Dr SKS Swedan & Partner

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr SKS Swedan and Partner on the 10 May 2016. Overall the practice is rated as inadequate.

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

- Some systems and processes had weaknesses or were not in place to keep patients safe. For example, the chaperoning policy and arrangements for reporting and preventing accidents and incidents were not robust.
- Medicines were not always managed safely and effectively. For example refrigerated medicines and Patient Group Directions to allow nurses to administer medicines in line with legislation.
- There were gaps in staff training and the induction programme including fire safety, infection control, annual basic life support and safeguarding.
- Practice performance had been affected by insufficient levels of staffing.
- There was evidence of systemic problems such as breakdowns in working relationships and divides between staff, including the leadership team.
- The leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care.
- Patients were generally positive about their interactions with staff and said they were treated with compassion and dignity.
- The provider was aware of and complied with the requirements of the duty of candour and the partners encouraged a culture of openness and honesty with patients.
- The practice acted on feedback from patients through the Friends and Family test. However, engagement and activity with the patient participation group was limited to one meeting annually.
- Patients generally said they found it easy to make an appointment with a named GP and urgent appointments were available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

The areas where the provider must make improvements are:

- Implement effective chaperoning arrangements and document patient's consent for intrauterine contraceptive device (IUCD, also known as 'the coil') and minor surgery procedures.
- Ensure patients records are contemporaneous and secure.
- Introduce and embed formal governance systems including effective recruitment arrangements and systems for assessing, monitoring, and addressing risks.
- Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the quality of service provision.
- Formalise the leadership structure and ensure there is appropriate leadership capacity to deliver all improvements required, including addressing staff issues such as interpersonal issues and ensuring adequate staff cover.
- Implement robust processes for identifying and accidents/ incidents.
- Take action to ensure safe and effective management of refrigerated medicines, ensure Patient Group Directions are in place to allow nurses to administer medicines in line with legislation, and obtain atropine medicine for patient's emergency use, (recommended for practices that fit coils/for patients with an abnormally slow heart rate).
- Ensure effective arrangements for infection control and management of risks such as Legionella.
- Ensure effective, induction, supervision and appraisal arrangements for all staff in accordance with their role.
- Ensure all staff receive training in Basic Life Support (BLS), infection control, fire safety, chaperoning, and child and adult safeguarding as appropriate to their role.

The areas where the provider should make improvement are:

- Seek to improve identification of and support for patients that are carers.
- Put systems in place to ensure all clinicians are kept up to date with safety alerts and clinical best practice guidelines and introduce a system to monitor use of prescription pads.
- Implement business continuity planning to address the possibility of the plan being damaged or destroyed in the event of premises damage.
- Update the patient's information leaflet to accurately reflect GPs sessions and make suitable arrangements to ensure patients are aware of translation services.

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, or 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 five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

The practice is rated as inadequate for providing safe services and improvements must be made.

- Arrangements for reporting incidents, near misses and concerns were not robust.
- When staff raised safety issues they were not always acted upon.
- Significant events were appropriately recorded and managed and when things went wrong patients received reasonable support, truthful information, and a written apology.
- Practice nursing staff did not receive safety alerts via the practice, were not involved in analysis of significant events, or included in practice meetings where safety issues were discussed.
- Not all arrangements for managing medicines such as refrigerated medicines were safe.
- Several processes were not robust enough to keep patients safe and safeguarded from abuse. For example there were gaps in staff training such as safeguarding, basic life support, infection control, fire safety and arrangements for patients chaperoning.
- The practice generally maintained appropriate standards of cleanliness and hygiene, but there were no sterile gloves available for clinical procedures where required or documentary evidence of medical equipment cleaning.
- Recruitment checks had generally been undertaken prior to employment. However, there were no reference checks undertaken for a member of non-clinical staff.
- Several procedures for monitoring and managing risks to patients and staff were missing or had weaknesses. For example Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings) and the arrangements for covering key members of staff. .
- Failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were mostly comparable to local and national averages.

Summary of findings

- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audit demonstrated limited quality improvement.
- Staff had the role specific skills and experience to deliver care and treatment. However, not all staff had received an annual appraisal or supervision to meet their learning needs and cover the scope of their work.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff understood the relevant consent and decision-making requirements of legislation, but patient's verbal consent had not been recorded and written consent had not been sought for minor surgery or Intrauterine Contraceptive Device (coils) procedures.
- Key clinical and management staff had either been off long term or had not been recruited and this had impacted on patients care, for example there had been a dip in health checks being offered to people between 40 and 74 years old.

The practice had an induction programme for all newly appointed staff. This covered such topics as infection prevention and control and confidentiality, but it did not include, fire safety, health and safety, or safeguarding.

Are services caring?

Requires improvement

The practice is rated as requires improvement for providing caring services.

- Data from the national GP patient survey generally showed patients rated the practice as comparable to others for aspects of GP care, but scores for nurses were lower. The practice said this may have been due to a high turnover of nursing staff.
- Patients generally said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. However, three patients expressed feeling that a particular member of reception staff had not always been polite.
- Information for patients about the services available was easy to understand and accessible.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality. However, several patients we spoke to expressed feeling that a member of reception staff had not always been polite.
- The practice had identified less than 1% of carers on its list and could not provide examples of how they use the register to improve care for carers. Written information was available to direct carers to the various avenues of support available to them.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, it attended quarterly cluster meetings with the CCG and responded to high numbers of patients with diabetes on its list by ensuring these patients were promptly signposted to local ultrasound, breast screening and retinal screening services.
- Most patients we spoke with and the PPG said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- Longer appointments had not been provided for patients with a learning disability.
- The practice patient's information leaflet did not accurately reflect GP sessions.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff.
- The practice nurse ran various health based community groups in a local church, which they had started on their own initiative and with support from another local practice, to encourage patient's general health, exercise and social interaction. Staff told us that four patients or families from the practice were attending these groups.

Are services well-led?

Inadequate

The practice is rated as inadequate for being well-led.

Summary of findings

- The practice had a vision to promote good outcomes for patients but there was no robust strategy or supporting business plans.
- The practice governance framework did not always support the delivery of safe or effective care. For example, some policies were inconsistently implemented or not in place, risks such as refrigerated medicines management were not properly managed and arrangements for business continuity emergency planning were not robust.
- There had been a high level of staff absence or turnover of key staff, management emails had not been dealt with in a timely way, and failsafes for smear test results had lapsed.
- There was evidence of divides between staff and breakdowns in working relationships including the leadership team.
- There was evidence of and that some staff experienced difficulty in approaching some members of the leadership team and that issues staff had raised had not been addressed, including safety issues.
- The leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care.
- There were other areas for improvement for example in training for staff including fire safety and basic life support training, medicines management, and systems for obtaining and recording patients consent.
- There was conflicting information from the practice, in relation to GP staffing, the timing of GP sessions, and the designated lead staff for infection control.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty with patients but not consistently with staff.
- The practice acted on feedback from patients through complaints and its friends and family survey test results.

The patient participation group only met annually, was not routinely kept updated, and did not receive PPG meeting minutes.

Summary of findings

The six population groups and what we found

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

Older people

Inadequate

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The percentage of patients with rheumatoid arthritis, on the register, who had had a face-to-face annual review in the preceding 12 months was 90%, compared to 91% within the CCG and 91% nationally.

People with long term conditions

Inadequate

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

- Patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was comparable with the CCG and national averages over all at 86% compared to the CCG average of 87% and the national average of 89%.
- The percentage of patients with hypertension having regular blood pressure tests was 84%, which was the same as the CCG and national averages of 84%.
- Longer appointments and home visits were available when needed.
- Patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Inadequate

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

- There were 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 A&E attendances. Immunisation rates were comparable for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practices' uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 81%, and the same as the national average of 82%. However, failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice nurse ran various health based community groups in a local church which they had started on their own initiative and with support from another local practice, to encourage patient's general health, exercise and social interaction. Staff told us that four patients or families from the practice were attending these groups.
- We saw positive examples of joint working with midwives and health visitors.
- Seventy-eight per cent of patients diagnosed with asthma, on the register had an asthma review in the last 12 months compared to 78% within the CCG and 75% nationally.
- Patient's verbal consent had not been recorded and written consent had not been sought for minor surgery or Intrauterine Contraceptive Device (coils) procedures.

Working age people (including those recently retired and students)

Inadequate

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

Summary of findings

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- The practice offered additional extended surgery hours through a local hub network of practices every weekday until 9.30pm and from 9am until 12.30pm on Saturdays.
- The practice was not meeting local targets for NHS health checks offered to people between 40 and 74 years old.

People whose circumstances may make them vulnerable

Inadequate 

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

- The practice did not have any homeless people or travellers registered on its list, staff told us these patients had never presented themselves at the practice but would be welcomed if they did.
- The practice held a register of patients with learning disabilities but had not always offered longer appointments for these patients.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. However, a locum GP and two non-clinical staff had not received training on safeguarding children and vulnerable adults relevant to their role.

People experiencing poor mental health (including people with dementia)

Inadequate 

The provider was rated as inadequate for safety, and for well-led, and requires improvement for effectiveness, caring and responsiveness. The issues identified as inadequate or requiring improvement affected all patients including this population group. There were, however, examples of good practice:

Summary of findings

- 100% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was comparable to CCG average of 87% and the national average of 84%.
- Performance for mental health related indicators was 76%, which was comparable to the CCG average at 87% and below the national average of 93%. We asked staff about the lower result for mental health and they told us they had no explanation for the results.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia but had not carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published January 2016. The results showed the practice was performing slightly below local and national averages. Three hundred and ninety two forms were distributed and 79 were returned. This represented 3% of the practice's patient list.

- 57% found it easy to get through to this surgery by phone compared to a CCG average of 61% and a national average of 73%.
- 72% were able to get an appointment to see or speak to someone the last time they tried (CCG average 76%, national average 85%).
- 70% described the overall experience of their GP surgery as fairly good or very good (CCG average 76%, national average 85%).
- 66% said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 66%, national average 78%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 29 comment cards which were all positive about the standard of care received. Patients said they felt they were listened to and the practice was always clean.

We spoke with six patients during the inspection. Most patients said they were satisfied with the care they received and thought staff were generally approachable, committed and caring. However, three said they felt a receptionist had not always been polite. Recent friends and family test survey results showed that most patients said they were either likely or extremely likely to recommend the surgery to someone new to the area.

Areas for improvement

Action the service MUST take to improve

- Implement effective chaperoning arrangements and document patient's consent for intrauterine contraceptive device (IUCD, also known as 'the coil') and minor surgery procedures.
- Ensure patients records are contemporaneous and secure.
- Introduce and embed formal governance systems including effective recruitment arrangements and systems for assessing, monitoring, and addressing risks.
- Seek and act on feedback from relevant persons for the purposes of continually evaluating and improving the quality of service provision.
- Formalise the leadership structure and ensure there is appropriate leadership capacity to deliver all improvements required, including addressing staff issues such as interpersonal issues and ensuring adequate staff cover.
- Implement robust processes for identifying and accidents/ incidents.
- Take action to ensure safe and effective management of refrigerated medicines, ensure Patient Group Directions are in place to allow nurses to administer medicines in line with legislation, and obtain atropine medicine for patient's emergency use, (recommended for practices that fit coils/for patients with an abnormally slow heart rate).
- Ensure effective arrangements for infection control and management of risks such as Legionella.
- Ensure effective, induction, supervision and appraisal arrangements for all staff in accordance with their role.
- Ensure all staff receive training in Basic Life Support (BLS), infection control, fire safety, chaperoning, and child and adult safeguarding as appropriate to their role.

Action the service SHOULD take to improve

- Seek to improve identification of and support for patients that are carers.

Summary of findings

- Put systems in place to ensure all clinicians are kept up to date with safety alerts and clinical best practice guidelines and introduce a system to monitor use of prescription pads.
- Implement business continuity planning to address the possibility of the plan being damaged or destroyed in the event of premises damage.
- Update the patient's information leaflet to accurately reflect GPs sessions and make suitable arrangements to ensure patients are aware of translation services.

Dr SKS Swedan & Partner

Detailed findings

Our inspection team

Our inspection team was led by:

The team included a GP specialist adviser, a practice manager specialist adviser and an Expert by Experience.

Background to Dr SKS Swedan & Partner

The Dr SKS Swedan & Partner practice provides services to approximately 3,100 patients under a General Medical Services (GMS) contract. The practice provides a full range of enhanced services including child immunisations, a baby clinic, and minor surgery. It is registered with the Care Quality Commission to carry on the regulated activities of maternity and midwifery services, family planning services, treatment of disease, disorder or injury, surgical procedures, and diagnostic and screening procedures.

The staff team at the practice included two part time female GP partners collectively providing eight sessions per week, two regular part time male locum GPs both working one session per week, a part time female practice nurse working eight hours per week, a part time practice manager working 26 hours per week, and a team of reception and administrative staff all working a mixture of part time hours.

The practice premises are located within the purpose built Lord Lister Health Centre and are shared with two other GP practices.

Access information we received from the practice was repeatedly conflicting, including with the practice patients information leaflet. We re-checked with the practice management team and have used the latest information received directly from the practice for the purposes of this report.

The practice reception is open between 8.30am to 6.00pm every weekday except Thursday when it closes at 1.00pm. GP appointments are available as follows:

- Mondays from 8.30am to 11.30am and 3.30pm to 6.00pm.
- Tuesdays and Fridays from 9.00am to 12.30pm and 4.00pm to 6.00pm.
- Wednesdays from 1.00pm to 6.00pm.
- Thursday alternating from 8.30am to 11.30am one week and every other Thursday from 9.00am to 12.30pm.

Extended hours are available through the Newham GP Co-op service on Tuesday and Thursday from 6.30pm to 9.00pm and on Saturday from 9.00am to 12.00pm. Additional extended surgery hours are offered through a local hub network of practices every weekday until 9.30pm and from 9am until 12.30pm on Saturdays. Patients are directed to the Newham GP Co-op service when the practice is closed. Appointments include pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who need them.

The practice is located in one of the most deprived areas in England. The area has a higher percentage than the national average of people whose working status is unemployed (13% compared to 5% nationally), and a lower percentage of people over 65 years of age (5% compared to 17% nationally). The average male and female life expectancy for the practice is 77 years for males (compared to 77 years within the Clinical Commissioning Group and 79 years nationally), and 83 years for females (compared to 82 years within the Clinical Commissioning Group and 83 years nationally).

Detailed findings

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This provider had not been inspected previously.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on Dr SKS Swedan and Partner

During our visit we:

- Spoke with a range of staff (GP partners, practice nurse, practice manager, and reception and administrative staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services were provided for specific groups of people and what good care looked like for them. The population groups are:

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Inadequate

Are services safe?

Our findings

Safe track record and learning

The system for identifying and reporting accidents and incidents was not robust. However, significant events otherwise identified were appropriately recorded and managed.

- There was a new accident or incident reporting book available that had not been used. We asked a member if the management team how accidents and incidents were usually reported and they told us that reporting forms were available and accessible to all staff. However, we found no evidence that either reporting system had ever been used and there was no old reporting book available. Staff had differing understandings of how to report an accident or incident and who to report to and one member of staff was not aware of any reporting system. There was no established recording system or reporting structure. We asked a member of the management team about managing accidents and incidents, they told us there were difficulties in implementing or maintaining any systems, and we found evidence of relationship difficulties between the leadership team.
- The practice identified clinical significant events and documentation supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, after the practice system showed an incorrect diagnosis for a patient the practice made contact with them to provide an explanation and apology. They re-checked and corrected the patient's records to ensure accuracy. The practice carried out an analysis of significant events and evidence showed that lessons were shared and action was taken to improve safety in the practice. For example, a patient's hospital letter had not been scanned into the patient record and was needed for reference when a prescription was required. A further copy of the letter was obtained and the practice investigated the incident as a significant event and changed processes to prevent recurrence by ensuring letters requiring scanning were scanned within 24 hours of receipt.
- We reviewed safety records, patient safety alerts and minutes of staff meetings. There was a system in place for cascading safety alerts for example in relation to measles, and safety issues were discussed with staff at monthly meetings where lessons resulting from patient safety issues were learnt and shared. However, the practice nurse did not attend any meetings at the practice or routinely receive minutes, nor did they receive safety alerts. The practice nurse demonstrated an awareness of safety issues and showed us relevant information received elsewhere, for example relating to vaccines for pregnant women.

Overview of safety systems and processes

The practice did not always have clearly defined systems and processes in place to keep patients safe and safeguard from abuse:

- Most arrangements were in place to safeguard children and vulnerable adults from abuse. Policies were accessible to all staff and reflected relevant legislation and local requirements. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare and there was a lead GP partner for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and some staff had received training on safeguarding children and vulnerable adults relevant to their role. Partner GPs and the Practice Nurse were trained to child protection or child safeguarding level 3. However, a locum GP and two non-clinical staff had not received training on safeguarding children and vulnerable adults relevant to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones had received a Disclosure and Barring Service (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). Staff told us they had had been briefed by GPs on how to chaperone and had a chaperone

policy available for reference. We reviewed the chaperone policy but it did not provide instructions on how to chaperone or state the need for chaperones to be trained or have a DBS check. We also checked patient records and found that chaperones had not always been offered as required. The chaperone policy stated that the practice nurse would be available to chaperone on request; however, the practice nurse only worked eight hours per week.

- The practice mostly maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. During the inspection a GP partner told us they were the infection control clinical lead. However, records showed they were not trained and there was no evidence they had liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and four of the eight staff members we checked had received infection control training. Annual infection control audits were undertaken by a non-clinical member of the management team, and we saw evidence that action was taken to address any improvements identified as a result. For example, the practice had changed to single use disposable clinical equipment such as otoscope tips (an otoscope is an instrument designed for visual examination of the eardrum and the passage of the outer ear). However, there were no sterile gloves available for patient's intrauterine contraceptive device (IUCD, also known as 'the coil') or minor surgery procedures. Staff told us that medical equipment such as the ear irrigator was cleaned regularly; however there was no documentary evidence of medical equipment cleaning to support this. After inspection a non-clinical member of the management team told us they were the lead for infection control, and we saw evidence they had been trained in February 2014.
- Not all arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG prescribing teams to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription pads were securely stored but there were no systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. However, old and new PGDs were mixed together and all except one had no authorisation sheet attached as they were loose in the filing box. Staff using PGDs did not know where they were located. We drew staffs attention to this and they put the PGDs in order on the day of inspection. We found most PGDs were satisfactory however one was out of date and another not signed.
- We found that refrigerated temperatures required for medicines had gone out of range five times within the last month and to 22 degrees Celsius on one occasion (the recommended safe range is between two and eight degrees Celsius) . Staff told us no action had been taken after the refrigerator temperature had gone out of range and that that the thermometer which generated the computer temperature monitoring graph was broken. A GP partner told us there was not a member of staff at the practice that knew how to interpret the graph output information, there were no instructions or user manual, and that high temperatures might be due to opening the medicines refrigerator door. A member of staff told us they had raised concerns about refrigerated medicines temperature monitoring but no action had been taken. We checked hand written daily monitoring records and found multiple gaps during April 2016 and May 2016 where no temperatures had been recorded. The cold chain policy had not been implemented and we asked senior practice management staff to quarantine affected medicines and stop administering them until they received safety advice from the relevant manufacturers that medicines were either safe for use, or required disposal. However, one of the GP partners initially said that temperatures going out of range without appropriate follow action up was "normal". We discussed this with the leadership team again and they confirmed medicines would not be used unless confirmed safe and staff listed medicines for quarantining. Immediately after inspection the practice sent us evidence it had ordered a new medicines refrigerator. However, it had not taken remaining actions in line with national guidelines and we subsequently followed up with the practice again, until it provided evidence of actions being completed.
- We reviewed five personnel files and found appropriate recruitment checks had mostly been undertaken prior

to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, there was no evidence of references for a member of non-clinical staff which was in breach of the practices recruitment policy.

Monitoring risks to patients

Risks to patients were not always assessed or well managed.

- Some procedures were in place for monitoring and managing risks to patient and staff safety, there was a poster in the reception office which identified local health and safety representatives. The practice told use premises risk assessments were carried out by the landlord and there was some documentary evidence of this such as regular fire drills and an up to date fire risk assessment carried out by the landlord which included actions taken as a result, for example removing clutter from public pathways. Two staff members were trained as fire marshals in February 2016 but no other staff were trained in fire safety. All electrical equipment was checked to ensure it was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and a Legionella risk assessment dated November 2014 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). However, the there was no evidence of actions taken to address areas of high risk identified in the Legionella risk assessment or practice specific health and safety risk assessment, for example to assess risks to its staff.
- Robust arrangements were not in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Staff had identified a shortage of practice nursing cover and there were no arrangements in place for cover in their absence. Staff told us they had tried to recruit more practice nurses and five nurses had left during the last two to three years. Failsafe systems to ensure results were received for all samples sent for the cervical screening programme had lapsed due to gaps in practice nursing staff cover, and had only recently restarted. For example, no records had been made between 25 August 2015 and 25 November 2015, or between 27 November 2015 and 25 April 2016.

Arrangements to deal with emergencies and major incidents

Not all arrangements were adequate to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Five out of nine staff members whose files we checked had received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely. However, the practice did not have emergency use atropine (recommended for practices that fit coils/for patients with an abnormally slow heart rate).
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage which included emergency contact numbers for staff. However, a copy was not kept off site to address the possibility of the plan being destroyed if there was premises damage such as a fire or flood.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep GPs up to date. GPs had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through audits.
- There were no such systems in place for the practice nurse and they stayed updated through their own initiative.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 92% of the total number of points available, with 7% exception reporting. (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).

Data from 1 April 2014 to 31 March 2015 showed the practice was an outlier for QOF clinical target:

- The ratio of reported versus expected prevalence for Chronic Obstructive Pulmonary Disease (COPD) which was 0.11 compared to 0.35 within the CCG and 0.63 nationally. However, the practice had a relatively young population and staff told us a large proportion of their patients were from ethnic and religious groups who tended not to smoke.

The practice was not an outlier for any other QOF (or other national) clinical targets. Data from 2014 - 2015 showed;

- Performance for diabetes related indicators was 86%, which was similar to CCG and national averages (CCG average 87%, national average of 89%)
- The percentage of patients with hypertension having regular blood pressure tests was 84%, which was similar to the CCG and national averages of 84%.
- Performance for mental health related indicators was 76%, which was similar to the CCG average of 87% and below the national of average 93%. We asked staff about the lower result for mental health and they had nothing to add to expain the results.

There was some evidence of quality improvement including clinical audit.

- There had been three clinical audits completed in the last two years, one of these was a completed audit cycle where the improvements made were implemented and monitored. For example, the practice had improved health checks for patients with schizophrenia by increasing the amount of patients receiving health checks from five patients (56%) to seven patients (78%) of patients.
- The practice participated in local audits and national benchmarking. Findings were used by the practice for example to improve prescribing for patients on antidepressants in line with best practice guidelines, and to ensure patients at risk were followed up promptly after being discharged from hospital.

Effective staffing

Staff had role specific skills, knowledge and experience to deliver effective care and treatment. However, there were gaps in some elements of staff management and training:

- The practice had an induction programme for all newly appointed staff. This covered topics such as confidentiality but it did not include fire safety, health and safety, or safeguarding.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. One of the partner GPs had a diploma in dermatology and was part way through completing training to initiate insulin for patients with diabetes. Staff administering vaccines, delivering contraceptive services, undertaking minor surgery and taking samples for the cervical screening programme had received specific training. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources.

Requires improvement

Are services effective?

(for example, treatment is effective)

- Not all staff had received an annual appraisal or support to meet their learning needs and cover the scope of their work. For example, one clinician that worked eight hours per week had never received supervision or appraisal and a member of the management team had not received an appraisal since 2013. Some staff received training that included safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training, and staff meetings and reviews of practice development needs had taken place. GPs had been revalidated and received clinical supervision.
- There had been gaps in practice nursing and management staff cover either due to staff turnover or absence. Staff told us their 2014-2015 QOF results were lower than the previous year and felt this was mainly around diabetes care, the lack of practice nursing capacity, and management of team sickness absence. Clinical Effectiveness Group (CEG) data showed the practice was below targets for patient's invitation and uptake of NHS health checks for 40 to 74 year olds in Q3 and Q4 of 2015.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff had not always sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance and the practice patient record system had a template to record patients consent. However, a GP partner told patients consent for minor surgery and Intrauterine Contraceptive Device (IUCD or "coils") procedures was implied. Patient's verbal consent had not been recorded and written consent had not been sought.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified some patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol. Patients were signposted to the relevant service, for example local carers support groups.
- The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 81%, and the same as the national average of 82%.

The practice encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90% to 94% and five year olds from 73% to 93%

Requires improvement

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 29 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when patients needed help and provided support when required.

Results from the national GP patient survey published in January 2016 showed patients generally felt they were treated with compassion, dignity and respect. The practice was comparable for its satisfaction scores on consultations with GPs but was below for nurses. For example:

- 75% said the GP was good at listening to them compared to the CCG average of 83% and national average of 89%.
- 78% said the GP gave them enough time (CCG average 79%, national average 87%).
- 91% said they had confidence and trust in the last GP they saw (CCG average 91%, national average 95%).
- 76% said the last GP they spoke to was good at treating them with care and concern (CCG average 76%, national average 85%).
- 73% said the last nurse they spoke to was good at treating them with care and concern which was comparable to the CCG average of 80%, and below the national average 91%.
- 73% said the last nurse they saw or spoke to was good at giving them enough time which was comparable to the CCG average of 82%, and below the national average of 92%.
- 71% said the last nurse they saw or spoke to was good at listening to them which was comparable to the CCG average of 82%, and below the national average of 91%.
- 79% said they found the receptionists at the practice helpful (CCG average 80%, national average 87%).

We asked staff about the lower GP Patient Survey scores for nurses and they told us the high turnover of nursing staff may have impacted on scores. There had been a high turnover of practice nurses and they were seeking to recruit a long term practice nurse.

Care planning and involvement in decisions about care and treatment

We spoke with six patients who all told us they felt involved in decision making about the care and treatment they received. They also told us they generally felt listened to and supported by staff; however, three patients expressed feeling that a particular member of reception staff had not always been polite and we shared this feedback with the practice team. Patients told us they had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responses to questions about their involvement in planning and making decisions about their care and treatment were similar to or below local or national averages. For example:

- 76% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 79% and national average of 86%.
- 68% said the last GP they saw was good at involving them in decisions about their care (CCG average 74%, national average 82%).
- 67% said the last nurse they saw was good at involving them in decisions about their care which was comparable to the CCG average 77%, and below the national average 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Requires improvement

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language, but there was no notice in the reception areas or practice leaflet informing patients this service was available.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. For example, mental health services such as "Help" and "Talk to us".

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 12 patients as carers which was less than 1% of the practice list. The practice could not provide examples of how they used the register to improve care for carers. However, written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual 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.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, it attended quarterly cluster meetings with the CCG and responded to high numbers of patients with diabetes on its list by ensuring these patients were promptly signposted to local breast screening, ultrasound and retinal screening services where needed.

- The practice offered extended hours through the Newham GP Co-op service on Thursday from 6.30pm to 8.30pm and on Saturday from 9.00am to 12.00pm for working patients who could not attend during normal opening hours.
- Staff told us longer appointments were offered for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS.
- There were disabled facilities such as step free access and a disabled toilet.
- There was no hearing loop; however, British Sign Language (BSL) services were available via the practices translation service provider and we saw evidence of its use.
- Baby changing facilities were available.

The practice nurse ran health based community groups in a local church which they had started on their own initiative with support from another local practice, to encourage patients to exercise and increase social interaction. Uptake at the practice was limited, for example:

- A "Health Club" exercise class mainly for Muslim women who felt more comfortable attending a women only class. Two patients from the practice had attended the group.
- A "Baby Toddler Group" in response to Newham's high rate of children under three years old and families living in cramped conditions, to provide space for children to exercise in a simulating environment, and to explore and discover their skills with "soft play" resources such as bouncy castles and a ball pool, as well as toys and dressing up clothes. Staff told us relatives and carers could make snacks and beverages, and a mid-day fruit and pasta meal was provided that was suitable for all religions. The practice told us two families had been referred to this group.

Access to the service

We received conflicting information from staff and the practice leaflet in relation to timing and provision of GPs sessions. We re-checked with the practice management team and used the latest information received directly from the practice for the purposes of this report. Staff told us they would update the patients practice leaflet.

The practice reception was open between 8.30am to 6.00pm every weekday except Thursday when it closed at 1.00pm. GP appointments were available as follows:

- Mondays from 8.30am to 11.30am and 3.30pm to 6.00pm.
- Tuesdays and Fridays from 9.00am to 12.30pm and 4.00pm to 6.00pm.
- Wednesdays from 1.00pm to 6.00pm.
- Thursday alternating from 8.30am to 11.30am one week and every other Thursday from 9.00am to 12.30pm.

Extended hours appointments were offered through a local hub network of practices every weekday until 9.30pm and from 9am until 12.30pm on Saturdays. Appointments included pre-bookable appointments, home visits, telephone consultations and urgent appointments for patients who need them. Patients were directed to the Newham GP Co-op service when the practice was closed.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 63% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 54% patients said they always or almost always see or speak to the GP they prefer (CCG average 47%, national average 59%).

Most people told us on the day of the inspection that they were able to get appointments when they needed them.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system for example a complaints booklet and poster in the reception area.

We looked at six complaints received in the last 12 months, two in detail and found these were dealt with satisfactorily in a timely way and with openness when dealing with the complaint. For example, the practice responded promptly to a patient who felt staff were unhelpful, they clarified expectations in relation to interpersonal conduct, made an apology and followed up with a written response. Lessons were learnt from individual concerns and complaints, and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, complaints were discussed in staff meetings and the practice contacted a patient to provide an explanation and apology after they had difficulty in getting an emergency appointment for their child. The practice provided a follow up appointment and changed its system to ensure staff give children priority appointments.

Are services well-led?

Inadequate

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

Our findings

Vision and strategy

- The practice did not have a mission statement, but staff knew and understood the practice vision and values by attending monthly whole staff meetings. The practice did not have a robust strategy or supporting business plans and governance arrangements were limited or had weaknesses.

Governance arrangements

The practice governance framework did not always support the delivery of safe care or effective care:

- The staffing structure was not clear and there was no staffing chart or reference list shared with staff whose roles and responsibilities were sometimes unclear, for example in relation to infection control.
- Some specific policies were available to all staff but not always implemented. For example the cold chain policy, recruitment policy and chaperone policy.
- Arrangements for identifying, recording and managing risks and implementing mitigating actions were not always robust. For example, accident and incident reporting arrangements were unclear and there was no evidence of actions taken to address areas of high risk identified in the Legionella risk assessment carried out in 2014 (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- A comprehensive understanding of the performance of the practice was maintained but not necessarily acted upon, for example in relation to lapsed failsafe procedures to follow up patient's cytology test results.
- Clinical audit was used to monitor quality and to make improvements.
- PGDs were disorganised, for example old and current documents were mixed together, one was out of date and another had no authorised signatures.
- The practice provided us with conflicting information, sometimes repeatedly in relation to GP sessions provided, the timing of these sessions, and the lead for infection control and it was difficult to establish an accurate picture of the practices arrangements.
- We noted that GP appointment information on the patient's information leaflet was inaccurate. Staff told us they would update the practice leaflet.
- After inspection we noted there had been a six week backlog of practice management related emails in March 2016 due to lack a of cover for absent staff.
- There were gaps in arrangements for staff recruitment, supervision and appraisal.
- Several staff members were registered as patients at the practice and there were no confidentiality arrangements in place to ensure staff medical records could not be viewed by practice colleagues.
- There was no backup of the business continuity plan or copy held off the premises to address the possibility of it being destroyed in the event of premises damage, such as a fire or flood.

Leadership and culture

On the day of inspection the leadership team did not consistently demonstrate they had the experience, capacity and capability to run the practice and ensure high quality care. For example, a GP partner had described unsafe arrangements for refrigerated medicines as "normal". There was evidence of divides between staff and the leadership team. For example, some staff told us they could approach some of the partners; however, other staff felt they could not.

There was evidence of breakdown in staff working relationships and staffing issues had not been managed well enough to assure safe or effective delivery of care. For example continuity of care had been compromised due to factors such as extended periods of staff absence and/ or a high turnover of key staff such as practice nurses. There were other areas that required improvement, for example staff induction and training such as fire safety and basic life support, medicines management, and systems for seeking and recording patients consent.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). The partners encouraged a culture of openness and honesty between the practice and its patients, for example following complaints and significant events. The practice had systems in place to ensure that when things went wrong with care and treatment:

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

Are services well-led?

Inadequate

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

- The practice kept written records of verbal interactions as well as written correspondence.

The leadership structure did not demonstrate operational effectiveness and not all staff felt supported by the leadership team.

- Staff told us the practice held regular team meetings and team social events.
- Some staff we spoke to were not involved in discussions about how to run and develop the practice and there was evidence staff had difficulty approaching one or other of the GP partners. The partners had not always encouraged all members of staff to identify opportunities to improve the service.

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

The practice listened to feedback from patients but had not proactively engaged patients. The practice did not always listen and respond to staff.

- The practice had gathered feedback from patients through analysing the Friends and Family test survey data and complaints received and had implemented improvements as a result. For example, it improved patient reminders for appointments by telephoning patients to confirm their attendance the following day, this also reduced wasted appointments.
- The PPG only met annually and had not carried out patient surveys; members told us they had submitted information for the practice to consider a few months previously but had not received meeting minutes and it was too early to know whether improvements had been made. PPG members were complimentary and positive about the practice. For example, they told us continuity of care was good and that the practice took account of the needs of patients who may be more vulnerable, for example very old and very young patients.
- The practice had gathered some feedback from staff through staff meetings, appraisals and generally through day to day discussion. Some staff issues had been addressed. However, there was evidence some staff had been discouraged from approaching GP partner staff, and that other issues raised, including safety issues had not been addressed.

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 Maternity and midwifery 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 person did not do all that was reasonably practicable to assess, monitor, manage and mitigate risks to the health and safety of service users such as infection control for example cleaning of medical equipment and providing sterile gloves for IUCD or minor surgery procedures. The registered person did not have staffing risk assessments, and there was no evidence that identified areas of high risk relating to Legionella had been addressed. The registered person had not ensured safe medicines management such as robust Implementation of Patient Group Directions to allow nurses to administer medicines in line with legislation and, nor had they ensured the safety of refrigerated medicines that had gone out of the recommended temperature range or obtained atropine medicine for patient's emergency use. This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:** We found that the provider could not demonstrate appropriate training and induction arrangements for

This section is primarily information for the provider

Requirement notices

staff such as safeguarding, fire safety, chaperoning, infection control, and basic life support training and regular support for all staff such as appraisal and supervision.

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

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** The registered person had not ensured systems and processes were established and operated effectively such as accident and incident reporting and recording, recruitment, dissemination of safety alerts information, and chaperoning. The provider had not ensured effective arrangements for patients chaperoning or maintenance of failsafe systems for patient's cervical cytology results. The registered person did not record patient's verbal or seek written consent for IUCD and minor surgical procedures and had not ensured confidentiality of medical records for staff that were registered as patients. The registered person did not seek and act on feedback from relevant persons for the purposes of continually evaluating and improving such services. The registered person did not have effective systems in place to assess, monitor and mitigate risks. The registered person had not addressed staffing issues such as interpersonal issues between staff and arrangements for the designated infection control lead were unclear. The registered person had not ensured the leadership had the experience, capacity and capability to run the practice and ensure high quality care. This was in breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.