergencies on the premises.
- When there were changes to services or staff the practice did not assess and monitor the impact on safety.

Inadequate

# Are services safe?

**Information to deliver safe care and treatment**

Staff did not have the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed information needed to deliver safe care and treatment was not available to staff. The practice did not have a documented approach to managing test results, although we did not find evidence of test results that were awaiting medical review.
- The practice did not have systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made some timely referrals in line with protocols.

**Appropriate and safe use of medicines**

The practice did not have reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment did not minimise risks.
- The practice told us that emergency equipment was checked by the lead GP, however we were unable to see evidence that this had been done or recorded on an ongoing basis. The oxygen masks and nebuliser masks we examined did not have an expiry date. A face mask in place inside the emergency bag appeared dirty, looked used, and was not in a sealed bag.
- The practice provided records for six months confirming temperatures from the vaccine fridge had remained within acceptable limits, between 2oC and 8oC. Best practice guidance recommends that a second thermometer or a temperature data logger should be used as a failsafe measure. However, although the practice had a data logger, this was not working and we were told this had not been operational for several days.
- Staff did not prescribe, administer or supply medicines to patients or give advice on medicines in line with current national guidance.
- The practice did not have a system in place to audit prescribing of all prescribers.
- The practice did not audit the prescribing of controlled drugs. The practice had had a significant event in 2015 when a prescription for 2160 Fentanyl patches was issued. The practice had failed to continue monitoring prescribing to ensure this type of incident did not occur again. In addition, we found evidence of inappropriate prescribing of controlled drugs.
- The practice had reviewed its antibiotic prescribing and acted to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was not monitored in relation to the use of medicines and was not followed up on appropriately. Patients were not involved in regular reviews of their medicines. The practice did not have a policy or protocol in place for monitoring patients who had been prescribed high-risk medicines. The lead GP told us that patients who have been prescribed high-risk medicines were dealt with on an individual prescription basis after checking records for monitoring. The practice was not using the patient record system which identified when on patients on high risk medications were due to have blood tests conducted. An alert was observed on a patients' record, highlighting the necessity for blood tests to be undertaken as high-risk medicines were prescribed. However, the required blood tests had not been conducted despite an alert being present.
- We did not see evidence of a system in place regarding patients who had passed the threshold for authorised number of repeat prescriptions. The practice was unable to show us evidence that patients were called in to see a GP for review.
- The practice was unable to demonstrate evidence of an audit trail regarding the management of information and changes to patient's medicines including changes made by other services. The lead GP told us of an incident relating to a patient and a delay that had occurred, in processing a change of a patient's medicine from a hospital letter. Although the practice now ensured post was dealt with daily, we did not see evidence this had been recorded as a significant event to detail what actions had been taken by the practice and that a written policy governing this had been put in place.

**Track record on safety**

Inadequate

# Are services safe?

- The practice did not have a good track record on safety. Issues found had been highlighted at previous inspections, and the practice has been unable to maintain improvement.
- The practice did not use comprehensive risk assessments in relation to safety issues.
- The practice did not monitor and review activity. This led to a lack of understanding of risks and gave an inaccurate picture of safety that did not lead to safety improvements.

**Lessons learned and improvements made**

The practice had limited systems in place to learn and make improvements when things went wrong.

- Staff we spoke with understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so. Although there was a system in place for recording and acting on significant events and incidents, there were limited systems for reviewing and investigating when things went wrong. The practice had limited learning from previous significant events included in the 2015 CQC report, and in relation to one significant event we saw, had not shared lessons with local practices, although latterly had identified they must act on this to improve safety in the practice.
- The practice had recorded two significant events in the past twelve and we saw that these had been investigated and outcomes recorded.
- It was unclear which staff members received safety alerts within the practice, and the practice was unable to demonstrate they had a written policy to refer to and a formal system to act upon those which were relevant to the practice. The lead GP told us there was no system or policy in place to deal with safety alerts. The lead GP stated that both he and the practice manager received safety alerts. However, the practice manager told us that safety alerts were dealt with by the lead GP and we saw evidence of one MHRA safety alert they had noted from March 2018.
- **Please refer to the Evidence Tables for further information.**

Inadequate

# Are services effective?

**At our previous inspection on 17 July 2017, we rated the practice as good for providing effective services.**

**At our follow, up inspection on 24 July 2018 we have new concerns regarding** safe and effective management of patients across all population groups using best practice guidelines; consent; women's health-cervical screening; childhood immunisations; quality improvement/clinical audit; risk assessments; staff training including specific role training and management of the healthcare assistant scope and role; and clinical meetings.

**We have rated the practice as inadequate for providing effective services overall and across all population groups.**

**Effective needs assessment, care and treatment**

The lead GP we spoke with was unable to demonstrate how they assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols. The practice told us the lead GP kept up to date with current evidence-based practice through annual appraisal and educational updates. However, we did not see evidence of an annual appraisal and educational updates were inadequate.

- The practice had failed to ensure that clinical protocols were available for the healthcare assistant (HCA) which outlined the framework for the management of specific clinical situations which had been assessed as within their scope of responsibility. There were no protocols to support these roles including defined circumstances where patients should be referred to a GP for further assessment.
- Patients' immediate and ongoing needs were not fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The lead GP told us he was aware of appropriate tools to assess the level of pain in patients.
- Clinical staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

The practice is rated as inadequate for providing safe and well-led services and for providing effective services, which affects all six population groups. This population group is rated as inadequate overall.

- Older patients who are frail or may be vulnerable did not routinely receive a full assessment of their physical, mental and social needs. The lead GP told us this would be offered on an opportunistic basis. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty.
- The practice followed up on older patients discharged from hospital. However, we did not see evidence of updated care plans and prescriptions to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

The practice is rated as inadequate for providing safe and well-led services and for providing effective services, which affects all six population groups. This population group is rated as inadequate overall.

- Patients with long-term conditions did not have a structured annual review to check their health. The lead GP told us they conducted polypharmacy reviews to ensure the patient's medicines needs were being met, however they do not have a system in place to risk manage this. For patients with the most complex needs, the lead GP did not work collaboratively as part of the multi-disciplinary team with other health and care professionals to deliver a coordinated package of care.
- The practice did not provide evidence that staff who were responsible for reviews of patients with long term conditions had received specific training.
- The lead GP told us that patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma were followed up by the practice nurse. However, we did not see evidence of this and the practice had reduced the practice nurse's hours from one whole day per week to one morning per week, which would severely impact on her capacity to provide the necessary level of care.
- The lead GP told us there was no audit of formal evidence as to whether adults with newly diagnosed cardiovascular disease were routinely offered statins for secondary prevention. People with suspected

hypertension were not routinely offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed opportunistically for stroke risk and treated as appropriate.

- The practice told us there was no current systematic process to demonstrate how patients with commonly undiagnosed conditions are identified, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension. In addition, they told us they did not offer spirometry which would benefit patients with respiratory disease.
- The Quality and Outcomes Framework (QOF) data for 2016/2017 showed that outcomes for patients with long-term conditions, for example diabetes, hypertension, atrial fibrillation and chronic obstructive pulmonary disease were comparable with local and national averages.
- However, the Quality and Outcomes Framework (QOF) practice scores had deteriorated from 81% in 2016/2017 to 71% 2017/2018. The practice shared this information with us on request and the figures for 2017/2018 have not been validated or published to date. The cervical screening rate for the practice showed a significant negative variation at 46%. Despite the low uptake and significant negative variation averages relating to cervical screening, the practice has reduced the practice nurse's hours to one morning per week.

Families, children and young people:

The practice is rated as inadequate for providing safe and well-led services and inadequate for providing effective services, which affects all six population groups. This population group is rated as inadequate overall.

- The practice childhood immunisation rates for 2016/17 show the percentage of children aged one with completed primary course of 5:1 vaccine as being 100% which is above rate set by the World Health Organisation target of 95%.
- However, the uptake rates for childhood immunisation rates for 2016/17 for children aged two years showed a significant negative variation. The practice scores included: PCV 55 %; Hib and Men C 46%; and MMR 55% The national target for England for this age group is 80%. We noted that these childhood immunisation rates had deteriorated from the rates achieved for 2015/16. The administration of childhood immunisations forms an integral part of the practice nurse's role. Despite the childhood immunisation rates being significantly below the national and the deterioration in childhood immunisation rates from the previous year, the practice had reduced the practice nurse's hours from one whole day per week to one morning per week. Poor uptake of childhood immunisations had been a finding at our previous inspections.
- The practice did not provide evidence of safety netting for children. The lead GP told us that he did not hold meetings with health visitors and communication and this was carried out by individual discussion, however the practice was unable to show us any evidence of this or minutes from past meetings.
- The practice did not have arrangements in place for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. The lead GP told us the practice nurse followed up children who failed to attend appointments and for childhood immunisations. However, the practice had recently reduced the practice nurse's hours from one whole day per week to one morning per week which will severely impact on the practice nurse's ability to offer adequate care and capacity to offer appointments.
- The Lead GP told us he referred pregnant and postnatal women to local services to ensure good clinical outcomes in line with best practice guidelines. Best practice guidelines include: vaccinations recommended during pregnancy, folic acid supplements, Vitamin D supplements for breastfeeding mothers, postnatal annual blood testing for women who had gestational diabetes and support. GP's working in primary care are ideally placed to commence high quality pregnancy care, because frequently women will attend the practice to confirm their pregnancy.

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

The practice is rated as inadequate for providing safe and well-led services and for providing effective services, which affects all six population groups. This population group is rated as inadequate overall.

- The practice's uptake for cervical screening was 46%, which was below the CCG average cervical screening rates at 57% and the national average of 72% and below the 80% coverage target for the national screening programme. The most recent achievement cervical

screening uptake rates are dated May 2018, which has become available, was 50%. The data in relation to the uptake of cervical screening in England is provided and published by Public Health England.

- Cervical screening is an integral part of the practice nurse's role. Despite cervical screening rates being significantly below the national target and low cervical screening rates have been a finding of our previous inspections, the practice had recently reduced the practice nurse's hours from one whole day per week to one morning per week which will severely impact on the nurse's ability to offer adequate care and capacity to offer appointments.
- The practice's uptake for breast screening was 51%, CCG average was 59% and the national uptake rate was 70.3%. In relation to bowel screening, the practice uptake rate was 29%, CCG 42.3% and national average was 55%. The lead GP did not provide any evidence of how the practice planned to increase attendance rates and ensure patients attended, wherever possible, for breast and bowel screening.
- The practice did not have systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time because they did not have a significant eligible patient population. Students are at greater risk of developing meningococcal A, B, C, W and Y. These bacteria can cause meningitis and septicemia and can become fatal within hours. Data available from NHS England shows us that the 15-44-year-old age group is the largest patient demographic at Fulham Cross Medical Centre.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. The lead GP told us the practice nurse was the lead professional in relation to conducting health checks. However, we did not see evidence of appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified, because the practice nurse was unavailable for interview. In addition, the practice had reduced the practice nurse's hours from one whole day per week to one morning per week, which would severely impact on her capacity to balance competing demands on her time and to provide adequate care.

People whose circumstances make them vulnerable:

The practice is rated as inadequate for providing safe, effective and well-led services, and good for caring which affects all six population groups. This population group is rated as inadequate overall.

- The lead GP did not provide evidence of arrangements in place for end of life care, and told us this is discussed by individual GP follow up appointments. However, there were no formal care plans to safety net patient care and preferences, and the lead GP was unsure how many patients had died in their preferred place of death. The lead GP did not know how many patients had died last year who had been included on the palliative care QOF register and how many of those patients had a non-cancer condition.
- End of life care was not delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable. The practice did not hold end of life care multi-disciplinary meetings and we did not see evidence of care plans.
- The practice used QOF registers for patients living in vulnerable circumstances including those with a learning disability. The practice did not keep registers for other vulnerable patient groups, for example, homeless people and travellers.
- The practice did not have had a system in place for vaccinating patients with an underlying medical condition according to the recommended schedule, and the lead GP told us this was achieved by individual GP consultation and new patient health checks.

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

The practice is rated as inadequate for providing safe and well-led services and for providing effective services, which affects all six population groups. This population group is rated as inadequate overall.

- The practice did not systematically risk assess and monitor the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. This was conducted by individual GP consultation. When patients failed to attend for administration of long term medication, reception staff referred those patients to an individual GP.

Inadequate

# Are services effective?

- The lead GP told us when patients were assessed to be at risk of suicide or self-harm, that another doctor within the practice had a special interest in mental health. He was unable to provide specific examples to demonstrate the practice had arrangements in place to help them to remain safe.
- 67% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This is statistically comparable to the CCG average 80% and the national average of 84%.
- 73% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This is comparable to the CCG average of 88% and the national average of 90%
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 83% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the CCG average 89% and the national average of 91%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The lead GP told us there was a very low prevalence of people with a learning disability within the practice population of 0.1%. and that the practice offered annual health checks opportunistically.

**Monitoring care and treatment**

There was minimal evidence of quality improvement, including clinical audit, being carried out within the practice. The practice provided an overview of two full cycle audits completed in 2018, which were related to clinical record keeping and cervical screening.

The practice told us they engaged with the local Medicines Optimisation Team to review prescribing but the lead GP told us the practice did not audit prescribers overall, did not audit controlled drugs prescribing and were unable to provide any recent audits undertaken. Data showed that antibiotic prescribing was low and other prescribing was comparable to local and national averages.

The practice did not have a comprehensive programme of quality improvement activity and did not routinely review the effectiveness and appropriateness of the care provided. Clinicians did not take part in any local and national improvement initiatives.

- We saw that QOF achievement for 2016/17 was 81%, compared to the CCG average of 92% and the national average of 96%. We asked the practice to provide us with QOF data for 2018/19, which is yet unpublished and unvalidated, and we saw that QOF achievement had deteriorated to 71%.

**Effective staffing**

Staff did not have the skills, knowledge and experience to carry out their roles.

- Some staff did not have appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews. We did not see evidence of role specific training for staff to enable them to provide good care for patients across all population groups.
- The lead GP had received cervical screening training, however, the practice nurse whose role included immunisation and taking samples for the cervical screening programme had not received specific training and could not demonstrate how they stayed up to date. Childhood immunisations and cervical screening are an integral part of a practice nurse's role.
- The provider did not have an overarching policy related to the scope of the healthcare assistant (HCA) and the roles carried out. This included outlining the framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment.
- We asked the practice for evidence of clinical protocols relating to specific tasks the HCA performed. The practice told us the HCA performed phlebotomy, ECG, blood pressure checks and health checks and submitted copies of two pages of what appears to be a diabetes workshop booklet, relating to the role and scope of the HCA. The practice did not understand that specific protocols must be in place relating to the role and scope of the HCA, and they told us that all practice policies and protocols apply to the healthcare assistant. The practice had no assurance the HCA was only carrying out tasks they were trained and competent to.

Inadequate

# Are services effective?

- The practice did not meet the learning needs of staff although staff told us they were provided with protected time and training to meet their needs. The practice did not maintain up to date records of skills, qualifications and training. We did not see evidence of appropriate systems in place to manage this, although staff told us they were encouraged and given opportunities to develop.
- The practice told us they provided staff with some ongoing support, and that there was an induction programme for new staff, supervision and revalidation. We were unable to see evidence of induction programmes and the practice was unable to provide evidence for six out of 12 staff appraisals. Training records we saw were chaotic and incomplete, and some training was completed by staff immediately prior to and on the day of inspection.
- We did not see evidence of a clear approach for supporting and managing staff when their performance was poor or variable.

**Coordinating care and treatment**

Staff did not work together and with other health and social care professionals to deliver effective care and treatment. The practice told us they did not participate in multi-disciplinary team working, meetings and did not currently share information with the wider healthcare team and other agencies.

- We did not see evidence to show that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice did not share clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They did not provide evidence they shared information with, and liaised, with community services, social services and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- We did not see evidence that patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice did not work with patients to develop personal care plans that were shared with relevant agencies.
- The practice was unable to provide evidence that reassured us end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances. The lead GP was unsure as to any information in this regard.

**Helping patients to live healthier lives**

Staff were not consistent and proactive in helping patients to live healthier lives.

- The practice did not have systematic risk assessment processes in place to identify patients who may need extra support and direct them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- We did not see evidence that staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes. The lead GP told us that he had good awareness of local services and pathways but was unable to cite or show us any examples of referring patients via social signposting. However, a patient who is also a carer told us the practice referred people to the Carer's Centre for support.
- The lead GP told us he discussed changes to care or treatment with patients and their carers as necessary.
- The practice did not show us evidence to demonstrate they supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

**Consent to care and treatment**

The practice did not always deal with consent in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making. However, we did not see evidence that clinicians supported patients to make decisions, or that they had assessed and recorded a patient's mental capacity to make a decision.
- The practice did not have a system in place to monitor the process for seeking consent appropriately.

Inadequate

# Are services effective?

**Please refer to the evidence tables for further information.**

Good

# Are services caring?

**At our previous inspection on 27 July 2017, we rated the practice as good for providing caring services. The practice is now rated as good for caring.**

### Kindness, respect and compassion

We observed staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff we spoke with demonstrated they understood patients' personal, cultural, social and religious needs.
- We received 36 patient Care Quality Commission comment cards, all of which were positive about the service, although six people complained about lengthy waiting times to see the GP in surgery. Patients told us that staff were kind, helpful and caring and they were treated with dignity and respect.
- The practice sought patient feedback through the NHS Friends and Family Test (FFT). Results for the period January 2018 to April 2018, showed that on average 91% of patients would be extremely likely to recommend the service.
- We spoke with three patients during the inspection, who were members of the patient participation group all were positive about their experiences at the practice.

### Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand. For example, a hearing loop was available, patients who first language was not English had access to interpreter services and those with a hearing impairment to British Sign Language (BSL) We saw the practice had designed a cervical smear easy read leaflet with visual cues for women whose first language was not English. The practice was not able to show us evidence this had increased uptake rates.
- Staff helped patients and their carers find further information and access community and advocacy services, for example, signposting them to the Carer's Centre.
- The practice had recorded 17 carers which is less than 1% of the practice population. We did not see evidence of action taken to improve the number of carers identified even though we have raised this at previous inspections.
- Results from the latest national GP patient survey showed patients on the whole responded positively to questions about their involvement in planning and making decisions about their care and treatment. For consultations with GPs, we found that 99% of patients who responded said they had confidence and trust in the GP they saw or spoke with (CCG average 94%; national average 96% and 95% of patients who responded, stated that the last time they saw or spoke to a GP, the GP was good or very good at treating them with care and concern (CCG average 82%; national 86%). For consultations with nurses, we found some responses were in line local and national averages. For example, 100% of patients who responded said that the last time they saw or spoke with a nurse, the nurse was good or very good at treating them with care and concern (CCG average 85%; national average 91%).

### Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect.

**Please refer to the evidence tables for further information.**

Inadequate

# Are services responsive to people's needs?

**At our previous inspection on 17 July 2017, we rated the practice as good for providing responsive services. The practice is now rated as inadequate for providing safe, effective, responsive and well-led services, the issues identified affect all population groups which are rated inadequate.**

The practice told us it organised and delivered services to meet patients' needs, for example it provided extended opening hours. Staff told us they understood the needs and preferences of the local population but had not undertaken any formal analysis or needs assessment.

• The practice engaged a locum practice nurse one day per week to undertake childhood immunisations and the cervical screening programme. Data showed that patient outcomes were below target. Childhood immunisations had been below target at our previous inspection. The practice had decreased its practice nurse availability since our previous inspection.

• The facilities and premises were sufficient for the services delivered.

• The practice did not make reasonable adjustments when patients found it hard to access services.

• Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was not co-ordinated with other services.

**Older people:**

**People with long-term conditions:**

**The practice is rated as inadequate for providing safe, effective and well-led services and good for caring, which affects all six population groups. This**

**population group is rated as inadequate overall.**

- The practice did not conduct systematic risk assessments using a failsafe approach to enable patients with a long-term condition to receive an annual review to check their health and medicines needs were being appropriately met. The lead GP told us this was done on an opportunistic basis.
- The practice did not hold regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

**Families, children and young people:**

**The practice is rated as inadequate for providing safe, effective and well-led services and good for caring, which affects all six population groups. This population group is rated as inadequate overall.**

- We did not find systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- We were not reassured that all parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

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

**The practice is rated as inadequate for providing safe, effective and well-led services and good for caring, which affects all six population groups. This**

**population group is rated as inadequate overall.**

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered extended opening hours on Monday and Tuesday evening until 8.30 pm, on Wednesday evening until 7.30 pm and offered telephone consultations.

**People whose circumstances make them vulnerable:**

The practice is rated as inadequate for providing safe, effective and well-led services and good for caring which affects all six population groups. This population group is rated as inadequate overall.

- The practice used only QOF register of patients living in vulnerable circumstances including those with a learning disability.

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

The practice is rated as inadequate for providing safe, effective and well-led services and good for caring which affects all six population groups. This population group is rated as inadequate overall.

- Staff interviewed did not have a good understanding of how to support patients with mental health needs.

Inadequate

# Are services responsive to people's needs?

- For those patients living with dementia the practice had made some adjustments in relation to become a dementia friendly practice. The practice did not provide evidence that clinical and non-clinical staff had undertaken dementia awareness training.
- The practice did not routinely offer annual health checks to patients with a learning disability, only on an opportunistic basis, as numbers of patients with a learning disability are low at 0.1%.

**Timely access to care and treatment**

Patients could access care and treatment from the practice although sometimes patients experienced delays when attending for appointments.

- Waiting times at the practice were often lengthy as reflected in patient feedback on comments cards and on NHS Choices and Google reviews websites, although staff told us they did inform and apologise to patients for delays. However, we did not see evidence the practice had responded to NHS Choices comments.
- Staff told us they could accommodate most patients with an appointment or telephone consultation. Patients reported that the appointment system was easy to use and they could get appointments when they needed them. However, our inspector observed that patients who called for an appointment were not appropriately managed. Patients were informed by staff there were no appointments available that day and there was no waiting list in place for appointment cancellations. There was no triage of patients undertaken; patients were not asked if they required an urgent appointment or if the patient was experiencing any 'red flag' symptoms. Patients were not offered any appointments within the group of practices in the area. Patients were not signposted to other services, for example, Urgent Care facilities, NHS 111, OOH services.
- Results from the latest national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. For example, 91 % of patients who responded said they could get through easily to the practice by phone CCG average 73% national average 71 % and 87 % of patients responded positively to the overall experience of making an appointment (CCG average 70 national average 73 %.

**Listening and learning from concerns and complaints**

The practice told us they took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff we spoke with demonstrated they would treat patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance.
- The practice had recorded six written complaints in the past 12 months. The practice told us they also recorded verbal complaints but none had been received in this period.
- We reviewed all the complaints and found that they were satisfactorily handled in a timely way. We saw that patients had been contacted and offered face-to-face discussions where appropriate.
- We were told that complaints were discussed in practice meetings and minutes from meetings reflected that complaints were shared with the team.

**Please refer to the evidence tables for further information.**

Inadequate

# Are services well-led?

**At our previous inspection on 17 July 2017 we found that the staffing structure had been strengthened and improvement made following previous inspections had been sustained and further driven. However, there remained areas of weakness in relation to clinical outcomes and clinical leadership capacity.**

**At our follow-up inspection on 24 July 2018 we found the practice did not have clear systems in place to assess, monitor and improve the quality and safety of the service or to mitigate the risks associated with safe care and treatment. The practice leadership did not demonstrate that they had knowledge or capacity to oversee high quality safe care. The practice had failed to address some of the concerns from our previous inspection, had failed to provide notifications and action plans to CQC in line with regulations, failed to sustain improvements made after previous inspections and new concerns were found on the day of the inspection.**

**The practice is now rated as Inadequate for providing well-led services.**

### Leadership capacity and capability

The delivery of high-quality care was not assured by the leadership, capacity, skills, governance or culture at the practice.

- There was a lack of clinical leadership and oversight at the practice. Leaders lacked knowledge about issues and priorities relating to the quality and future of services. Although the practice had previously been rated inadequate and placed into special measures, they were unable to sustain improvements that had been made. They lacked capacity and did not understand the challenges presented and therefore were unable to address them.
- Leaders at all levels were visible and staff felt able to approach them if necessary.
- The practice did not have effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

### Vision and strategy

The practice's mission statement was 'to provide high quality of care and service, delivered by a dedicated team of doctors with the support of a primary care team and wider health professionals to meet the needs of individuals, as well as focusing on continued health promotion and chronic disease management, for better management of health problems and improved outcomes'. We did not see evidence of the practice working with other healthcare professionals in line with their mission statement. The practice manager provided a business plan document, however this had not been shared with any of the practice team.

### Culture

Although practice leaders told us there was a culture to deliver high-quality sustainable care, we found the capacity to prioritise quality improvement was limited, there was a poor track record in terms of maintaining improvement and the practice was reactive rather than proactive.

However, staff we spoke with told us:

- They felt respected, supported and valued and there were positive relationships between staff and the management team. They were happy to work at the practice. They could raise concerns and had confidence that these would be addressed. We saw from training records that staff had received duty of candour and whistleblowing training.
- We saw evidence that only six out of 12 staff had received an appraisal in the last year.
- We did not see evidence from training records that staff had received equality and diversity training.

### Governance arrangements

There were no clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were ineffective. They were not consistently implemented or monitored and there was a lack of day-to-day oversight by the leaders to ensure effective management of safety and risk.
- There was no evidence of regular structured or formalised clinical meetings to demonstrate shared learning. The practice told us that clinical meetings were informal communications and not minuted. We were informed that learning from significant events, patient

safety alerts, clinical guidance and complaints was discussed in clinical and practice meetings, However, they could not provide evidence of this in the absence of meeting minutes.

- There was no formal system to act upon patient safety alerts. The practice could not provide evidence of action taken regarding recent patient safety alerts, for example, patient searches.
- There were gaps in staff training and some training, including role-specific training, had not been undertaken at a level and frequency outlined in its own policy.
- Although staff we spoke with told us they were clear on their roles and responsibilities we found that some delegated responsibility had not been undertaken and there was insufficient management monitoring and oversight of this.

**Managing risks, issues and performance**

There were no clear and effective processes for managing risks or prioritising quality improvement. In particular:

- The practice provided records for six months confirming temperatures from the vaccine fridge had remained within acceptable limits, between 2oC and 8oC. Best practice guidance recommends that a second thermometer or a temperature data logger should be used as a failsafe measure. However, although the practice had a data logger, this was not working and we were told this had not been operational for several days. A second thermometer provides a method of cross-checking the accuracy of the temperature. If a second thermometer is unavailable, the fridge thermometer should be calibrated monthly to confirm accuracy.
- The practice had failed to address all the actions of risk assessments for health and safety and an infection prevention and control audit (IPC). We saw that the practice had completed a Legionella Risk Assessment, and regularly flushed taps and tested water temperatures. However, we noted that hot water had been tested and recorded at 50oC and not the minimum required standard of 55oC required for healthcare premises.
- The arrangements the practice had in place in relation to infection prevention and control (IPC) did not mitigate the risk of infection.
- The practice had failed to maintain an inventory of all medical equipment, and were unable to provide evidence that all medical equipment had been calibrated in line with guidance. The practice was unable to evidence when the equipment belonging to long term locum GPs was last calibrated in line with guidance.
- The practice had failed to ensure that clinical protocols were available for healthcare assistant's (HCA)'s outlining the framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment.
- There was minimal evidence of quality improvement, including clinical audit, being carried out within the practice. The practice provided two full cycle audits from 2018, one of which related to performance review of poor record keeping. in relation to the lead GP. The second audit was an internal review of overall cervical screening rates. The lead GP told us that there had been no recent formalised clinical audits undertaken.
- The practice had a business continuity plan and emergency equipment and medicines were available.
- Clinicians we spoke with knew how to identify and manage patients with severe infections including sepsis. However, there was no red flag symptoms protocol, non-clinical staff were unable to demonstrate an understanding of red flag symptoms and how to respond and managers confirmed there had been no formal training.
- The provider had failed to take action following our previous inspections when we noted low number of carers had been identified, which had decreased from 21 carers to 17 carers since our last inspection.

**Appropriate and accurate information**

We found the information used in reporting, performance management and delivering quality care was not always accurate, valid, reliable, timely or relevant. Leaders and staff did not always receive information to enable them to challenge and improve performance. For example, concerns identified in 2014 regarding change of registration

Inadequate

# Are services well-led?

status from being a single provider to a partnership had not been actioned, and staff responsible for making statutory CQC notifications had not done so within required timescales.

**Engagement with patients, the public, staff and external partners**

The practice told us it gathered feedback from patients through the NHS Friends and Family Test (FFT), NHS choices comments, comments and complaints received directly and its patient participation group (PPG). We spoke with three members of the PPG at the inspection, who told us they met regularly. From the FFT, when asked how likely they were to recommend their GP practice to friends and family if they needed similar care or treatment, patients said: January 2018 93%; February 2018 95%; March 2018 86%; and April 2018 88%. Staff we spoke with told us they would not hesitate to give feedback and discuss any concerns they had. Six staff out of 12 had received an annual appraisal.

**Continuous improvement and innovation**

There is little innovation or service development. The clinical and non-clinical leaders could not demonstrate that improvement was a priority as the practice had failed to sustain improvements made following previous inspections, which included a failure to comply with CQC notification regulations. There was minimal evidence of learning and reflective practice.

**Please refer to the evidence tables for further information.**

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**The practice did not have clear systems to keep people safe and safeguarded from abuse:**<br>• The provider had failed to provide evidence of current medical indemnity insurance for all clinical staff.<br>• The provider had failed to ensure that comprehensive risk assessment systems were put in place across all population groups, in line with best practice guidance.<br>• The provider had failed to ensure that patients with Long-Term Conditions or are regarded as being high risk, had been comprehensively risk assessed and their care had been safely managed.<br>• The provider had failed to provide assurance that the cold chain had been safely managed.<br>• The provider had failed to provide a fail-safe system in relation to safeguarding vulnerable adults and children.<br>• The provider had failed to provide adequate GP and nursing capacity to safely meet patient's needs.<br>• The provider had failed to ensure that prescribers within the practice and ensure that a regular planned programme of audit in relation to prescribers at the practice, is in place that meets with best practice guidance.<br>• The provider had failed to provide safe management of prescribing including controlled drugs and high risk medicines.<br>• The provider had failed to implement a safe system of appropriate triaging, prioritising and 'red flag' screening of patients who requested an appointment, and that staff were trained to deliver this.<br>• The provider had failed to mitigate the risk of infection and to provide a safe and effective approach to IPC including water testing relating to Legionella.<br>• The provider had failed to ensure premises and equipment are adequately risk assessed and maintained in accordance with the latest guidance. |

This section is primarily information for the provider

# Requirement notices

- The provider had failed to provide a system to ensure that all patients who have abnormal test results are safely managed.
- The provider had failed to provide safe recruitment processes.
- The provider had failed to ensure that clinical protocols were available for healthcare assistants outlining the framework for the management of specific clinical situations or definition of circumstances where patients should be referred to a GP for further assessment.

**This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Maternity and midwifery services<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br><br>**There was a lack of systems and processes established and operated effectively to ensure compliance with requirements to demonstrate good governance. In particular we found:**<br><br>• The provider had failed to significantly strengthen and sustain clinical leadership and oversight arrangements.<br>• The provider had failed to provide a failsafe system in respect of patient safety alerts.<br>• The provider had failed to ensure that all staff employed by the practice are appropriately trained and competent for the roles they perform.<br>• There was little evidence of quality improvement, including clinical audit being carried out within the practice.<br>• There were gaps in staff training and some training, including role-specific training, had not been undertaken at a level and frequency outlined in its own policy. There was no formal strategy and business plan written in line with health and social priorities of the area or to meet the needs of the practice population.<br>• There was no evidence of structured clinical meetings to demonstrate shared learning. |

This section is primarily information for the provider

# Requirement notices

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.