Custom House Medical, Teaching and Training Practice

Quality Report

Custom House Medical, Teaching and Training Practice,
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Inadequate
Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This practice is rated as Inadequate overall. (Previous inspection 14 December 2016 – Requires improvement)

The key questions are rated as:

Are services safe? – Inadequate

Are services effective? – Inadequate

Are services caring? – Inadequate

Are services responsive? – Inadequate

Are services well-led? – Inadequate

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

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

We carried out an announced comprehensive inspection at Custom House Medical, Teaching and Training Practice on 23 January 2018. We inspected the provider as part of our inspection programme to follow up on areas we found the practice should improve at our previous inspection 14 December 2016.

At this inspection we found:

- The practice had experienced significant changes in staffing , including practice management and a high turnover of GPs.
- Premises improvement works were underway.
- A broad range of clinical and patient satisfaction performance indicators were below local and national averages.
- Risks to patients were not always assessed and well managed including premises, equipment, fire safety and infection control.
- There were gaps in staff training and recruitment checks including safeguarding and references checks for clinical staff.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance.
- Information about services and how to complain was available and easy to understand but limited improvement was made to the quality of care in response to concerns.

Summary of findings

- The practice did not have effective governance systems to ensure effective management of significant events and safety alerts, but was aware of and complied with the requirements of the duty of candour.

The areas of practice where the provider **must** make improvements are:

- Ensure care and treatment is provided in a safe way to patients.
- Ensure all premises and equipment used by the service provider are fit for use.
- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.
- Ensure persons employed in the provision of the regulated activity receive the appropriate support, training, professional development, supervision and appraisal necessary to enable them to carry out the duties.
- Ensure recruitment procedures are established and operated effectively to ensure only fit and proper persons are employed.

The areas where the provider **should** make improvements are:

- Review arrangements for recording clinical audits.
- Review arrangements for responding to patient feedback.

I am placing this service in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The 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 the 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

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people	**Inadequate**
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**

Custom House Medical, Teaching and Training Practice

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 adviser and a practice manager specialist adviser.

Background to Custom House Medical, Teaching and Training Practice

Custom House Medical, Teaching and Training Practice is situated within NHS Newham Clinical Commissioning Group (CCG) and we visited the premises as part of our inspection. The practice provides services to approximately 10,300 patients under a Personal Medical Services (PMS) contract and has a website www.customhousesurgery.com .

The staff team at includes two GP partners (one female working seven sessions and one male working nine sessions per week), two salaried GPs (one female working six sessions and one male working eight sessions per week), three locum GPs (two female and one male collectively working ten sessions per week), a male clinical pharmacist working six sessions per week, an female advanced nurse practitioner working ten sessions per week, two female practice nurses (one working 31 hours and the other 23 hours per week), a full time female healthcare assistant, and a counsellor working eight hours per week. Non-clinical staff include a part time business manager, a part time patient liaison manager, a full time practice manager, and a team of reception and administrative staff working a mixture of hours. The practice provides teaching for medical students and training for qualified GPs.

The practices' opening hours are 8am to 6.30pm Monday to Friday. GP and practice nurse appointments are available Monday to Friday 8am to 6.30pm. Appointments include home visits, telephone consultations and online pre-bookable appointments and urgent appointments are available for patients who need them. Extended hours are not provided but are available through the Newham GP Co-op service every weekday from 6.30pm to 10pm, and Saturday and Sunday from 8am to 8pm. Patients telephoning when the practice is closed are transferred automatically to the local out-of-hours service provider. The practice closes its doors on the last Thursday of each month to undertake practice meetings, during this time the local GP Co-op service takes over the phones, however the emergency mobile remains available to assist with home visits.

The Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. The practice area has a relatively high population of people whose working status is unemployed at 11% compared to

Detailed findings

4% nationally, and a lower percentage of people over 65 years of age at 7% compared to 17% nationally. The local ethnicity demographic is approximately White 43%, Mixed race 6%, Asian 19%, Black 28%, Other race 4%.

The practice is registered with the Care Quality Commission to carry on the regulated activities of family planning services, treatment of disease, disorder or injury, surgical procedures and diagnostic and screening procedures. The practice is also carrying out maternity and midwifery services but was not registered with the CQC to undertake this regulated activity as is legally required and had not kept its CQC Registered manager requirements up to date. We also found the provider was registered to undertake surgical procedures but was no longer doing so and needed to deregister accordingly. We notified the provider of its duty to register correctly at the beginning of this inspection process.

Inadequate

Are services safe?

Our findings

At our previous inspection on 14 December 2016 we found an out of date vial of medicine and recommended the practice ensure the proper and safe management of medicines. The practice was rated as good overall for providing safe services.

At this inspection on 23 January 2018 we rated the practice, and all of the population groups, as inadequate for providing safe services due to multiple concerns including: management of significant events, safety alerts, safety risk assessments and processes, staff safety training and checks including recruitment, safeguarding, equipment safety, emergency equipment and medicines, risk assessments undertaken and appropriate follow up, fire safety and infection control.

Safety systems and processes

There were inadequate systems in place to keep patients safe and safeguarded from abuse.

- The practice had some safety risk assessments and policies such as infection control and legionella but some were incomplete such as infection control, or missing such as a fire risk assessment. There was no evidence staff received safety information for the practice as part of their induction but most staff had subsequently received the majority of relevant training.
- There were weaknesses in systems to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff but overdue a year for review with some contact details of who to go to for further guidance missing or out of date. For example, the safeguarding adult's policy did not have relevant persons or contact details including the nominated practice GP lead. There were three vulnerable adults on the practice system but only one had a system alert to inform staff. Contact details on the child safeguarding policy were also out of date. The practice system generated list of 23 protected children which was different to the out of date paper copy the lead GP was using.
- There were gaps or insufficiencies in clinical and non-clinical staff safeguarding training. For example, there was no evidence of child or adult safeguarding training for a GP. A practice nurse had Level 1 child safeguarding training (which should be level 2) and there was no evidence of adult safeguarding training for a practice nurse and member of non-clinical staff. The practice training records matrix did not accurately reflect training certificates or evidence found. Filing systems were not maintained or organised to evidence staff training. Staff we spoke to were aware of what would constitute a safeguarding concern and who the practice safeguarding lead GP was but there was no method to ensure safeguarding was discussed at clinical or practice meetings.
- There was evidence the practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out some staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required including for non-clinical staff undertaking chaperoning duties, but a DBS risk assessment consideration for non-clinical staff was not included in the practice recruitment protocol. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). There were no references checks for a recently employed salaried GP or arrangements to assess or regularly review the immunisation status of relevant staff in line with immunisation against infectious diseases requirements.
- Arrangements to manage infection prevention and control were variable. For example, an infection control audit undertaken by an external infection control professional in 2016 identified several requirements such as replacement of taps and appropriate arrangements for sharps bins. Work to replace taps was underway and sharps bins had been stored correctly. However a sharps bin was unlabelled in a treatment room and the sharps, needle stick and splashing injuries protocol contact details were out of date and had no date for review. The clinical waste bin was locked but not secured and was in a publicly accessible area outside the practice. Clinical equipment such as the ear irrigator and nebuliser were visibly clean but systems to ensure they remained clean were either not in place or informed by levels of usage to determine cleaning frequency. For example, there were no arrangements for

cleaning of the nebuliser and records showed the ear irrigator was cleaned monthly, but practice nursing staff estimated the ear irrigator would be used about 26 times per week which would be over a hundred times between cleaning which had not been assessed. All single use equipment such as nebuliser mouthpieces was disposable. The most recent infection and prevention audit dated October 2017 had been undertaken by practice staff but it was incomplete.

- The premises cleaning schedule did not include each room so it was not possible to track which areas had been cleaned and when. The practice was mostly visibly clean except for the patient toilet which was dirty on the day of inspection. Three patient's feedback indicated the patient toilet was dirty at times. We noted the patient toilet floor that appeared grimy was imminently due to be replaced as part of planned works by the end of February 2018.
- The practice had generally ensured that facilities were safe but we could not verify equipment was safe or maintained according to manufacturers' instructions. For example, several items had no sticker to indicate an electrical safety or calibration check had been carried out recently or at all; including baby scales, blood pressure monitoring machines, examination lamps and IT equipment. We asked staff how they ensured all items were checked and they showed us evidence for individual items being checked. However, there was no inventory or other system to ensure all equipment was safety checked as required.

Risks to patients

Systems to assess, monitor and manage risks to patient safety were not always effective.

- Some important safety signage in the practice was blank such as action to take in the event of fire and to indicate the nominated responsible safety manager. We noted some of this was completed on the day of inspection. There was no evidence of a fire risk assessment undertaken at any time or plan for this to be undertaken which was in breach of the practices own fire safety policy. A fire risk assessment had been specifically recommended by fire contractors that had attended to maintain fire extinguishers during October 2017. There were gaps in fire safety training and no practice fire practice drills had been undertaken, although the fire alarm was tested weekly and the designated lead was a trained fire marshall.
- There was no system to assess day to day risks in the building and we found a broken chair that came apart when lifted in the reception area, and the patient toilet seat and taps were broken as well as torn flooring. There were no caution or out of use signs posted. We saw a plan of improvement work was underway to improve access for wheelchair users and make necessary repairs including to flooring, toilets, sinks and taps by the end of February 2018. We also noted one of the examination couches had a transparent leaflet shelf mounted directly above it on the wall which posed a risk of accident or injury.
- There were out of date blood glucose kits stored in a staff area that expired 2016 and 2017 alongside others that were in date. There were also disposable clinical items that were no longer in use in a storage cupboard. There were no arrangements or plans to clear out old stock but all disposable items we checked in clinical areas were in date.
- The offer of a chaperone was not indicated by signage in the reception area. Relevant signage was in clinical rooms but staff did not always record whether a chaperone had been offered to patients. We checked the chaperone policy that was last reviewed in 2016 and stated the offer of a chaperone should be recorded on a patients noted including when declined.
- There were arrangements for planning and monitoring the number and mix of staff needed. We noted the practice had recently recruited permanent salaried GPs and intended to recruit more to further address this issue.
- There were induction templates for temporary staff tailored to their role that had not been completed, but staff had received initial orientation which included practice IT systems. Most staff had subsequently received relevant training but some gaps remained including fire and safeguarding training, and in role specific training such as wound care.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. However, one of the two defibrillators was subject to a safety alert that had not been acted upon, therefore it was unclear whether the defibrillator was safe and fit for use, and its pads

were out of date. There were no formal arrangements to ensure the defibrillators were in working order although staff told us they were checked regularly. The second defibrillator was fit for use and had in date pads. Emergency oxygen was satisfactory and appropriate checks were in place.
- Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

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

- The practice kept prescription stationery securely and monitored its use.
- Systems for managing vaccines minimised risks.
- Most emergency medicines were available with the exception of hydrocortisone for injection which is used for anaphylaxis (allergic reaction). There was a checklist to ensure emergency medicines were in place and remained fit for use but it was not clear enough to use effectively because it contained a mixture of brand names and medicines names. This meant there was room for confusion or error as some medicines such as injectable benzyl penicillin could not be easily found by staff including for use in the event of an emergency.
- Data showed there was good antimicrobial stewardship at the practice; however, there was no evidence clinicians had audited antimicrobial prescribing. One of the practice nurses was a prescriber and routinely prescribed antibiotics as well as adjusting medicines for patients with diabetes, but there was no system or process to audit their work for quality and safety purposes. There was no evidence in the relevant nurse's file that they had completed training as a prescribed or that that they attended regular updates.
- Staff generally prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. However, patients' health was not routinely monitored to ensure medicines were being used safely and followed up on appropriately. There was no formal process for obtaining relevant test results to monitor patients prescribed high risk medicines. We checked several patient records and found some blood tests were overdue.

Track record on safety

- There were gaps in arrangements for safety risk assessments.
- The practice did not routinely or consistently monitor and review activity to understand risks and gain a clear, accurate and current picture to deliver safety improvements.

Lessons learned and improvements made

There was variable learning and improvement when things went wrong.

- There was a system for recording and acting on significant events. Staff understood their duty to raise concerns and report incidents and near misses and leaders and managers supported them when they did so. However, significant events reporting forms were mostly incomplete. Systems for reviewing and investigating when things went wrong were not consistently implemented; there was no meeting structure to ensure significant events were discussed at staff meetings. There was inadequate detail in the recording of the event, a lack of root cause analysis, and no evidence of lessons being shared and themes identified with actions taken to improve safety in the practice.
- We found evidence of the practice fulfilling its duty of candour and some limited evidence of effective follow up for significant event. For example, after a patients consultant recommended a medicine for them to take which was different to the usual way the medicine is prescribed, but the GP missed this details and prescribed the medicine in the usual way. No harm

came to the patient and the practice telephoned the patient to apologise and cover the cost of a new prescription in line with the consultants' advice. However, there was no evidence staff met to discuss and analyse this incident or of actions to prevent recurrence.

- There was a system for receiving and acting on safety alerts but it was not always effective. Staff told us GPs had delegated lead areas for receiving and acting on safety alerts but this was not formalised and there was no clear method to ensure alerts follow up. We checked the practice protocol dated 2016 that had not been reviewed or approved; it stated a previous managers email address would receive the alerts that would be monitored and actioned by two further non-clinical staff. A safety alert for one of the defibrillators had not been acted upon.
- A member of management staff told us they had followed up on an alert for pregnant patients taking a specific medicine. We checked patient records and there was no evidence a systematic review had been undertaken; however, patients in scope had the medicine reviewed at some point, none were at risk of harm, and the practice had implemented a popup alert for clinicians in the event they attempted to prescribe the medicine.

Inadequate

Are services effective?

(for example, treatment is effective)

Our findings

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

At our previous inspection on 14 December 2016 we rated the practice as requires improvement for providing effective services as data from the Quality and Outcomes Framework (QOF) showed patient outcomes were lower in certain areas compared to the national average, including diabetes and mental health. We recommended the practice improve its QOF performance, particularly for long term conditions.

Arrangements had not sufficiently improved and new concerns were identified when we undertook this follow up inspection on 23 January 2018. Consequently, the practice is rated as inadequate for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were 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.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice used a patient information board in the reception area and arranged email consultations for certain groups of patients, such as housebound patients or their carers seeking advice on a straightforward issues which did not require a consultation.
- The practice remained an outlier for some of its diabetes and mental health QOF targets. The practice was not an outlier for any other QOF (or other national) clinical targets. (QOF is a system intended to improve the quality of general practice and reward good practice).

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan. Over a 12 month period the practice carried out 103 health checks for older people.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changing needs.

People with long-term conditions:

At our previous inspection on 14 December 2016, performance data for diabetes showed patient outcomes were below the national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 68% against the national average of 88%.

At this inspection 23 January 2018:

- Performance data for diabetes remained below national averages, although there was some evidence of improvement since our previous inspection. The percentage of patients with diabetes, on the register, in whom the last IFCC HbA1c (blood sugar level) was 64 mmol/mol or less in the preceding 12 months was significantly below average at 58%, compared to the CCG average of 74% and the national average of 80%. Overall exception reporting for diabetes was 8% compared to 7% in the CCG and 11% nationally. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects)
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months had increased to 85% compared to the CCG average of 92% and the national average of 89%.
- The percentage of patients with diabetes whose last measured total cholesterol was 5 mmol/l or less was below average at 66% compared to 80% within the CCG and 80% nationally.

Inadequate

Are services effective?

(for example, treatment is effective)

- The percentage of patients with hypertension having regular blood pressure tests was 81% compared to the CCG average of 83% and the national average of 83%.
- The percentage of patients with Chronic Obstructive Pulmonary Disease (COPD) who had a review undertaken including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months was 92% compared to the CCG average of 94% and the national average of 90%
- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care. However, patients in this population group did not have care plans where needed to best help them understand and manage aspects of their care independently, such as diet and exercise. Clinical staff showed us a previous template for a patient with diabetes but it was no longer in use. There were appropriate consultation notes on the patient record including lifestyle advice but this was not something patients could refer to as needed, and did not serve as a care plan.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90%.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.

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

- The practice's coverage for the cervical screening programme was 71%, compared to the CCG average of 64% and the national average of 72%. This was not in line with the 80% coverage target for the national screening programme.
- There were no effective failsafe systems for patient's cervical screening (women's smear tests) to ensure samples sent had been received and screened by the laboratory. We found no evidence of patient harm but asked to see relevant protocols. There were three separate protocols covering the smears process but they were not implemented or had weaknesses. For example, one protocol was for smear follow ups dated 2004 but no action had been taken to ensure results were received for all samples sent. Another protocol was dated 2009 and stated sample takers inadequate smear rates audits would be undertaken annually, the practice had undertaken cervical screening audits in 2015 and 2016 but no audit was undertaken in 2017. The third protocol was for informing patients of test results and was dated 2007. None of the protocols had a date for review.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. Palliative care plans were in place for patients at the end of life.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had 19 patients on the register with a learning disability, 17 (89%) of these patients had received an annual health check in the last 12 months.

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

At our previous inspection on 14 December 2016 performance for mental health related indicators was below the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan was 53% against the national average of 88%.

At this inspection 23 January 2018:

- Performance for mental health had improved but some elements remained below national averages. For example 75% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was below the CCG average of 89% and the national average of 90%. Overall exception

reporting for mental health was 4% compared to 6% in the CCG and 11% nationally. Overall exception reporting for depression was 38% compared to 26% in the CCG and 23% nationally.

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months. This was comparable to the CCG average of 85% and the national average of 84%
- The practice considered the physical health needs of patients including those with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption was 86% compared to CCG 92% in the CC and 91% nationally; and the percentage of patients experiencing poor physical or mental health who had received discussion and advice about smoking cessation was 95% compared to 97% in the CCG and 95% nationally.

Monitoring care and treatment

There was some evidence that clinical quality improvement activity was being undertaken to review the effectiveness and appropriateness of the care provided, although outcomes could not always be clearly ascertained.

The most recent published Quality Outcome Framework (QOF) results were 94% of the total number of points available compared with the clinical commissioning group (CCG) average of 95% and national average of 97%. The overall exception reporting rate was 8% compared with the CCG average of 7% and national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate).

- The practice used information about care and treatment to make improvements such as best practice guidelines.
- The practice was involved in quality improvement activity and had undertaken two clinical audits. Both of these were completed audit cycles but the outcomes were not always clearly recorded. For example, the practice undertook a completed audit for women with a gynaecological condition that may be associated with abnormal blood sugar or cholesterol levels. The audit was to ensure clinical care was in line with The Royal College of Obstetricians and Gynaecologists (RCOG) best practice guidelines. In the first cycle, it was unclear how many patients were included in the audit but 29% had a blood test to establish blood sugar levels. Clinicians refreshed on best practice guidelines and reviewed patients care and in the second cycle where 108 patients were audited, the number of patients that had a blood sugar test had increased to 64%. This audit also appeared to show improvement in rates of patient's cholesterol testing but this could not be precisely ascertained.
- The second audit was for patients with depression to ensure treatment in line with National Institute for Clinical Excellence (NICE) guidelines. The process was similar to the audit described above and delivered a 28% improvement in patients degree of depression being assessed using an approved clinical tool, a 65% improvement in patients having their risk of suicide assessed, a 10% improvement in patients having their medicines reviewed or offered, and a 32% increase in patients offered counselling.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, Newham has the highest level of tuberculosis (TB) in the country and the practice took part in a CCG funded research project which screens and treats patients for latent TB.

Effective staffing

Staff generally had the skills, knowledge and experience to carry out their roles.

- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- Relevant nursing staff had not received specific wound care training which was part of their role. We found no evidence of an induction process for healthcare assistants including the requirements of the Care Certificate.
- The practice understood the learning needs of staff but had not always provided protected time and training to meet them.
- Records of skills, qualifications and training were not maintained or organised. Staff were encouraged to develop but opportunities were limited as no protected time was given.

Inadequate

Are services effective?

(for example, treatment is effective)

- The practice did not always provide staff with ongoing support. An induction procedure was not formalised and there was no evidence of one-to-one meetings for clinical supervision. All staff had received an appraisal and clinicians were registered with relevant bodies such as the GMC and NMC. Revalidation arrangements were in place.
- The practice had not ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- 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 ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were generally proactive in helping patients to live healthier lives.

- The practice generally identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives and patients at risk of developing a long-term condition. However, systems to identify carers were not clear and the practice had not coded carers correctly on its computer system.
- Staff encouraged and supported patients to be involved in monitoring and managing their health and discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example tackling obesity. Smoking cessation services were delivered by a local pharmacist.

Consent to care and treatment

The practice had not always obtained consent to care and treatment in line with legislation and guidance.

- Not all clinicians understood the requirements of legislation and guidance when considering consent and decision making. Relevant nursing staff told us they had not received training on the Mental Capacity Act 2005 which is applicable to their role. We found these staff did not always understand how to assess mental capacity appropriately. For example, how to make a preliminary first hand assessment of a patients mental capacity where applicable.
- We checked nursing consultation records that included a patient with an examination in an intimate area and a cervical screening test and they did not have a record of patient consent or offer of chaperone.
- GPs had generally assessed and recorded a patient's mental capacity to make a decision. However, systems to obtain and record patients consent were not consistently in place. For example, the electronic template for patients having a COIL fitted did not include the question of consent but were unable to verify whether this was sought and recorded as relevant staff were off duty.
- There was no monitoring the process for seeking consent appropriately.

Inadequate

Are services caring?

Our findings

We rated the practice, and all of the population groups, as inadequate for caring.

At our previous inspection on 14 December 2016, we noted patients expressed concerns about the appointment system. The practice had changed its appointment system in October 2016 but no surveys had been undertaken to monitor patient satisfaction rates. The practice's achievement was below the CCG and national averages for its satisfaction scores on consultations with GPs and nurses. The practice was rated as good overall for providing caring services at its previous inspection and we recommended it should improve GP patient survey results to ensure better patient satisfaction.

Arrangements had not sufficiently improved, and in some cases worsened when we undertook this follow up inspection on 23 January 2018. No effective action had been taken to improve the current low performing areas. The practice is rated as inadequate for providing caring services.

Kindness, respect and compassion

We observed staff treated patients with kindness, respect and compassion on the day of our inspection; but patient's feedback did not always indicate this was the case.

- Staff we spoke with understood patients' personal, cultural, social and religious needs.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. However, there were CCTV cameras installed around the practice including one that was pointing directly at an examination couch. All cameras were unplugged and staff told us they were out of use, but this was not clear and there was no related signage to assure patients of their privacy.
- 27 of the 42 patient Care Quality Commission comment cards we received were entirely positive about the service experienced, 12 were mixed and three negative. Themes in the mixed and negative cards predominantly related to getting an appointment. There were also concerns expressed regarding premises maintenance, access, cleanliness and staff attitude. However, we noted premises improvements were underway and the majority of patients said that staff were caring, helpful and kind. We also observed reception staff managing some challenging patient situations compassionately and professionally.
- The results of the practice NHS Friends and Family Test (FFT) from October 2017 to December 2017 inclusive showed an average of 77% of patients would recommend the practice.

Results from the July 2017 annual national GP patient survey showed the practice was below average for patients feeling they were treated with compassion, dignity and respect. Three hundred and fifty six surveys were sent out and 93 were returned. This represented about 1% of the practice population. The practice was below average for its satisfaction scores on all measures including consultations with GPs and nurses and results had worsened since our previous inspection. For example:

- 69% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 82% and the national average of 89%. This result was 79% at our previous inspection.
- 65% of patients who responded said the GP gave them enough time; CCG - 78%; national average - 86%. (74% at our previous inspection).
- 75% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 91%; national average - 96%. (90% at our previous inspection).
- 63% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 77%; national average - 86%. (72% at our previous inspection).
- 75% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 81%; national average - 91%. (76% at our previous inspection).
- 71% of patients who responded said they found the receptionists at the practice helpful; CCG - 78%; national average - 87%. (77% at our previous inspection).

Further data we did not report on at our previous inspection also showed the practice was below average:

- 77% of patients who responded said the nurse was good at listening to them; (CCG) - 83%; national average - 91%.

- 74% of patients who responded said the nurse gave them enough time; CCG - 83%; national average - 92%.
- 90% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 92%; national average - 97%.

Staff at the practice were not aware of the below average and deteriorating scores, but told us several longstanding clinicians had left and there had been a turnover of locum staff which they felt had impacted on these scores. However, no effective action had been taken to improve.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care but were not aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. There were no notices in the reception area to indicate this service was available or in languages other than English.
- We observed staff communicated with patients in a way that they could understand, but staff were not aware there was a hearing loop for deaf or hard of hearing patients. During the inspection it was identified the hearing loop was broken.
- Easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services.

There was no clear method to proactively identify patients who were carers and the practice's computer system did not alert staff to all carers. There were 15 carers identified through a search on the practice computer system, but 39 showing on its registration list because the practice had not coded all carers on its computer system. The highest search number of 39 patients identified as carers was less than 1% of the practice list which is low and there were no specific ways the practice supported carers.

- Staff told us that if families had experienced bereavement, a GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Results from the national GP patient survey showed patients scored the practice as below average regarding patient involvement in planning and making decisions about their care and treatment. These results had also worsened since our previous inspection:

- 67% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 79% and the national average of 86%.
- 62% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 74%; national average - 82%.
- 74% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 81%; national average - 90%.
- 67% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 77%; national average - 85%.

The GP Patient survey data we refer to was published in July 2017 and corresponds to the period 1 January 2017 to 31 March 2017 which was soon after our previous inspection. However, this issue was highlighted at our previous inspection and the practice remained unaware of the data and had not taken any action to improve the satisfaction scores.

Privacy and dignity

The practice did not always respect and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice did not comply with the Data Protection Act 1998 because patient's paper notes were accessible in an unsecured reception area that was unstaffed and accessible to patients in the evening.
- Some staff had not entered into a confidentiality agreement including a member of management staff and a GP.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as inadequate for providing responsive services across all population groups.

At our previous inspection on 14 December 2016, we rated the practice as requires improvement for providing responsive services as results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was below local and national averages. The practice had made efforts to improve its appointment system prior to our previous inspection; however, we recommended it further improve in this area.

Arrangements had not sufficiently improved when we undertook this follow up inspection on 23 January 2018. The practice is rated as inadequate for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example by providing in house wound care, phlebotomy (blood tests), stoma care, and ECG (electrocardiogram) and 24hr ECG heart monitoring.
- The facilities and premises were not entirely appropriate for the services delivered such as flooring and taps that needed replacing but premises improvements were underway and due to be completed by early February 2018.
- The practice made some reasonable adjustments when patients found it hard to access services for example wheelchair access.
- The practice arranged email consultations for certain groups of patients, such as housebound patients or their carers seeking advice on a straightforward questions not requiring a consultation.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- Patients had a named GP who supported them in whatever setting they lived, whether it was at home or a supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met, but were not issued with a care plan where appropriate. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- The practice ran a GP and practice nurse specialist diabetes clinic twice weekly and a chronic disease management GP led clinic weekly.
- The practice pharmacist ran a weekly Chronic Obstructive Pulmonary Disease (COPD) review clinic.

Families, children and young people:

- There were no systems 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.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The practice ran a weekly GP led walk in young person's clinic for those aged 13 to 19 years, and weekly GP led family planning and well women's clinics.
- The practice undertook post-natal and ante natal checks but the provider was not registered to undertake this activity.

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

- The practice was aware of the needs of this population group and provided online services such as repeat prescription requests and advanced booking of appointments.

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

- Extended hours appointments were through the Newham GP Co-op service every weekday from 6.30pm to 10pm, and Saturday and Sunday from 8am to 8pm.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice ran a controlled drugs clinic for patients dependent on specific medicines such as opiates.

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

- Staff interviewed generally had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice ran a weekly GP led mental health clinic and employed its own counsellor that provided clinics all day Friday. Patients who failed to attend were proactively followed up by a phone call from a GP.

Timely access to the service

Patient feedback indicated patients were not always able to access care and treatment within an acceptable timescale for their needs.

- The practice had a website which offered online appointment booking and prescription requests through the online national patient access system.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use but data showed it was not sufficiently accessible.
- Patients had access to initial assessment, test results, diagnosis and treatment.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was below local and national averages. This was supported by completed CQC patient comment cards.

- 56% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 75% and the national average of 80%. This result had worsened from 69% at our previous inspection.
- 28% of patients who responded said they could get through easily to the practice by phone compared with the CCG average of 56% and the national average of 71%. This result had improved from 22% since our previous inspection.
- 54% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 64% and the national average of 76%.
- 52% of patients who responded said their last appointment was convenient compared with the CCG average of 67% and the national average of 81%.
- 43% of patients who responded described their experience of making an appointment as good compared with the CCG average of 61% and the national average of 73%.
- 37% of patients who responded said they don't normally have to wait too long to be seen compared with the CCG average of 41% and the national average of 58%.

Practice staff such as nurses and doctors were not aware of this data. There were no effective actions or developments to improve satisfaction scores since our previous inspection, or plans to improve.

Listening and learning from concerns and complaints

The practice took formal written complaints and concerns seriously and responded to them appropriately to improve the quality of care. However, patient feedback was not always used to inform and deliver improvement.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made formal complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. We reviewed two of nine formal complaints received in the last 12 months and found these were dealt with satisfactorily in a timely way, and with openness when dealing with the complaint.

There was evidence the practice learned lessons from individual complaints and acted as a result to improve the

Inadequate

Are services responsive to people's needs?

(for example, to feedback?)

quality of care. For example, after a complaint regarding a prescription delay. The practice contacted the patient to apologise and explain it would be reviewing its policy. Following the complaint the practice changed its internal arrangements with the local pharmacist to deal with prescription queries more effectively. However, other sources of patient's feedback not been collected and themes in expressed concerns had not been acted upon. For example, no independent surveys had been undertaken and we looked at the practice NHS Choices feedback which averaged 1.5 starts out of a possible five stars. Themes of concerns included patient's access to appointments.

Are services well-led?

Inadequate

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

Our findings

We rated the practice as inadequate for providing a well-led service.

At our previous inspection on 14 December 2016, we noted below average QOF performance and GP Patient survey results but actions to make improvements had been taken. We rated the practice as good for providing well-led services.

At this inspection 23 January 2018, QOF performance and GP Patient survey results had not sufficiently improved, some elements had worsened and new risks and concerns were identified. The practice is now rated as inadequate for providing well-led services.

Leadership capacity and capability

The leaders did not have the capacity and skills to deliver high-quality care.

- Leader's knowledge about issues and priorities relating to the quality of services was variable. There was an awareness of low QOF performance in some areas but GP Patient Survey results had not been responded to and there was no evidence leaders understood these challenges well enough to address them effectively. For example, the plan to improve on QOF was to hold "QOF points" clinics one day every week to try to catch up at the end of the year. This was not informed by what might be best for patient care and there was no forward strategy for next year in this area.
- Leaders at all levels were visible and approachable. They worked closely with staff and others and told us they prioritised compassionate and inclusive leadership.
- The practice Patient Participation Group (PPG) told us there had been a recent breakdown in communications within the practice between themselves and management staff and that they were not kept informed of important developments, such as premises improvements and their recent queries that had not been responded to.
- There were no effective processes to develop leadership capacity and skills.
- There was an overall lack of insight and proactivity to manage a range of risks and to drive improvement. For example, quality, safety and business risks were not being addressed such as low QOF performance, lack of caution or out of order signage, and CCTV cameras whose function was not clear.

Vision and strategy

The practice had a mission statement but no strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear mission statement and set of values which staff were aware of and understood, but there were no supporting business plans to achieve priorities or practice strategy to measure against.
- The mission statement was to provide dedicated patient care in an environment which is efficient, calm and conducive to promoting good health. Also to provide patients with high quality, accessible care in a safe, responsive and courteous manner.
- The practice services generally met the clinical needs of its population. There were no care plans for patients with long term conditions but palliative care plans were in place for patients.

Culture

We found limited evidence of a culture of high-quality sustainable care.

- However, staff stated they felt respected, supported and valued and there were positive relationships between staff and teams.
- Openness, honesty and transparency were demonstrated when responding to some incidents and complaints. Significant events management was ineffective but the provider was aware of and had examples of compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so.
- Processes for providing all staff with the development they need had weaknesses including induction, training and appraisal.
- Clinical staff, such as nurses were not given protected time for professional development and evaluation of their clinical work.
- The practice promoted equality and diversity and staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

Inadequate

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

Governance arrangements

There was a list of lead roles with staff delegated responsibilities and systems of accountability. However, there were clinical and non-clinical staff leadership and management challenges such as high GP turnover and a new practice manager that had started six months previously.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control, but neither of these areas had been managed effectively.
- Policies, procedures and activities did not operate to ensure safety. For example, the protocol for safety alerts was out of date, the process was unreliable and safety alerts were not consistently acted upon.
- Staff files were not organised and were incomplete and the training monitoring matrix did not align with training evidence available on site.
- The practice did not maintain systems for appropriate standards of premises or equipment maintenance or hygiene.
- The practice had not ensured effective arrangements for patient consent or monitoring of patients on high risk medicines.

Managing risks, issues and performance

Processes for managing risks, issues and performance were not clear or effective.

- There was no effective process to identify, understand, monitor and address current and future risks including risks to patient safety. Management staff were not aware of arrangements for the Control of Substances Hazardous to health (COSHH) but we found related data sheets kept within the cleaning cupboard.
- There were no processes to manage current and future performance with the exception of HR procedures for individual staff. Performance monitoring of some clinical staff was not demonstrated through audit of their consultations, prescribing or referral decisions.
- Practice leaders did not have oversight of crucial areas such as safety alerts or safeguarding because information sources for safeguarding were conflicting and meeting agendas had no standing agenda for these important items. Meeting minutes did not contain a method to ensure clear actions agreed, timescales for actions, or to follow up on previous matters discussed.
- There was evidence of clinical audit to improve patient outcomes although outcomes could not always be clearly ascertained.
- The practice had plans in place and had trained staff for major incidents but there was no fire safety risk assessment, adequate fire action signage, or staff training or drills. The practice was in breach of its own fire safety policy.

Appropriate and accurate information

The practice had not acted on its performance information.

- Quality and operational information was not used to ensure and improve performance or combined with the views of patients.
- The practice had not kept its registration with the CQC up to date as required. For example, it was undertaking the regulated activity of maternity and midwifery services that it was not registered for and had not cancelled its registration to undertake surgical procedures which it was no longer undertaking. The registered Manager had left in 2016 without relevant applications to deregister them or register a new Registered Manager being made to the CQC. The provider's statement of purpose was also out of date.
- Information we received from the practice during the inspection process was contradictory or inaccurate. For example, prior to inspection the provider submitted information that stated none of its nurses were independent prescribers; however, on the day of inspection we found one of its nursing team was a prescriber and no effective arrangements were in place to ensure their work was overseen appropriately to ensure patient safe or effective care.
- Data security arrangements were ineffective such as patient's paper clinical notes being openly accessible to the public and gaps in formal confidentiality agreements for staff.

Engagement with patients, the public, staff and external partners

The practice engaged with and involved patients and staff in discussing and planning services.

- There was an active patient participation group (PPG) that identified recent communication problems with

Are services well-led?

Inadequate

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

some managers. However, they also told us told us improvements had been made as a result of the practice listening to PPG feedback, such as in the reception area.

- We found no evidence the practice had gathered feedback from staff but staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Continuous improvement and innovation

Systems and processes for learning, continuous improvement and innovation were limited to clinical audit to improve patients outcomes.

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 Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How the regulation was not being met:** The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular: • Fire safety including staff training • Lead for health and safety not sufficiently formalised or clear • Patients on high risk medicines • Leaflet shelf immediately above an examination couch • Cervical screening • Safety alerts follow up Arrangements for the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated were ineffective. In particular: • Lack of completion or follow up of related audit • Systems to ensure premises and equipment cleaning • Clinical waste bin • Sharps bin This was in breach of regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The registered person did not have systems and processes in place that operated effectively to prevent abuse of service users. In particular:

- Child safeguarding
- Adult safeguarding

This was in breach of regulation 13(1)&(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The registered person had failed to ensure that all equipment used by the service was properly maintained. In particular: • Electrical and calibration testing • Out of date defibrillator pads The registered person had failed to ensure that all premises and equipment used by the service were secure. In particular: • Unsecured clinical waste bin in a publicly accessible area. This was in breach of regulation 15(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

There were no systems or processes that enabled the registered person to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk. In particular:

- To regularly review the immunisation status of relevant staff and providing vaccinations to staff as necessary in line with Immunisation against infectious diseases requirements
- To monitor the quality and safety of practice nurse prescribing
- Premises issues such as lack of signage to clarify CCTV arrangements
- Patient care plans
- Patient consent and chaperoning
- To follow up at risk patients following attendance in hospital

The registered person had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:

- Patient survey results
- Communications with the PPG
- Clinical performance results
- Premises maintenance such as cleaning
- To ensure patients are offered a chaperone where needed
- Coding patients such as carers

This was in breach of regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing
Family planning services	**How the regulation was not being met:**
Surgical procedures	The service provider had failed to ensure that persons employed in the provision of a regulated activity
Treatment of disease, disorder or injury	

This section is primarily information for the provider

Requirement notices

received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. In particular:

- Safeguarding training
- Mental Capacity Act 2005 awareness / training
- Wound care
- In house appraisal
- Protected time including for CPD
- Induction

This was in breach of regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed **How the regulation was not being met:** The registered person's recruitment procedures did not ensure that only persons of good character were employed. In particular: • To risk assess the need for a DBS check for non-clinical staff The registered person had not ensured that all the information specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 was available for each person employed. In particular: • References checks • A full employment history, together with a satisfactory written explanation of any gaps in employment This was in breach of regulation 19(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.